SHRM® Health Care Benchmarking Study

2010 Executive Summary

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SHRM CUSTOMIZED BENCHMARKING SERVICE

- Database of more than 6,000 organizations
- To order a complete analysis of the results customized to your organization, please see pages 21-22.

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In 2009, the average annual cost of health care per covered employee was $8,026, a 14.1% increase from the 2008 average health care cost of $7,033. Organizations offered an average of two health care plans for employees to choose. While preferred provider organizations (PPOs) were the most prevalent plan type offered to employees, they were not the least expensive plan type available—an indication that organizations are not basing health care decisions on costs alone. Because health care is one of the most desired employee benefits, organizations have to balance the plan’s cost with its components, which should be desirable enough to attract and retain organizational talent.

About This Report
The purpose of the SHRM Health Care Benchmarking Study is to provide HR professionals with key health care measures. In business, where the need to measure is strong, benchmarking can help identify an organization’s health care plan’s strengths and weaknesses, create a framework for managing change and encourage employees toward continuous improvement.

Yet for some HR professionals, when it comes to measuring activities around health care costs, concrete measures can feel elusive. Numbers that relate to the context of a specific business, particularly the same industry, employee size, organizational revenue and geographic location, are usually difficult to find. But it is precisely this organizational profiling that is most beneficial in order to enable similar organizations to compare themselves to each other.

This executive summary contains key metrics from nearly 3,000 organizations on health-care-related costs and practices such as premiums, cost-sharing, deductibles, co-pays, self-insurance and stop loss funding. SHRM’s database collection initiative in early 2010 yielded more than 3,000 additional organizations that together are part of the SHRM Customized Benchmarking Service, which is detailed on page 21. This executive summary and the SHRM Customized Benchmarking Service provide more than 140 benchmarks for many industries, so that comparisons can be made, when appropriate, within a similar industry.

On March 23, 2010, the Affordable Care Act was signed into law, becoming the largest health care reform bill in decades. The requirements outlined in this legislation, such as the elimination of lifetime maximum benefits, make some of the measures of coverage in the current report not relevant to future benchmarks in health care. However, these metrics are included in this report because at the time they were important strategic decisions for employers in selecting benefits that make their organizations competitive in attracting and retaining talent.

For information about additional metrics, please see a sample customized report on page 23. A glossary of metric terms, definitions and calculations is available on page 15.
Key Metrics and Data Collected
(Number of organizations responding = 2,971)

| Health Care Coverage and Specific Stop Loss Coverage Prevalence | Health Care Cost, Waiting Period and Specific Stop Loss Coverage Amount | Consumer-Driven Health Plan
---|---|---
- Percentage of organizations providing employee health care coverage | - Total annual health care cost per covered employee* | - Employer contribution to monthly health care premium for employee-only coverage*
- Percentage of organizations providing spouse health care coverage | - Waiting period (in months) for coverage for new employees | - Percentage of premium employer pays for employee-only coverage*
- Percentage of organizations providing same-sex domestic partner health care coverage* | - Amount of specific stop loss (SSL) coverage* | - Percentage of premium employer pays for spouse or domestic partner coverage*
- Percentage of organizations providing opposite-sex domestic partner health care coverage* | - Percentage of organizations with self-funded health care* | - Annual out-of-network deductible for employee-only coverage*
- Percentage of organizations with self-funded health care* | - Percentage of organizations with specific stop loss (SSL) coverage* | - Co-pay for in-network primary care office visits for employee-only coverage*
- Percentage of organizations with specific stop loss (SSL) coverage* | - Health Maintenance Organization, Exclusive Provider Organization, Preferred Provider Organization, Point of Service and Indemnity Plans | - Maximum lifetime benefit amount for employee-only coverage*

| Health Care Costs for All Plans Combined | Prescription Drug Coverage | Consumer-Driven Health Plan: High-Deductible Plan
---|---|---
- Employer contribution to monthly health care premium for employee-only coverage* | - Employer co-pay for generic medication | - Employer contribution to monthly health care premium for employee-only coverage*
- Percentage of premium employer pays for employee-only coverage | - Employee co-pay for formulary brand medication | - Percentage of premium employer pays for employee-only coverage*
- Percentage of premium employer pays for spouse or domestic partner coverage | - Employee co-pay for non-formulary brand medication | - Percentage of premium employer pays for spouse or domestic partner coverage*
- Annual out-of-network deductible for employee-only coverage | - Employee co-pay for generic medication 90-day mail-order supply | - Annual out-of-network deductible for employee-only coverage*
- Co-pay for in-network primary care office visits for employee-only coverage | - Employee co-pay for formulary brand medication 90-day mail-order supply | - Co-pay for in-network primary care office visits for employee-only coverage*
- Maximum lifetime benefit amount for employee-only coverage

| Employee Participation and Plans Offered | | Consumer-Driven Health Plan: Health Savings Account and Health Reimbursement Account
---|---|---
- Percentage of employees enrolled | - Prescription Drug Coverage | - Employer contribution to a health savings account*
- Percentage of organizations offering plan | - Consumer-Driven Health Plan: High-Deductible Plan | - Maximum allowable employee contribution to a health savings account
- Number of health care plans offered | - Consumer-Driven Health Plan: Health Savings Account and Health Reimbursement Account | - Employer contribution to a health reimbursement account

*Metrics reported in this executive summary. The full SHRM Customized Benchmarking Database contains more than 140 metrics and is available at www.shrm.org/benchmarks.

Industries Surveyed

- Administrative, support, waste management, remediation services
- Arts, entertainment, recreation
- Association—professional/trade
- Biotech
- Construction, mining, oil and gas
- Educational services
- Finance
- Government/public administration—federal
- Government/public—state/local
- Health care, social assistance
- High-tech
- Insurance
- Management companies, enterprises
- Manufacturing (durable goods)
- Manufacturing (nondurable goods)
- Pharmaceutical
- Publishing, broadcasting, other media
- Real estate, rental, leasing
- Retail/wholesale trade
- Services—accommodation, food and drinking places
- Services—professional, scientific, technical
- Telecommunications
- Transportation, warehousing
- Utilities
- Other services
Methodology

Purpose
The 2010 SHRM Health Care Benchmarking Study was conducted in order to collect health care metrics across various industries. The study collected data on health-care-related costs and practices such as premiums, cost-sharing, deductibles, co-pays, self-insurance and stop loss coverage. In addition, organizational data, such as employee size and geographic region, were obtained. Data were collected for 2009, along with expectations for revenue change in 2010.

Survey
The survey was created by SHRM’s Strategic Research Program and was reviewed by the SHRM Total Rewards Special Expertise Panel. The panel is made up of SHRM members who are experts in the field of health care, compensation, retirement, bonuses and other rewards.

Participants
SHRM members who were HR managers, assistant or associate directors, directors, assistant or associate vice presidents, vice presidents or presidents were included in the sample. The members had to meet the following criteria: have a valid e-mail address and business phone number, have not been selected to participate in a survey with SHRM in the past three months, and be residents of the United States.

Procedure
In February 2010, an e-mail that included a link to the SHRM Benefits Benchmarking Survey was sent to 13,000 randomly selected SHRM members who were senior HR professionals. Of these, 2,971 senior HR professionals responded on behalf of their organizations, yielding a response rate of 23%. The survey was accessible for a period of eight weeks.

In an effort to encourage participation in the study, respondents were informed that they would be entered into a drawing to be one of 40 respondents to receive a $25 American Express gift certificate. In addition, participants received an all-industry report that consisted of 63 metrics. Ten reminders were sent over a period of eight weeks.

Quality Control
Every effort was made to ensure the accuracy of the data. The data were put through a rigorous accuracy check process. The survey included many quantitative questions that were checked to ensure that they were understood by respondents and that the data submitted were accurate. For example, the total cost of health care paid by the organization had to be less than the total cost of operating expenses for the organization. Overall, there were few inconsistencies identified within the data. When inconsistencies were identified, steps were taken to resolve the discrepancy. If the data could not be verified and appeared inaccurate, they were excluded from the analysis. This was done to ensure that the highest quality data were included in the study.
Benchmarking is rapidly becoming an indispensable tool for HR professionals. It is a mechanism for measuring processes, practices and results against the competition or “peer” companies in order to improve performance. Used wisely, it can transform a company’s HR and people management strategies by showing how human capital practices influence organizational performance.

HR professionals can use benchmarking data to compare their organization against its competitors or other similar organizations. For example, HR professionals can compare their organization’s health care costs with similar organizations to see if the discrepancy is large enough to warrant further analysis. Benchmarking also protects areas or programs that are performing well. For instance, if line executives want to lower health care costs by increasing premiums and co-pays, benchmarking data may show that the organization’s current health care costs are in line with its industry. In fact, lowering costs far below competitors’ costs might actually jeopardize the organization’s ability to attract and retain the right talent to achieve organizational objectives.

Benchmarking can also create support and momentum for organizational change. For example, making changes to existing pay practices may be difficult, unless there is objective benchmarking data that can support otherwise. Likewise, if the HR professional wants to alter an organization’s long-standing practice of not offering same-sex domestic partner dependent care coverage, making that argument alone, without benchmarking data, is very difficult. Benchmarking data can help make the case.

CEOs and board-level executives also depend on quality benchmarking data to make strategic decisions that affect their organizations. In fact, benchmarking is more effective when used as part of an overall business strategy. It is less effective, however, when companies use benchmarking only for short-term cost reductions and not part of a long-term strategy. An example of this occurs when an organization lowers training budgets to meet short-term budget goals. While this may achieve a short-term objective, it may have a negative impact on the development of skills needed for organizational success. Thus, over the long term, the knowledge and skills of the organization’s human capital start to lag behind the market, and the organization loses its competitive advantage.

Understanding the Data
As you compare your own data against data from other organizations, keep the following in mind:

1. A deviation between your figure (for any health care metrics) and the comparative figure is not necessarily favorable or unfavorable; it is merely an indication that additional analyses may be needed. Health care metrics that relate more closely to the context of your organization’s industry, revenue size, geographic location and employee size are more descriptive and meaningful than information that is more generic in nature; such as all industries combined. The larger the discrepancy between your figure and those found in this executive summary, the greater the need for additional scrutiny.

2. In cases where you determine that large deviations do exist, it may be helpful to go back and calculate the same health care metric for your organization over the past several years to identify any existing trends.
3. The information in this executive summary should be used as a tool for decision-making rather than an absolute standard. Because companies differ in their overall business strategy, location, size and other factors, any two companies can be well managed, yet some of their health care metrics may differ greatly. No decision should be made solely based on the results of any one study.

**Working With the Data**

The information in this executive summary is designed to be a tool to help you evaluate decisions and activities that affect your organization’s total rewards strategy. When reviewing these data, it is important to realize that business strategy, organizational culture, leadership behaviors and industry pressures are just a few of the many factors that drive various health care metrics. For example, an industry that generally hires nonskilled labor, such as construction, may have less costly benefits packages than the high-tech industry, which hires specialized knowledge workers. This is because organizations in the high-tech industry may need to have richer, more attractive benefits plans to make them more enticing in order to attract “hard-to-find” knowledge workers.

Absolute measures are not meaningful in isolation—they should be compared with one or more measures to determine whether a satisfactory level exists. Other measures, for example, might be your organization’s past results in this area or comparatives based on organizational size, industry or geographic location.

**Notes and Caveats**

**Number of organizations:** The number of organizations (indicated by “n”) is noted in each table and indicates the number of organizations (not individuals) that provided data relevant to a particular table. The number of organizations varies from table to table because some organizations did not respond to all of the questions. Organizations may not have responded to a question on the survey because all or some part(s) of the question were not applicable or because the requested data were unavailable. This also accounts for the varying number of responses within a table.

**Confidence level and margin of error:** A confidence level and margin of error give readers some measure of how much they can rely on survey responses to represent all of SHRM member organizations. Given the level of response to the survey, SHRM Research is 95% confident that responses given by all responding organizations can be generalized to all SHRM members, in general, with a margin of error of approximately 1.8%. For example, 71% of the responding organizations reported that they were for-profit. With a 1.8% margin of error, the reader can be 95% confident that between 69.2% and 72.8% of SHRM members come from for-profit organizations. It is important to know that as the sample size decreases, the margin of error increases.

**Minimum respondents for summary calculations:** No summary calculations were made for items with fewer than 10 participating organizations. Tables illustrating 25th percentile, median and 75th percentile should be interpreted with caution when the number of responding organizations is small.

**Extreme values dropped:** Due to the nature of the data in the current study, data that were three standard deviations above the average were excluded. In other words, 0.5% of the data were omitted from the analysis. The extreme outliers, or data anomalies, can skew the results, leading to much higher averages among the measures.

**Table and figure percentages:** Where relevant, data depicted in tables and figures may not add to exactly 100% due to rounding. In addition, percentages may exceed 100% due to multiple response options (i.e., organizations may respond to more than one category for the same question).

**Other categories:** In some cases, participating organizations included “other” as a response to a survey question. Efforts were made to examine the verbatim content of the “other” responses and recategorize them into the categories listed. Oftentimes, verbatim content was distinctive to the organization, making it impossible to recategorize.
Key Findings

Cost of Health Care
The average annual health care cost per covered employee in 2009 for all industries was $8,026, including employer-paid premiums, administration costs and any possible individual medical claims covered by the employer. That is, organizations typically paid $8,026 in health care costs for each employee who enrolled in an employer-sponsored health care plan. Yet, actual health care costs for any organization depend on many factors. Though not an exhaustive list, these factors include the level of health care coverage being offered, demographic make-up of those being insured, the actual percentage the organization contributes to health care premiums and the history of insurance claims the organization filed in previous years. Of the four sectors listed in Table 1, publicly owned for-profit companies had the highest average health care premium for employee-only coverage at $448. Most organizations use health care plans as a part of a total rewards strategy to recruit and retain talent. Based on the knowledge, skills and abilities (KSAs) of the workforce they need to attract, organizations will often balance plan benefits with the costs that their industry financial margins can support. The industry with the highest average employer contribution to monthly health care premium for employee-only coverage was government/public—state/local industry, showing a 124% increase over the construction, mining, oil and gas industry, which had the lowest number in this category.

In addition, organizations that had three or more plans were noted to have lower median health care costs than those organizations that offered only one plan type to their employees. By offering two or more plans, organizations may be able to save costs because employees who use health care less frequently are more likely to choose a less expensive plan with lower premiums. For example, healthy, early-career employees often choose plans based on less costly premiums with lower health care coverage because their health care use is lower.

As organizations combat higher health care costs, they often design health care benefits to incentivize employees for making financially sound health care choices. Such strategies include providing lower employee co-pays for in-network office visits, offering lower employee deductibles for less costly plans and paying a higher proportion of premiums for employees.

| Table 1: Employer Contribution to Monthly Health Care Premium for Employee-Only Coverage (by Organization Sector) |
|---|---|---|---|---|
| N | 25th Percentile | Median | 75th Percentile | Average |
| All industries | 729 | $175 | $306 | $405 | $338 |
| Government agency | 113 | $60 | $265 | $338 | $284 |
| Nonprofit organization | 390 | $150 | $280 | $372 | $306 |
| Privately owned for-profit organization | 174 | $281 | $386 | $472 | $410 |
| Publicly owned for-profit organization | 52 | $86 | $393 | $530 | $448 |

Source: SHRM Health Care Benchmarking Study (2010)
**Does Organizational Size Matter?**

Organizational size makes a difference when it comes to health care costs. In small-staff-sized organizations (1-99 FTEs), the employer contribution for monthly health care premium for employee-only coverage was $378, compared with $319 and $314 in medium (100-499 FTEs) and large (500 or more FTEs) organizations, respectively. With fewer employees, small organizations have less negotiating power to obtain better rates of coverage on a per-employee basis. Because small organizations typically have a less diverse workforce than large ones, they also have less opportunity to offer a range of plans that would include less expensive health care plans catered to a healthier population that values lower premiums. From an insurer’s perspective, a small organization is unable to spread the financial risks the provider may incur if there are several employees who need expensive medical treatment. When an employee in a small organization has a serious illness, the cost for that risk is spread over fewer employees, and therefore, the cost per employee is greater than in larger organizations. This higher risk for the insurer translates to higher premium costs for the organization. This means smaller organizations shoulder higher health care costs. Yet because smaller organizations are generally seen as important growth engines for the economy, there is a concern that high health care costs for small organizations may inhibit economic growth.

Overall, large organizations offer more plans than do small organizations. While this is true in health care, it is also true for other benefits, as noted in SHRM’s 2010 Employee Benefits survey report. Large organizations typically have more money to invest in their total rewards strategy and thereby offer a greater variety of benefits. Finally, large organizations typically have larger HR departments and therefore have the staff resources to negotiate extensively with vendors in crafting tailored health care plans for their organizations. The actual costs of employer contributions to monthly health care premiums for employee-only coverage based on organizational size are listed in Table 2.

**Response to Costs: Consumer-Driven Health Care Plans**

As frustration mounts about rising health care costs, global competition and lower quality of health care, new solutions are spawned. The consumer-driven health care plan (CDHP) has emerged over the last several years as a

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### Table 2: Employer Contribution to Monthly Health Care Premium for Employee-Only Coverage (by Organization Staff Size)

<table>
<thead>
<tr>
<th>Staff Size</th>
<th>N</th>
<th>25th Percentile</th>
<th>Median</th>
<th>75th Percentile</th>
<th>Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Small (1 to 99 eligible employees)</td>
<td>240</td>
<td>$186</td>
<td>$314</td>
<td>$421</td>
<td>$378</td>
</tr>
<tr>
<td>Medium (100 to 499 eligible employees)</td>
<td>268</td>
<td>$167</td>
<td>$302</td>
<td>$405</td>
<td>$319</td>
</tr>
<tr>
<td>Large (500 or more eligible employees)</td>
<td>216</td>
<td>$171</td>
<td>$305</td>
<td>$395</td>
<td>$314</td>
</tr>
</tbody>
</table>

Source: SHRM Health Care Benchmarking Study (2010)

### Table 3: Consumer-Driven Health Care Plans

<table>
<thead>
<tr>
<th></th>
<th>N</th>
<th>25th Percentile</th>
<th>Median</th>
<th>75th Percentile</th>
<th>Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employer contribution to monthly health care premium for employee-only coverage</td>
<td>121</td>
<td>$126</td>
<td>$272</td>
<td>$334</td>
<td>$241</td>
</tr>
<tr>
<td>Percentage of premium employer pays for employee-only coverage</td>
<td>286</td>
<td>75%</td>
<td>86%</td>
<td>98%</td>
<td>80%</td>
</tr>
<tr>
<td>Percentage of premium employer pays for spouse or domestic partner coverage</td>
<td>269</td>
<td>50%</td>
<td>75%</td>
<td>86%</td>
<td>67%</td>
</tr>
<tr>
<td>Annual out-of-network deductible for employee-only coverage</td>
<td>227</td>
<td>$1,500</td>
<td>$2,500</td>
<td>$3,000</td>
<td>$2,880</td>
</tr>
<tr>
<td>Maximum lifetime benefit amount for employee-only coverage</td>
<td>117</td>
<td>$1,000,000</td>
<td>$2,000,000</td>
<td>$5,000,000</td>
<td>$3,850,509</td>
</tr>
</tbody>
</table>

Source: SHRM Health Care Benchmarking Study (2010)
nontraditional form of health care coverage that helps lower costs. A CDHP is a high-deductible plan that is combined with tax-advantaged spending accounts. There are two types of spending accounts: health savings accounts (HSAs) and health reimbursement accounts (HRAs). The basic difference between the two is their relative portability: HRAs are owned and funded by employers, while HSAs are employee-owned and fully portable spending accounts funded by the employees.

While organizations may initially offer a CDHP to save costs, 86% of the organizations offering CDHPs already have two or more plans in place. Organizations incentivize employees to join consumer-driven health care plans by providing the highest average percentage of premium the employer pays for employee-only coverage, at 80% (Table 3). This suggests that CDHPs are being explored by those organizations without doing away with more traditional health care plans such as health maintenance organizations, preferred provider organizations, etc. Evidence exists supporting the notion that employee participation in a CDHP increases when organizations fund tax-advantaged accounts. A study conducted by United Health Group found that in organizations that contributed to health savings accounts, a vast majority of employees (91%) opened such accounts.6 However, in organizations that did not provide any contribution to HSAs, only 45% of employees started such accounts. The average HSA contribution for all organizations was $682 in 2009.

**Domestic Partnership Coverage**

A domestic partnership is a committed relationship between two unrelated adults that is the approximate equivalent of marriage. The term was first used to recognize same-sex couples who were not able to marry, but it is now used to recognize committed relationships between opposite-sex partners as well. Employers may choose to extend benefits to same-sex or opposite-sex domestic partners of employees.

Because benefits packages are an effective recruiting tool, many organizations may find that including domestic partner health care coverage is helpful in retaining and attracting talent. Thirty-eight percent of organizations currently offer domestic partnership coverage for same-sex couples, and 37% offer domestic partnership coverage for opposite-sex couples.7 Large organizations are more likely than small organizations to offer this type of coverage. This may be because larger organizations often have a more diverse workforce than do smaller organizations. Recruiting activities of large organizations often are more mindful of targeting a diverse workforce, not only because their hiring goals are often greater than at smaller companies, thereby forcing them to seek alternative sourcing strategies, but also because they may be under greater scrutiny to demonstrate inclusive work practices to external audiences.

The decision to offer opposite-sex domestic partnership benefits typically occurs after the decision is made to offer same-sex domestic partnership coverage. Yet, there were industry differences for same-sex domestic partnership coverage as well. For example, when controlling for organizational size, the industry where smaller organizations (fewer than 500 employees) offered the highest percentage of same-sex domestic partnership coverage was biotech, at 60%, whereas the lowest were manufacturing (durable goods), manufacturing (nondurable goods) and government/public—state/local, each at 23% (Table 4). There were also regional differences in whether organizations offered same-sex domestic partner coverage (Table 5). This suggests that several factors may influence whether an organization adopts same-sex partner benefits, including the values of the organization, the competitiveness of the job market for a particular industry, and social, cultural and political differences among geographic areas.

**Self-Insurance and Stop Loss Coverage**

Organizations with self-insured employee health care programs pay for medical claims and fees out of current revenue. The alternative to a self-funded plan is a fully insured plan, where the employer pays a fixed premium to a third party that covers the medical claims. Self-insuring a medical plan can provide some savings advantages to employers, such as eliminating state premium and broker and insurance commission taxes, and avoiding compliance with state-mandated benefits regulations. Self-funding a health insurance plan can also provide motivation to an organization to implement strategies to reduce claims, such as prevention and wellness programs. Adopting a self-funded health care plan could be a successful strategy for organizations with the financial reserves to save on medical costs.
Because employers must pay medical claims using their current reserves, self-insured plans expose organizations to the financial volatility of large, unforeseen claims. For this reason, self-funded plans are much more common among organizations with large revenues and relatively uncommon at organizations with smaller revenues, although small, self-funded employers do exist. Seventy-eight percent of organizations with $1 billion or greater in revenue are self-funded, while only 25% of organizations with less than $5 million in revenue are self-funded, as illustrated in Table 6. Similar findings exist when organizations are compared by staff size. More than two-thirds of employers with 500 or more employees eligible for medical benefits are self-funded (70%). That percentage decreases to 21% for organizations with 1-99 eligible employees (see Table 7). Self-funded plans

<table>
<thead>
<tr>
<th>Region</th>
<th>n</th>
<th>Prevalence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pacific West (Alaska, California, Hawaii)</td>
<td>305</td>
<td>70%</td>
</tr>
<tr>
<td>Northeast (Connecticut, Delaware, Maryland)</td>
<td>265</td>
<td>45%</td>
</tr>
<tr>
<td>Southeast (Alabama, District of Columbia)</td>
<td>161</td>
<td>25%</td>
</tr>
<tr>
<td>Southwest Central (Arizona, California)</td>
<td>150</td>
<td>28%</td>
</tr>
<tr>
<td>North Central (Illinois, Indiana, Iowa)</td>
<td>169</td>
<td>26%</td>
</tr>
</tbody>
</table>

Source: SHRM Health Care Benchmarking Study (2010)

<table>
<thead>
<tr>
<th>Revenue Size</th>
<th>n</th>
<th>Self-Funded</th>
<th>Fully Insured</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under $5 million</td>
<td>271</td>
<td>25%</td>
<td>75%</td>
</tr>
<tr>
<td>$5 million to $24.9 million</td>
<td>358</td>
<td>21%</td>
<td>79%</td>
</tr>
<tr>
<td>$25 million to $99.9 million</td>
<td>299</td>
<td>37%</td>
<td>63%</td>
</tr>
<tr>
<td>$100 million to $999.9 million</td>
<td>243</td>
<td>60%</td>
<td>40%</td>
</tr>
<tr>
<td>$1 billion and over</td>
<td>68</td>
<td>78%</td>
<td>22%</td>
</tr>
</tbody>
</table>

Source: SHRM Health Care Benchmarking Study (2010)

<table>
<thead>
<tr>
<th>Staff Size</th>
<th>n</th>
<th>Self-Funded</th>
<th>Fully Insured</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 to 99 eligible employees</td>
<td>936</td>
<td>21%</td>
<td>79%</td>
</tr>
<tr>
<td>100 to 499 eligible employees</td>
<td>1,105</td>
<td>38%</td>
<td>62%</td>
</tr>
<tr>
<td>500 or more eligible employees</td>
<td>739</td>
<td>70%</td>
<td>30%</td>
</tr>
</tbody>
</table>

Source: SHRM Health Care Benchmarking Study (2010)
demand more financial resources and administrative oversight from organizations.⁹

One way a self-funded organization can protect itself from the financial hazards of large claims is by purchasing stop loss coverage. When either a particular claim or the total cost of all claims exceeds a certain amount, the claims in excess of a predetermined limit are reimbursed to the employer by the stop loss coverage provider. This is an option for organizations that wish to take advantage of the benefits of a self-funded medical plan while limiting its risks. In fiscal year 2009, the average amount of coverage for an individual claim at organizations with specific stop loss coverage was $162,036. Such coverage protects organizations from claims that exceed this amount.
With the average annual cost of health care per covered employee at $8,026, employer-paid health care plans may be hurting U.S. companies relative to their foreign-based competitors. High health care costs may also be making jobs in the United States less available because organizations may opt to open offices overseas where employee salaries and benefits costs are significantly lower. Instead of hiring a worker in the United States, the company could then hire a worker in another country to do the job.

The U.S. health care system is complex, and the recently passed health care reform legislation is only the start of a solution to the health care crisis. Small businesses, usually the engine of economic growth, are penalized by having the highest health care costs compared with medium and large-sized firms. While this is because small organizations have less negotiating power with insurance providers due to the smaller number of employees, it may also be because they have less HR staff to evaluate health care options and effectively negotiate their costs with vendors. Yet even with these challenges, organizations are trying many alternatives to reduce costs. One strategy to reduce unnecessary health care claims is to choose health care benefits that encourage employees to become better consumers of health care services. An example of such benefits strategy is a consumer-directed health plan. A well-designed CDHP that covers the initial health care costs from an HSA will keep a similar level of coverage an employee receives while decreasing the organization's overall health care costs. Implementing and boosting employee participation in wellness and work/life balance programs can also improve the organization’s return on investment. Wellness programs potentially can affect an organization’s financial performance in multiple ways. Programs such as smoking cessation, gym memberships and blood pressure and cholesterol screenings increase the health and prosperity of participating employees. They can prevent costly treatment for serious illnesses down the road through early detection and preempt lost productivity from unscheduled absenteeism.

Providing sustainable solutions for the U.S. health care crisis will require commitment and compromise by all stakeholders—providers, insurers and consumers alike. Yet external pressures—recovery from a deep recession, high unemployment, escalating medical costs and lack of available health care—have shifted the national mood that change is necessary. While additional legislation is certain to follow, there is hope that a sustainable health care system will evolve. HR professionals, with their skills in benefits management, can help organizations evaluate health care options that can lower costs while still offering attractive benefits to recruit and retain talent.
Profile of Organizations Responding to the Survey

The make-up of organizations that responded to the survey varied greatly. Factors such as workforce size, industry, revenue and geographic location all affect an organization’s health care practices and costs. The profile of organizations whose responses are included this executive summary is comparable to the make-up of organizations responding to the full 2010 SHRM Health Care Benchmarking Study. Tables below provide a breakdown of the range of employers that responded to this survey.

### HR Department Level

<table>
<thead>
<tr>
<th>Category</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Corporate (companywide)</td>
<td>75%</td>
</tr>
<tr>
<td>Facility/location</td>
<td>15%</td>
</tr>
<tr>
<td>Business unit/division</td>
<td>10%</td>
</tr>
</tbody>
</table>

(n = 2,961)

### Organizational Revenue in 2009

<table>
<thead>
<tr>
<th>Revenue Range</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than $5 million</td>
<td>24%</td>
</tr>
<tr>
<td>$5 million to $24.9 million</td>
<td>28%</td>
</tr>
<tr>
<td>$25 million to $99.9 million</td>
<td>23%</td>
</tr>
<tr>
<td>$100 million to $999.9 million</td>
<td>19%</td>
</tr>
<tr>
<td>More than $1 billion</td>
<td>5%</td>
</tr>
</tbody>
</table>

Note: Percentages do not total 100% due to rounding.  
(n = 1,292)

### Industry

<table>
<thead>
<tr>
<th>Industry</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Administrative, support, waste management, remediation services</td>
<td>1%</td>
</tr>
<tr>
<td>Arts, entertainment, recreation</td>
<td>1%</td>
</tr>
<tr>
<td>Association–professional/trade</td>
<td>2%</td>
</tr>
<tr>
<td>Biotech</td>
<td>1%</td>
</tr>
<tr>
<td>Construction, mining, oil and gas</td>
<td>3%</td>
</tr>
<tr>
<td>Educational services</td>
<td>6%</td>
</tr>
<tr>
<td>Finance</td>
<td>5%</td>
</tr>
<tr>
<td>Government/public–state/local</td>
<td>4%</td>
</tr>
<tr>
<td>Government/public administration–federal</td>
<td>0%</td>
</tr>
<tr>
<td>Health care, social assistance</td>
<td>17%</td>
</tr>
<tr>
<td>High-tech</td>
<td>4%</td>
</tr>
<tr>
<td>Insurance</td>
<td>4%</td>
</tr>
<tr>
<td>Management companies, enterprises</td>
<td>0%</td>
</tr>
<tr>
<td>Manufacturing (durable goods)</td>
<td>12%</td>
</tr>
<tr>
<td>Manufacturing (nondurable goods)</td>
<td>6%</td>
</tr>
<tr>
<td>Pharmaceutical</td>
<td>1%</td>
</tr>
<tr>
<td>Publishing, broadcasting, other media</td>
<td>2%</td>
</tr>
<tr>
<td>Real estate, rental, leasing</td>
<td>2%</td>
</tr>
<tr>
<td>Retail/wholesale trade</td>
<td>4%</td>
</tr>
<tr>
<td>Services–accommodation, food and drinking places</td>
<td>4%</td>
</tr>
<tr>
<td>Services–professional, scientific, technical</td>
<td>12%</td>
</tr>
<tr>
<td>Telecommunications</td>
<td>1%</td>
</tr>
<tr>
<td>Transportation, warehousing</td>
<td>4%</td>
</tr>
<tr>
<td>Utilities</td>
<td>2%</td>
</tr>
<tr>
<td>Other services</td>
<td>0%</td>
</tr>
</tbody>
</table>

Note: Percentages do not total 100% due to rounding.  
(n = 2,958)
### Number of FTEs for the Organizational Level

<table>
<thead>
<tr>
<th>Category</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fewer than 100</td>
<td>33%</td>
</tr>
<tr>
<td>100 to 249</td>
<td>24%</td>
</tr>
<tr>
<td>250 to 499</td>
<td>15%</td>
</tr>
<tr>
<td>500 to 999</td>
<td>10%</td>
</tr>
<tr>
<td>1,000 to 2,499</td>
<td>8%</td>
</tr>
<tr>
<td>2,500 to 7,499</td>
<td>6%</td>
</tr>
<tr>
<td>7,500 or more</td>
<td>3%</td>
</tr>
</tbody>
</table>

Note: Percentages do not total 100% due to rounding. *(n = 2,892)*

### Region

<table>
<thead>
<tr>
<th>Region</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Southeast</td>
<td>23%</td>
</tr>
<tr>
<td>(Alabama, District of Columbia, Florida, Georgia, Kentucky, Mississippi, North Carolina, South Carolina, Tennessee, Virginia, West Virginia)</td>
<td></td>
</tr>
<tr>
<td>North Central</td>
<td>23%</td>
</tr>
<tr>
<td>(Illinois, Indiana, Iowa, Michigan, Minnesota, Nebraska, North Dakota, Ohio, South Dakota, Wisconsin)</td>
<td></td>
</tr>
<tr>
<td>Northeast</td>
<td>20%</td>
</tr>
<tr>
<td>(Connecticut, Delaware, Maine, Maryland, Massachusetts, New Hampshire, New Jersey, New York, Pennsylvania, Rhode Island, Vermont)</td>
<td></td>
</tr>
<tr>
<td>Southwest Central</td>
<td>19%</td>
</tr>
<tr>
<td>(Arizona, Arkansas, Colorado, Kansas, Louisiana, Missouri, New Mexico, Oklahoma, Texas, Utah)</td>
<td></td>
</tr>
<tr>
<td>Pacific West</td>
<td>15%</td>
</tr>
</tbody>
</table>

*(n = 2,959)*

### Profit Status

<table>
<thead>
<tr>
<th>Status</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Privately owned for-profit organization</td>
<td>53%</td>
</tr>
<tr>
<td>Publicly owned for-profit organization</td>
<td>18%</td>
</tr>
<tr>
<td>Nonprofit organization</td>
<td>22%</td>
</tr>
<tr>
<td>Government agency</td>
<td>7%</td>
</tr>
</tbody>
</table>

*(n = 2,961)*
STATISTICAL DEFINITIONS

“n”
Letter “n” in tables and figures indicates the number of respondents to each question. Therefore, when it is noted that n = 25, it indicates that the number of respondents was 25.

Percentile
The percentile is the percentage of responses in a group that have values less than or equal to that particular value. For example, when data are arranged from lowest to highest, the 25th percentile is the point at which 75% of the data are above and 25% are below it. Conversely, the 75th percentile is the point at which 25% of the data are above and 75% are below it.

Median (50th percentile)
The median is the midpoint of the set of numbers or values arranged in ascending order. It is recommended that the median is used as a basis for all interpretations of the data when the average and median are discrepant.

Average
The average is the sum of the responses divided by the total number of responses. It is also known as the mean. This measure is affected more than the median by the occurrence of outliers (extreme values). For this reason, the average reported may be greater than the 75th percentile or less than the 25th percentile.

FTE
FTE is an abbreviation for full-time equivalent. Full-time equivalents represent the total labor hours invested. To convert part-time staff into FTEs, divide the total number of hours worked by part-time employees during the work year by the total number of hours in the work year (e.g., if the average work week is 37.5 hours, total number of hours in a work year would be 37.5 hours/week x 52 weeks = 1,950). Converting the number of employees to FTEs provides a more accurate understanding of the level of effort being applied in an organization. For example, if two employees are job-sharing, the FTE number is only one.

HEALTH CARE COVERAGE AND STOP LOSS COVERAGE PREVALENCE

Percentage of Organizations Providing Employee Health Care Coverage
This percentage represents those organizations that offer health care coverage as a benefit to their employees. It is calculated by dividing the number of organizations that offer health care benefits by the total number of organizations, regardless of whether they offer health care coverage.

Percentage of Organizations Providing Spouse Health Care Coverage
This percentage represents those organizations that offer spouse health care coverage as a benefit to their employees. It is calculated by dividing the number of organizations that offer spouse health care benefits by the total number of organizations, regardless of whether they offer spouse health care coverage.
Percentage of Organizations Providing Same-Sex Domestic Partner Health Care Coverage
This percentage represents those organizations that offer same-sex domestic partner health care coverage as a benefit to their employees. This benefit recognizes the family as the intimate, committed relationship of two unrelated people of the same sex that is the approximate equivalent of marriage but does not involve formal marriage. It is calculated by dividing the number of organizations that offer same-sex domestic partner health care benefits by the total number of organizations, regardless of whether they offer same-sex domestic partner health care coverage.

Percentage of Organizations Providing Opposite-Sex Domestic Partner Health Care Coverage
This percentage represents those organizations that offer opposite-sex domestic partner health care coverage as a benefit to their employees. This benefit recognizes the family as the intimate, committed relationship of two unrelated people of the opposite sex that is the approximate equivalent of marriage but does not involve formal marriage. It is calculated by dividing the number of organizations that offer opposite-sex domestic partner health care benefits by the total number of organizations, regardless of whether they offer opposite-sex domestic partner health care coverage.

Percentage of Organizations With Self-Funded Health Care
This percentage represents those organizations whose health care is self-funded by the organization. A self-funded health care plan is one in which no insurance company or service plan collects premiums and assumes risk. In a sense, the employer is acting as its own insurance company, paying the medical claims submitted by its employees. This percentage is calculated by dividing the number of organizations with self-funded health care by the total number of organizations, regardless of whether their health care is self-funded.

Percentage of Organizations With Stop Loss Coverage
This percentage represents those organizations that contract with a third-party insurance provider to cover medical claims if they exceed a specified dollar amount over a set period of time. It is calculated by dividing the number of organizations that have stop loss coverage by the total number of organizations, regardless of whether they have stop loss coverage.

EMPLOYEE PARTICIPATION AND PLANS OFFERED

Percentage of Employees Enrolled
This percentage represents the number of employees in an organization that have elected to sign up for an organization’s health care plan. It is calculated by dividing the number of employees who enroll in an organization’s health care plan by the total number of employees in the organization, regardless of whether they have elected health care coverage from the organization.

Percentage of Organizations Offering Plan
This percentage represents the number of organizations offering at least one of the following health care plans: health maintenance organization (HMO), exclusive provider organization (EPO), preferred provider organization (PPO), point of service (POS), indemnity and consumer-driven health plan (CDHP). It is calculated by dividing the number of organizations offering a specific plan by the total number of organizations, regardless of whether they offer a specific plan.

Number of Health Care Plans Offered
Organizations may offer a number of different health care plans to meet the needs of their employee population. This percentage represents the number of organizations that offer one or more health care plans from which their employees can choose.

HEALTH CARE COST, WAITING PERIOD AND STOP LOSS COVERAGE AMOUNT

Total Annual Health Care Cost per Covered Employee
Health care expense per covered employee is calculated by taking the total health care expenses paid by the organization in a given year and dividing that by the number of employees who are enrolled in a health care plan.
Waiting Period (in Months) for Coverage for New Employees
This category of data represents the period of time between an employee’s first day of employment and the date when the employee becomes eligible for benefits.

Amount of Stop Loss Coverage
Organizations often contract with a third-party insurance provider to cover medical claims if they exceed a specified dollar amount over a set period of time. This benchmark represents the dollar amount per employee at which the stop loss coverage begins.

HEALTH CARE COSTS FOR ALL PLANS COMBINED

Employer Contribution to Monthly Health Care Premium for Employee-Only Coverage
This benchmark is the monthly dollar amount that the employer pays for health care to cover an employee who is enrolled in an organization’s health care plan.

Percentage of Premium Employer Pays for Employee-Only Coverage
The percentage of premium the organization pays for employee-only coverage is calculated by dividing the dollar amount the organization pays for employee-only coverage premiums by the total premium dollar amount.

Percentage of Premium Employer Pays for Spouse or Domestic Partner Coverage
The percentage of premium the organization pays for spouse or domestic partner coverage is calculated by dividing the dollar amount the organization pays for spouse or domestic partner coverage premiums by the total premium dollar amount.

Annual-Out-of-Network Deductible for Employee-Only Coverage
This benchmark is the yearly amount of out-of-pocket expenses that the employee pays for health care services when the provider does not participate with the employee’s health care plan.

Co-Pay for In-Network Primary Care Office Visits for Employee-Only Coverage
This benchmark represents the payment at the time of service to a provider that participates with the employee’s health plan. Co-pays are made in addition to deductibles.

Maximum Lifetime Benefit Amount for Employee-Only Coverage
This benchmark represents the total dollar amount of health care benefit that is available during an employee’s entire time of enrollment in an organization’s health care plan.

Health Maintenance Organization
Health maintenance organizations (HMOs), typically referred to as managed care plans, are pre-paid medical group practice plans that provide comprehensive predetermined medical care benefits for pre-negotiated amounts. Some HMO plans utilize gatekeepers to ensure that certain medical services are used only when absolutely necessary.

Exclusive Provider Organization
Exclusive provider organizations (EPOs) are self-funded medical plans that combine aspects of a PPO and an HMO. EPOs provide specific benefit levels if care is provided by a specific network of service providers, otherwise no payment will be made.

Preferred Provider Organization
Preferred provider organizations (PPOs) are formed by an insurance company, an employer or a group of employers who negotiate discounted fees with networks of health-care providers. In return, the employers guarantee a certain volume of patients and prompt payment. PPO participants’ out-of-pocket costs are usually lower than under a fee-for-service plan.

Point of Service
Point of service (POS) plans allow employees to use both in-network and out-of-network providers, although benefits are greater if in-network providers are used. Often combining aspects of a PPO and an HMO, some POS plans utilize gatekeepers to ensure that certain medical services are used only when absolutely necessary.
**Indemnity**
Indemnity plans are full-choice health care plans that allow covered employees to go to any qualified physician or hospital they choose, as there is no incentive or requirement to use a particular network of providers. Medical claims are then submitted to the insurance company for payment. Indemnity plans are also known as fee-for-service health care plans.

**Consumer-Driven Health Plan: High-Deductible Health Plan**
A consumer-driven health care plan is a high-deductible health plan that is presented along with a tax-advantaged spending account. Presently, two types of plans meet these criteria—health savings accounts (HSAs) and health reimbursement accounts (HRAs).

**CONSUMER-DRIVEN HEALTH PLAN: HEALTH SAVINGS ACCOUNT AND HEALTH REIMBURSEMENT ACCOUNT**

**Employer Contribution to Health Savings Account**
Health savings accounts, a component of consumer-driven health care plans, allow employers and employees to contribute to tax- deductible accounts for the benefit of employees covered under high-deductible health plans. This benchmark indicates the amount employers contribute to health savings accounts.

**Maximum Allowable Employee Contribution to Health Savings Account**
Health savings accounts, a component of consumer-driven health care plans, allow employers and employees to contribute to tax-deductible accounts for the benefit of employees covered under high-deductible health plans. This benchmark indicates the maximum amount that an employee may contribute to health savings accounts.

**Employer Contribution to Health Reimbursement Account**
Health reimbursement accounts, a component of consumer-driven health care plans, are tax-free accounts funded by employers. Any benefit dollars that are left in the account at year-end can roll over and be used to cover future medical expenses.

**PRESCRIPTION DRUG COVERAGE**

**Employee Co-Pay for Generic Medication**
This benchmark represents the payment made at the time of purchase for generic prescription drug medication. Generic medication is equal in therapeutic dose to brand-name original drugs and is typically cost-effective. Co-pays are made in addition to deductibles.

**Employee Co-Pay for Formulary Brand Medication**
This benchmark represents the payment made at the time of purchase for formulary prescription drug medication. Formulary brand medications are a list of preferred drugs that will be covered by a plan at a discount, and they differ from plan to plan. Drugs are selected to be included in this list because they are cost-effective or have a generic substitution available. Co-pays are made in addition to deductibles.

**Employee Co-Pay for Non-Formulary Brand Medication**
This benchmark represents the payment made at the time of purchase for non-formulary prescription drug medication. Non-formulary brand medications are not on the formulary list of drugs, and therefore, no discount is usually offered. Some plans may refuse to cover a non-formulary drug if a physician has prescribed a generic substitution. Co-pays are made in addition to deductibles.

**Employee Co-Pay for Generic Medication 90-Day Mail-Order Supply**
This benchmark represents the payment made at the time of purchase for a 90-day supply of generic prescription drug medication when the prescription is ordered through the mail. Generic medication is equal in therapeutic dose to brand-name original drugs and is typically cost-effective. Co-pays are made in addition to deductibles.

**Employee Co-Pay for Formulary Brand Medication 90-Day Mail-Order Supply**
This benchmark represents the payment made at the time of purchase for a 90-day supply of formulary prescription drug medication when the prescription is ordered through the mail. Formulary brand medications are a list of preferred drugs that will be covered by a plan at a discount, and they
differ from plan to plan. Drugs are selected to be included in this list because they are cost-effective or have a generic substitution available. Co-pays are made in addition to deductibles.

**Employee Co-Pay for Non-Formulary Brand Medication 90-Day Mail-Order Supply**

This benchmark represents the payment made at the time of purchase for a 90-day supply of non-formulary prescription drug medication when the prescription is ordered through the mail. Non-formulary brand medications are not on the formulary list of drugs, and therefore, no discount is usually offered. Some plans may refuse to cover a non-formulary drug if a physician has prescribed a generic substitution. Co-pays are made in addition to deductibles.
Endnotes

1 SHRM Customized Benchmarking Database [unpublished data].


4 Due to the nature of the data in the current study, only data that were three standard deviations above the average were excluded. In other words, this study includes data in which 99.5% of the data fall below the given data point. Extreme outliers can skew the results, leading to higher (or lower) averages among the measures.


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This report includes
Customized tables based on your criteria 5
A glossary of terms 17

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**Selection Criteria**

<table>
<thead>
<tr>
<th>Industry</th>
<th>Your Industry</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff Size</td>
<td>Your FTE</td>
</tr>
</tbody>
</table>

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Understanding the Data

As you compare your own data against the other organizations, please keep the following in mind:

1. The attached report is based on data derived from the SHRM Customized Benchmarking Database, which contains data from a non-random collection of U.S. companies of all sizes and types. The report is designed to target companies that closely match the above selected criteria so that a more focused and comparable analysis and interpretation can be performed. Therefore, any interpretations of these data should be kept within this context.

2. A deviation between your figure for any health care measure and the comparative figure is not necessarily favorable or unfavorable; it is merely an indication that additional analyses may be needed. Health care measures that relate more closely to the context of your organization’s industry and employee size are more descriptive and meaningful than information that is more generic in nature, such as all industries combined. The larger the discrepancy between your figure and those found in this report, the greater the need for additional scrutiny.

3. In cases where you determine that potentially serious deviations do exist, it may be helpful to go back and calculate the same health care measure for your organization over the past several years to identify any existing trends.

4. The information in this report should be used as a tool for decision-making rather than an absolute standard. Because companies differ in their total rewards strategy, location, size and other factors, any two companies can be well managed, yet some of their health care measures may differ greatly. No decision should be made solely based on the results of any one study.

Working With the Data

The information in this report is designed to be a tool to help you evaluate decisions and activities that affect your organization’s employee health care benefits. When reviewing these data, it is important to realize that business strategy, organizational culture, benefit philosophies and industry pressures are just a few of the many factors that drive various benefit measures. For example, an industry that generally hires nonskilled labor, such as manufacturing, may have less costly benefit packages than the high-tech industry that hires specialized knowledge workers. This is because organizations in the high-tech industry may need to have richer, more attractive benefit plans to make themselves more enticing in order to attract “hard-to-find” knowledge workers.
Absolute measures are not meaningful in isolation—they should be compared with one or more measures to determine whether a satisfactory level exists. Other measures, for example, might be your organization’s past results in this area or comparatives based on organizational size, industry or geographic location.

Each page in the custom tables contains customized health benchmarks in aggregated form. There may be discrepancies between your organization’s health care benchmarks and the average or median numbers for a particular category. It is particularly helpful to communicate to line managers and other executives that just because your organization has benchmarks that are different from the average or median, it does not mean they are favorable or unfavorable. Rather this difference may be the result of your organization’s particular total rewards strategy, special circumstances or other business initiatives.

Notes

The data in this report were collected in the spring of 2010 and reflect 2009 data. The “n” is comprised of the organizations that responded to the specific benchmark. Therefore, the number of peer organizations may vary from benchmark to benchmark. Some benchmarks are less frequently collected by organizations or may be more difficult to obtain. Therefore, some benchmarks show a smaller “n” than others. Data are not displayed when there are fewer than five organizations for a specific metric.

Disclaimer

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# SHRM Customized Health Care Benchmarking Report

## Health Care Coverage and Stop Loss Coverage Prevalence

<table>
<thead>
<tr>
<th>Percentage of Organizations Providing Employee Health Care Coverage</th>
<th>Percentage of Organizations Providing Spouse Health Care Coverage</th>
<th>Percentage of Organizations Providing Same-Sex Domestic Partner Health Care Coverage</th>
<th>Percentage of Organizations Providing Opposite-Sex Domestic Partner Health Care Coverage</th>
<th>Percentage of Organizations with Self-Funded Health Care</th>
<th>Percentage of Organizations with Stop Loss Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>n</td>
<td>111</td>
<td>103</td>
<td>29</td>
<td>25</td>
<td>14</td>
</tr>
<tr>
<td>Percent</td>
<td>100%</td>
<td>94%</td>
<td>32%</td>
<td>29%</td>
<td>38%</td>
</tr>
</tbody>
</table>
SHRM CUSTOMIZED HEALTH CARE BENCHMARKING REPORT

EMPLOYEE PARTICIPATION AND PLANS OFFERED

<table>
<thead>
<tr>
<th>Plan Type</th>
<th>Percentage of Employees Enrolled</th>
<th>Percentage of Organizations Offering Plan</th>
<th>Number of Health Care Plans Offered</th>
</tr>
</thead>
<tbody>
<tr>
<td>n</td>
<td>93</td>
<td>112</td>
<td>113</td>
</tr>
<tr>
<td>HMO</td>
<td>49%</td>
<td>37%</td>
<td>56%</td>
</tr>
<tr>
<td>EPO</td>
<td>47%</td>
<td>6%</td>
<td>32%</td>
</tr>
<tr>
<td>PPO</td>
<td>65%</td>
<td>81%</td>
<td>12%</td>
</tr>
<tr>
<td>POS</td>
<td>45%</td>
<td>17%</td>
<td>12%</td>
</tr>
<tr>
<td>Indemnity</td>
<td>26%</td>
<td>3%</td>
<td>12%</td>
</tr>
<tr>
<td>CDHP</td>
<td>38%</td>
<td>16%</td>
<td>12%</td>
</tr>
</tbody>
</table>
## HEALTH CARE COST, WAITING PERIOD AND STOP LOSS COVERAGE AMOUNT

<table>
<thead>
<tr>
<th></th>
<th>Total Annual Health Care Cost per Covered Employee</th>
<th>Waiting Period in Months for Coverage for New Employees</th>
<th>Amount of Stop Loss Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>n</td>
<td>75</td>
<td>109</td>
<td>8</td>
</tr>
<tr>
<td>25th Percentile</td>
<td>$4,047</td>
<td>1</td>
<td>$75,000</td>
</tr>
<tr>
<td>Median</td>
<td>$5,743</td>
<td>2</td>
<td>$150,000</td>
</tr>
<tr>
<td>75th Percentile</td>
<td>$7,174</td>
<td>3</td>
<td>$225,000</td>
</tr>
<tr>
<td>Average</td>
<td>$6,013</td>
<td>2</td>
<td>$182,426</td>
</tr>
</tbody>
</table>

* To ensure that the data are seen as credible, data for metrics with an "n" of less than 5 are not displayed.
### HEALTH CARE COSTS FOR ALL PLANS COMBINED

<table>
<thead>
<tr>
<th>Employer Contribution to Monthly Health Care Premium for Employee-Only Coverage</th>
<th>Percentage of Premium Employer Pays for Employee-Only Coverage</th>
<th>Percentage of Premium Employer Pays for Spouse or Domestic Partner Coverage</th>
<th>Annual Out-of-Network Deductible for Employee-Only Coverage</th>
<th>Co-Pay for In-Network Primary Care Office Visits for Employee-Only Coverage</th>
<th>Maximum Lifetime Benefit Amount for Employee-Only Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>n</td>
<td>48</td>
<td>87</td>
<td>76</td>
<td>65</td>
<td>68</td>
</tr>
<tr>
<td>25&lt;sup&gt;th&lt;/sup&gt; Percentile</td>
<td>$170</td>
<td>70%</td>
<td>50%</td>
<td>$350</td>
<td>$15</td>
</tr>
<tr>
<td>Median</td>
<td>$335</td>
<td>80%</td>
<td>75%</td>
<td>$780</td>
<td>$20</td>
</tr>
<tr>
<td>75&lt;sup&gt;th&lt;/sup&gt; Percentile</td>
<td>$455</td>
<td>90%</td>
<td>80%</td>
<td>$1,600</td>
<td>$25</td>
</tr>
<tr>
<td>Average</td>
<td>$298</td>
<td>78%</td>
<td>63%</td>
<td>$1,276</td>
<td>$18</td>
</tr>
</tbody>
</table>

* To ensure that the data are seen as credible, data for metrics with an "n" of less than 5 are not displayed.
### SHRM CUSTOMIZED HEALTH CARE BENCHMARKING REPORT

#### HEALTH MAINTENANCE ORGANIZATION

<table>
<thead>
<tr>
<th></th>
<th>Employer Contribution to Monthly Health Care Premium for Employee Only-Coverage</th>
<th>Percentage of Premium Employer Pays for Employee-Only Coverage</th>
<th>Percentage of Premium Employer Pays for Spouse or Domestic Partner Coverage</th>
<th>Annual Out-of-Network Deductible for Employee-Only Coverage</th>
<th>Co-Pay for In-Network Primary Care Office Visits for Employee-Only Coverage</th>
<th>Maximum Lifetime Benefit Amount for Employee-Only Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>n</td>
<td>12</td>
<td>24</td>
<td>25</td>
<td>28</td>
<td>15</td>
<td>7</td>
</tr>
<tr>
<td>25&lt;sup&gt;th&lt;/sup&gt; Percentile</td>
<td>$185</td>
<td>70%</td>
<td>45%</td>
<td>$0</td>
<td>$15</td>
<td>$1,400,000</td>
</tr>
<tr>
<td>Median</td>
<td>$320</td>
<td>80%</td>
<td>65%</td>
<td>$250</td>
<td>$20</td>
<td>$2,040,000</td>
</tr>
<tr>
<td>75&lt;sup&gt;th&lt;/sup&gt; Percentile</td>
<td>$395</td>
<td>95%</td>
<td>80%</td>
<td>$500</td>
<td>$25</td>
<td>$3,000,000</td>
</tr>
<tr>
<td>Average</td>
<td>$470</td>
<td>77%</td>
<td>54%</td>
<td>$425</td>
<td>$17</td>
<td>$1,230,466</td>
</tr>
</tbody>
</table>

* To ensure that the data are seen as credible, data for metrics with an "n" of less than 5 are not displayed.
### SHRM CUSTOMIZED HEALTH CARE BENCHMARKING REPORT

#### EXCLUSIVE PROVIDER ORGANIZATION

<table>
<thead>
<tr>
<th></th>
<th>Employer Contribution to Monthly Health Care Premium for Employee-Only Coverage</th>
<th>Percentage of Premium Employer Pays for Employee-Only Coverage</th>
<th>Percentage of Premium Employer Pays for Spouse or Domestic Partner Coverage</th>
<th>Annual Out-of-Network Deductible for Employee-Only Coverage</th>
<th>Co-Pay for In-Network Primary Care Office Visits for Employee-Only Coverage</th>
<th>Maximum Lifetime Benefit Amount for Employee-Only Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>n</td>
<td>27</td>
<td>72</td>
<td>68</td>
<td>38</td>
<td>59</td>
<td>24</td>
</tr>
<tr>
<td>25&lt;sup&gt;th&lt;/sup&gt; Percentile</td>
<td>$78</td>
<td>75%</td>
<td>50%</td>
<td>$150</td>
<td>$15</td>
<td>$0</td>
</tr>
<tr>
<td>Median</td>
<td>$266</td>
<td>80%</td>
<td>75%</td>
<td>$205</td>
<td>$20</td>
<td>$51,125</td>
</tr>
<tr>
<td>75&lt;sup&gt;th&lt;/sup&gt; Percentile</td>
<td>$346</td>
<td>95%</td>
<td>85%</td>
<td>$367</td>
<td>$25</td>
<td>$2,050,000</td>
</tr>
<tr>
<td>Average</td>
<td>$254</td>
<td>77%</td>
<td>62%</td>
<td>$267</td>
<td>$21</td>
<td>$1,276,034</td>
</tr>
</tbody>
</table>

* To ensure that the data are seen as credible, data for metrics with an "n" of less than 5 are not displayed.
### SHRM CUSTOMIZED HEALTH CARE BENCHMARKING REPORT

#### PREFERRED PROVIDER ORGANIZATION

<table>
<thead>
<tr>
<th></th>
<th>Employer Contribution to Monthly Health Care Premium for Employee-Only Coverage</th>
<th>Percentage of Premium Employer Pays for Employee-Only Coverage</th>
<th>Percentage of Premium Employer Pays for Spouse or Domestic Partner Coverage</th>
<th>Annual Out-of-Network Deductible for Employee-Only Coverage</th>
<th>Co-Pay for In-Network Primary Care Office Visits for Employee-Only Coverage</th>
<th>Maximum Lifetime Benefit Amount for Employee-Only Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>n</td>
<td>58</td>
<td>63</td>
<td>40</td>
<td>49</td>
<td>47</td>
<td>23</td>
</tr>
<tr>
<td>25&lt;sup&gt;th&lt;/sup&gt; Percentile</td>
<td>$188</td>
<td>70%</td>
<td>48%</td>
<td>$350</td>
<td>$15</td>
<td>$6,000</td>
</tr>
<tr>
<td>Median</td>
<td>$320</td>
<td>80%</td>
<td>70%</td>
<td>$600</td>
<td>$20</td>
<td>$2,000,000</td>
</tr>
<tr>
<td>75&lt;sup&gt;th&lt;/sup&gt; Percentile</td>
<td>$431</td>
<td>93%</td>
<td>80%</td>
<td>$1,500</td>
<td>$25</td>
<td>$5,000,000</td>
</tr>
<tr>
<td>Average</td>
<td>$339</td>
<td>77%</td>
<td>60%</td>
<td>$1,098</td>
<td>$21</td>
<td>$2,918,739</td>
</tr>
</tbody>
</table>

* To ensure that the data are seen as credible, data for metrics with an "n" of less than 5 are not displayed.
### SHRM CUSTOMIZED HEALTH CARE BENCHMARKING REPORT

#### POINT OF SERVICE

<table>
<thead>
<tr>
<th>n</th>
<th>9</th>
<th>11</th>
<th>8</th>
<th>7</th>
<th>8</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td>25&lt;sup&gt;th&lt;/sup&gt; Percentile</td>
<td>$167</td>
<td>70%</td>
<td>45%</td>
<td>$300</td>
<td>$15</td>
<td>*</td>
</tr>
<tr>
<td>Median</td>
<td>$308</td>
<td>79%</td>
<td>70%</td>
<td>$500</td>
<td>$20</td>
<td>*</td>
</tr>
<tr>
<td>75&lt;sup&gt;th&lt;/sup&gt; Percentile</td>
<td>$421</td>
<td>92%</td>
<td>85%</td>
<td>$1,500</td>
<td>$25</td>
<td>*</td>
</tr>
<tr>
<td>Average</td>
<td>$286</td>
<td>76%</td>
<td>59%</td>
<td>$1,166</td>
<td>$23</td>
<td>$1,650,952</td>
</tr>
</tbody>
</table>

* To ensure that the data are seen as credible, data for metrics with an “n” of less than 5 are not displayed.
## SHRM CUSTOMIZED HEALTH CARE BENCHMARKING REPORT

### INDEMNITY

<table>
<thead>
<tr>
<th></th>
<th>Employer Contribution to Monthly Health Care Premium for Employee-Only Coverage</th>
<th>Percentage of Premium Employer Pays for Employee-Only Coverage</th>
<th>Percentage of Premium Employer Pays for Spouse or Domestic Partner Coverage</th>
<th>Annual Out-of-Network Deductible for Employee-Only Coverage</th>
<th>Co-Pay for In-Network Primary Care Office Visits for Employee-Only Coverage</th>
<th>Maximum Lifetime Benefit Amount for Employee-Only Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>n</td>
<td>23</td>
<td>31</td>
<td>28</td>
<td>24</td>
<td>26</td>
<td>19</td>
</tr>
<tr>
<td>25&lt;sup&gt;th&lt;/sup&gt; Percentile</td>
<td>$101</td>
<td>74%</td>
<td>40%</td>
<td>$150</td>
<td>$5</td>
<td>$0</td>
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<tr>
<td>Median</td>
<td>$356</td>
<td>84%</td>
<td>77%</td>
<td>$580</td>
<td>$15</td>
<td>$1,075,000</td>
</tr>
<tr>
<td>75&lt;sup&gt;th&lt;/sup&gt; Percentile</td>
<td>$454</td>
<td>94%</td>
<td>89%</td>
<td>$1,100</td>
<td>$20</td>
<td>$2,100,000</td>
</tr>
<tr>
<td>Average</td>
<td>$378</td>
<td>79%</td>
<td>67%</td>
<td>$932</td>
<td>$16</td>
<td>$1,158,174</td>
</tr>
</tbody>
</table>

* To ensure that the data are seen as credible, data for metrics with an "n" of less than 5 are not displayed.
### SHRM CUSTOMIZED HEALTH CARE BENCHMARKING REPORT

#### CONSUMER-DRIVEN HEALTH PLAN:
HIGH-DEDUCTIBLE HEALTH PLAN

<table>
<thead>
<tr>
<th></th>
<th>Employer Contribution to Monthly Health Care Premium for Employee-Only Coverage</th>
<th>Percentage of Premium Employer Pays for Employee-Only Coverage</th>
<th>Percentage of Premium Employer Pays for Spouse or Domestic Partner Coverage</th>
<th>Annual Out-of-Network Deductible for Employee-Only Coverage</th>
<th>Co-Pay for In-Network Primary Care Office Visits for Employee-Only Coverage</th>
<th>Maximum Lifetime Benefit Amount for Employee-Only Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>n</td>
<td>6</td>
<td>14</td>
<td>12</td>
<td>13</td>
<td>18</td>
<td>8</td>
</tr>
<tr>
<td>25th Percentile</td>
<td>$156</td>
<td>75%</td>
<td>57%</td>
<td>$1,550</td>
<td>$0</td>
<td>$1,000,000</td>
</tr>
<tr>
<td>Median</td>
<td>$252</td>
<td>88%</td>
<td>75%</td>
<td>$2,250</td>
<td>$10</td>
<td>$2,500,000</td>
</tr>
<tr>
<td>75th Percentile</td>
<td>$358</td>
<td>98%</td>
<td>88%</td>
<td>$3,500</td>
<td>$15</td>
<td>$4,500,000</td>
</tr>
<tr>
<td>Average</td>
<td>$279</td>
<td>83%</td>
<td>64%</td>
<td>$2,788</td>
<td>$6</td>
<td>$3,857,614</td>
</tr>
</tbody>
</table>

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## SHRM CUSTOMIZED HEALTH CARE BENCHMARKING REPORT

### CONSUMER-DRIVEN HEALTH PLAN: HEALTH SAVINGS ACCOUNT AND HEALTH REIMBURSEMENT ACCOUNT

<table>
<thead>
<tr>
<th></th>
<th>Employer Contribution to Health Savings Account</th>
<th>Maximum Allowable Employee Contribution to Health Savings Account</th>
<th>Employer Contribution to Health Reimbursement Account</th>
</tr>
</thead>
<tbody>
<tr>
<td>n</td>
<td>23</td>
<td>15</td>
<td>12</td>
</tr>
<tr>
<td>25&lt;sup&gt;th&lt;/sup&gt; Percentile</td>
<td>$45</td>
<td>$2,500</td>
<td>$500</td>
</tr>
<tr>
<td>Median</td>
<td>$450</td>
<td>$2,750</td>
<td>$750</td>
</tr>
<tr>
<td>75&lt;sup&gt;th&lt;/sup&gt; Percentile</td>
<td>$1,100</td>
<td>$3,000</td>
<td>$1,125</td>
</tr>
<tr>
<td>Average</td>
<td>$743</td>
<td>$2,452</td>
<td>$1,581</td>
</tr>
</tbody>
</table>

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## SHRM CUSTOMIZED HEALTH CARE BENCHMARKING REPORT

**PRESCRIPTION DRUG COVERAGE**

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>n</td>
<td>75</td>
<td>78</td>
<td>81</td>
<td>72</td>
<td>69</td>
<td>71</td>
</tr>
<tr>
<td>25&lt;sup&gt;th&lt;/sup&gt; Percentile</td>
<td>$10</td>
<td>$20</td>
<td>$35</td>
<td>$15</td>
<td>$40</td>
<td>$65</td>
</tr>
<tr>
<td>Median</td>
<td>$15</td>
<td>$25</td>
<td>$50</td>
<td>$20</td>
<td>$50</td>
<td>$95</td>
</tr>
<tr>
<td>75&lt;sup&gt;th&lt;/sup&gt; Percentile</td>
<td>$18</td>
<td>$35</td>
<td>$70</td>
<td>$25</td>
<td>$75</td>
<td>$125</td>
</tr>
<tr>
<td>Average</td>
<td>$13</td>
<td>$26</td>
<td>$47</td>
<td>$26</td>
<td>$59</td>
<td>$98</td>
</tr>
</tbody>
</table>

* To ensure that the data are seen as credible, data for metrics with an "n" of less than 5 are not displayed.
HEALTH CARE GLOSSARY OF
METRIC TERMS, DEFINITIONS AND CALCULATIONS

Statistical Definitions

“n”
Letter “n” in tables and figures indicates the number of respondents to each question. Therefore, when it is noted that n = 25, it indicates that the number of respondents was 25.

Percentile
The percentile is the percentage of responses in a group that have values less than or equal to that particular value. For example, when data are arranged from lowest to highest, the 25th percentile is the point at which 75% of the data are above and 25% are below it. Conversely, the 75th percentile is the point at which 25% of the data are above and 75% are below it.

Median (50th percentile)
The median is the midpoint of the set of numbers or values arranged in ascending order. It is recommended that the median is used as a basis for all interpretations of the data when the average and median are discrepant.

Average
The average is the sum of the responses divided by the total number of responses. It is also known as the mean. This measure is affected more than the median by the occurrence of outliers (extreme values). For this reason, the average reported may be greater than the 75th percentile or less than the 25th percentile.

FTE
FTE is an abbreviation for full-time equivalent. Full-time equivalents represent the total labor hours invested. To convert part-time staff into FTEs, divide the total number of hours worked by part-time employees during the work year by the total number of hours in the work year (e.g., if the average work week is 37.5 hours, total number of hours in a work year would be 37.5 hours/week x 52 weeks = 1,950). Converting the number of employees to FTEs provides a more accurate understanding of the level of effort being applied in an organization. For example, if two employees are job-sharing, the FTE number is only one.
Health Care Coverage and Stop Loss Coverage Prevalence

Percentage of Organizations Providing Employee Health Care Coverage
This percentage represents those organizations that offer health care coverage as a benefit to their employees. It is calculated by dividing the number of organizations that offer health care benefits by the total number of organizations, regardless of whether they offer health care coverage.

Percentage of Organizations Providing Spouse Health Care Coverage
This percentage represents those organizations that offer spouse health care coverage as a benefit to their employees. It is calculated by dividing the number of organizations that offer spouse health care benefits by the total number of organizations, regardless of whether they offer spouse health care coverage.

Percentage of Organizations Providing Same-Sex Domestic Partner Health Care Coverage
This percentage represents those organizations that offer same-sex domestic partner health care coverage as a benefit to their employees. This benefit recognizes the family as the intimate, committed relationship of two unrelated people of the same sex that is the approximate equivalent of marriage but does not involve formal marriage. It is calculated by dividing the number of organizations that offer same-sex domestic partner health care benefits by the total number of organizations, regardless of whether they offer same-sex domestic partner health care coverage.

Percentage of Organizations Providing Opposite-Sex Domestic Partner Health Care Coverage
This percentage represents those organizations that offer opposite-sex domestic partner health care coverage as a benefit to their employees. This benefit recognizes the family as the intimate, committed relationship of two unrelated people of the opposite sex that is the approximate equivalent of marriage but does not involve formal marriage. It is calculated by dividing the number of organizations that offer opposite-sex domestic partner health care benefits by the total number of organizations, regardless of whether they offer opposite-sex domestic partner health care coverage.

Percentage of Organizations With Self-Funded Health Care
This percentage represents those organizations whose health care is self-funded by the organization. A self-funded health care plan is one in which no insurance company or service plan collects premiums and assumes risk. In a sense, the employer is acting as its own insurance company, paying the medical claims submitted by its employees. This percentage is calculated by dividing the number of organizations with self-funded health care by the total number of organizations, regardless of whether their health care is self-funded.
Percentage of Organizations With Stop Loss Coverage
This percentage represents those organizations that contract with a third-party insurance provider to cover medical claims if they exceed a specified dollar amount over a set period of time. It is calculated by dividing the number of organizations that have stop loss coverage by the total number of organizations, regardless of whether they have stop loss coverage.

Employee Participation and Plans Offered

Percentage of Employees Enrolled
This percentage represents the number of employees in an organization that have elected to sign up for an organization’s health care plan. It is calculated by dividing the number of employees who enroll in an organization’s health care plan by the total number of employees in the organization, regardless of whether they have elected health care coverage from the organization.

Percentage of Organizations Offering Plan
This percentage represents the number of organizations offering at least one of the following health care plans: health maintenance organization (HMO), exclusive provider organization (EPO), preferred provider organization (PPO), point of service (POS), indemnity and consumer-driven health plan (CDHP). It is calculated by dividing the number of organizations offering a specific plan by the total number of organizations, regardless of whether they offer a specific plan.

Number of Health Care Plans Offered
Organizations may offer a number of different health care plans to meet the needs of their employee population. This percentage represents the number of organizations that offer one or more health care plans from which their employees can choose.

Health Care Cost, Waiting Period and Stop Loss Coverage Amount

Total Annual Health Care Cost per Covered Employee
Health care expense per covered employee is calculated by taking the total health care expenses paid by the organization in a given year and dividing that by the number of employees who are enrolled in a health care plan.
Waiting Period (in Months) for Coverage for New Employees
This category of data represents the period of time between an employee’s first day of employment and the date when the employee becomes eligible for benefits.

Amount of Stop Loss Coverage
Organizations often contract with a third-party insurance provider to cover medical claims if they exceed a specified dollar amount over a set period of time. This benchmark represents the dollar amount per employee at which the stop loss coverage begins.

Health Care Costs for All Plans Combined

Employer Contribution to Monthly Health Care Premium for Employee-Only Coverage
This benchmark is the monthly dollar amount that the employer pays for health care to cover an employee who is enrolled in an organization’s health care plan.

Percentage of Premium Employer Pays for Employee-Only Coverage
The percentage of premium the organization pays for employee-only coverage is calculated by dividing the dollar amount the organization pays for employee-only coverage premiums by the total premium dollar amount.

Percentage of Premium Employer Pays for Spouse or Domestic Partner Coverage
The percentage of premium the organization pays for spouse or domestic partner coverage is calculated by dividing the dollar amount the organization pays for spouse or domestic partner coverage premiums by the total premium dollar amount.

Annual-Out-of-Network Deductible for Employee-Only Coverage
This benchmark is the annual amount of out-of-pocket expenses that the employee pays for health care services when the provider does not participate with the employee’s health care plan.

Co-Pay for In-Network Primary Care Office Visits for Employee-Only Coverage
This benchmark represents the payment at the time of service to a provider that participates with the employee’s health plan. Co-pays are made in addition to deductibles.
**Maximum Lifetime Benefit Amount for Employee-Only Coverage**
This benchmark is the total dollar amount of health care benefit that is available during an employee’s entire time of enrollment in an organization’s health care plan.

**Health Maintenance Organization**
Health maintenance organizations (HMOs), typically referred to as managed care plans, are pre-paid medical group practice plans that provide comprehensive predetermined medical care benefits for pre-negotiated amounts. Some HMO plans utilize gatekeepers to ensure that certain medical services are used only when absolutely necessary.

**Exclusive Provider Organization**
Exclusive provider organizations (EPOs) are self-funded medical plans that combine aspects of a PPO and an HMO. EPOs provide specific benefit levels if care is provided by a specific network of service providers, otherwise no payment will be made.

**Preferred Provider Organization**
Preferred provider organizations (PPOs) are formed by an insurance company, an employer or a group of employers who negotiate discounted fees with networks of health-care providers. In return, the employers guarantee a certain volume of patients and prompt payment. PPO participants’ out-of-pocket costs are usually lower than under a fee-for-service plan.

**Point of Service**
Point of service (POS) plans allow employees to use both in-network and out-of-network providers, although benefits are greater if in-network providers are used. Often combining aspects of a PPO and an HMO, some POS plans utilize gatekeepers to ensure that certain medical services are used only when absolutely necessary.

**Indemnity**
Indemnity plans are full-choice health care plans that allow covered employees to go to any qualified physician or hospital they choose, as there is no incentive or requirement to use a particular network of providers. Medical claims are then submitted to the insurance company for payment. Indemnity plans are also known as fee-for-service health care plans.

**Consumer-Driven Health Plan: High-Deductible Health Plan**
A consumer-driven health care plan is a high-deductible health plan that is presented along with a tax-advantaged spending account. Presently, two types of plans meet these criteria—health savings accounts (HSAs) and health reimbursement accounts (HRAs).
**Consumer-Driven Health Plan: Health Savings Account and Health Reimbursement Account**

**Employer Contribution to Health Savings Account**
Health savings accounts, a component of consumer-driven health care plans, allow employers and employees to contribute to tax-deductible accounts for the benefit of employees covered under high-deductible health plans. This benchmark indicates the amount employers contribute to health savings accounts.

**Maximum Allowable Employee Contribution to Health Savings Account**
Health savings accounts, a component of consumer-driven health care plans, allow employers and employees to contribute to tax-deductible accounts for the benefit of employees covered under high-deductible health plans. This benchmark indicates the maximum amount that an employee may contribute to health savings accounts.

**Employer Contribution to Health Reimbursement Account**
Health reimbursement accounts, a component of consumer-driven health care plans, are tax-free accounts funded by employers. Any benefit dollars that are left in the account at year-end can roll over and be used to cover future medical expenses.

**Prescription Drug Coverage**

**Employee Co-Pay for Generic Medication**
This benchmark represents the payment made at the time of purchase for generic prescription drug medication. Generic medication is equal in therapeutic dose to brand-name original drugs and is typically cost-effective. Co-pays are made in addition to deductibles.

**Employee Co-Pay for Formulary Brand Medication**
This benchmark represents the payment made at the time of purchase for formulary prescription drug medication. Formulary brand medications are a list of preferred drugs that will be covered by a plan at a discount, and they differ from plan to plan. Drugs are selected to be included in this list because they are cost-effective or have a generic substitution available. Co-pays are made in addition to deductibles.

**Employee Co-Pay for Non-Formulary Brand Medication**
This benchmark represents the payment made at the time of purchase for non-formulary prescription drug medication. Non-formulary brand medications are not on the formulary list of drugs, and therefore, no discount is usually offered.
Some plans may refuse to cover a non-formulary drug if a physician has prescribed a generic substitution. Co-pays are made in addition to deductibles.

**Employee Co-Pay for Generic Medication 90-Day Mail-Order Supply**
This benchmark represents the payment made at the time of purchase for a 90-day supply of generic prescription drug medication when the prescription is ordered through the mail. Generic medication is equal in therapeutic dose to brand-name original drugs and is typically cost-effective. Co-pays are made in addition to deductibles.

**Employee Co-Pay for Formulary Brand Medication 90-Day Mail-Order Supply**
This benchmark represents the payment made at the time of purchase for a 90-day supply of formulary prescription drug medication when the prescription is ordered through the mail. Formulary brand medications are a list of preferred drugs that will be covered by a plan at a discount, and they differ from plan to plan. Drugs are selected to be included in this list because they are cost-effective or have a generic substitution available. Co-pays are made in addition to deductibles.

**Employee Co-Pay for Non-Formulary Brand Medication 90-Day Mail-Order Supply**
This benchmark represents the payment made at the time of purchase for a 90-day supply of non-formulary prescription drug medication when the prescription is ordered through the mail. Non-formulary brand medications are not on the formulary list of drugs, and therefore, no discount is usually offered. Some plans may refuse to cover a non-formulary drug if a physician has prescribed a generic substitution. Co-pays are made in addition to deductibles.
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