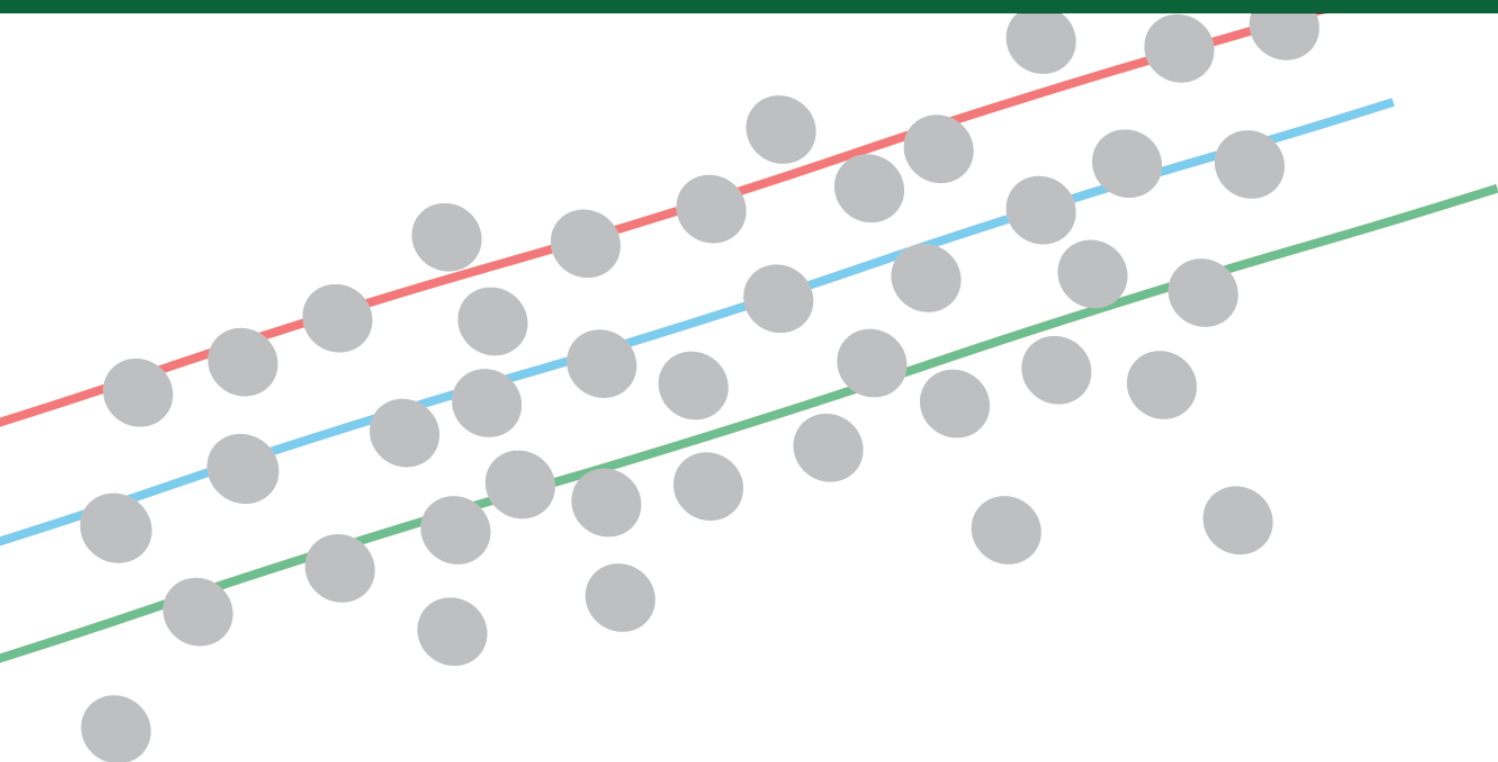


2016

# Health Care Benefits Benchmarking Survey

Ninth Edition



**ECONOMIC  
RESEARCH**

INSTITUTE

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Data Effective Date: January 1, 2016

Organizations Represented: 71

Number of Employees at Participating Organizations: 114,290

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# 2016 Health Care Benefits Benchmarking Survey Ninth Edition

## Overview

### Survey Scope/ Methodology

ERI Economic Research Institute and ERI Salary Surveys are the sponsors for the 2016 Health Care Benefits Benchmarking Survey. This ninth edition of the survey is offered through ERI Salary Surveys.

Questionnaires were designed and distributed for this ninth edition of the Health Care Benefits Benchmarking Survey in October 2015. Participation was solicited from employers in the public, private, and non-profit sectors, as well as government entities in the United States. Data input was collected in the period from October 1, 2015, to February 19, 2016. The requested effective date of benefits data was January 1, 2016.

Seventy one (71) U.S. organizations contributed data to the survey. Characteristics of participants varied greatly and are illustrated in the “Characteristics of Participating Organizations” section of the survey. Twenty (20) industry groups are represented in the United States.

In accordance with our objective to publish only the most accurate and representative information possible, each data submission was thoroughly reviewed by our experienced research staff before it was included in the survey. Areas in question were reconciled with participants before inclusion.

The data received have been analyzed to the maximum degree possible. Because of this, some small sample sizes are displayed for some organization types and descriptions. Data cuts are provided by organization sector, industry group, organization size (by number of employees), and geographic region. Please note that percentages in tables that are intended to represent the entire sample may not total 100% due to rounding. The total number of responses may also vary from section to section since all respondents do not necessarily provide input on each question asked and some questions may not be applicable to some organizations. Specific data may not be reported in this reference report where insufficient data was received to questions presented in the survey questionnaire.

Although questions were asked in the survey questionnaire regarding health care benefits for retirees and part-time employees, no contribution information or costs were requested. As such, employee and organization contributions reported in this survey are reported for full-time, active employees only. Part-time employees and retirees were assumed not to be covered and were excluded from the calculations.

Geographic regions for the United States in this survey are defined as:

**Northeast Region:** Connecticut, Delaware, Maine, Maryland, Massachusetts, New Hampshire, New Jersey, New York,, Pennsylvania, Rhode Island, Vermont

**North Central Region:** Idaho, Illinois, Indiana, Iowa, Kansas, Michigan, Minnesota, Missouri, Montana, Nebraska, North Dakota, Ohio, South Dakota, Wisconsin, Wyoming

**South Central Region:** Arizona, Arkansas, Colorado, Louisiana, New Mexico, Oklahoma, Texas, Utah

**Southeast Region:** Alabama, District of Columbia, Florida, Georgia, Kentucky, Mississippi, North Carolina, South Carolina, Tennessee, Virginia, West Virginia

**West Coast Region:** Alaska, California, Hawaii, Nevada, Oregon, Washington

A companion benefit report for nonprofit organizations covering health care data, general benefit practices, medical insurance, dental insurance, vision insurance, life insurance, disability insurance, retirement plan practices, paid leave, and executive perquisites is also sponsored by ERI Salary Surveys and may be purchased online at [salary-surveys.eri.com](http://salary-surveys.eri.com). The **2016 Benefits in Nonprofit Organizations Survey** report will be released in July 2016.

ERI Economic Research Institute and ERI Salary Surveys wish to express sincere appreciation for data contributions made by numerous participating organizations. Their active participation was indispensable in making this reference report an accurate representation of employee health care benefits programs effective as of January 1, 2016.

This survey report was prepared by Lyle Leritz, PhD, Managing Director, ERI Salary Surveys. The **2016 Health Care Benefits Benchmarking Survey** was released in April 2016.

# Executive Summary

Employers are now able to offer a wide range of benefit plans to employees. They can work with an insurance broker or other benefits professional to select health insurance programs that meet the needs of employees or they may provide benefit options through a private insurance exchange. The selection of an appropriate health plan can be a confusing and time-consuming process for both the employer and the employee. Choosing a plan with the lowest premium often leads to dissatisfaction once out-of-pocket costs are realized. As a result, it is important to consider the value of the plan, not just of the plan's costs, but also its coverage, out-of-pocket expenses, and comparison to other plans.

Despite the rollout of government-regulated insurance exchanges, employer-offered plans are still the most cost-effective option for employees. The majority of executives continue to believe that maintaining an attractive health care plan is critical for attracting and maintaining quality employees. While it would be easy to just compare the cost of paying penalties for not offering coverage with the cost of health coverage, there would also be indirect costs that must be considered such as higher turnover, negative morale, inability to attract talent, and even additional compensation that may be required to make up for lost health coverage.

Making decisions about health coverage to comply with health care reform involves many variables. Until now, many employers' primary health care strategy has been focused on easing the year-to-year cost trend. Under the Affordable Care Act (ACA), employers will be subject to a forty percent (40%) excise tax on the value of health insurance benefits above a certain amount beginning in 2018. With these new layers of costs to come, employers are now faced with more decisions that demand actively managing risk.

Health insurance consistently consumes a bigger share of employer costs. Because of this, employers will have to continue to reduce costs by reducing the level of benefits offered or by shifting additional costs to employees. In fact, despite a slowdown in the growth of group health plan premiums, higher deductibles and higher out-of-pocket maximums have clearly shifted more costs to employees.

Another approach taken by many employers is to move to less costly options such as a High Deductible Health Plan coupled with a Health Savings Account instead of the more traditional medical plans. High deductible plans carry lower premiums and shift more medical costs to employees.

This Executive Summary presents selected findings based on this year's survey. Some trend information is provided but trends can be influenced by the mix of survey participants from year to year. This report is offered on an annual basis so that trends may be identified, as possible. Annual participation is encouraged.

Seventy-one (71) data submissions representing 114,290 employees were received from participants in this survey. Data for one hundred nineteen (119) medical plans in the United States and seventy-seven (77) dental plans were reported.

Representation by region in the United States is as follows:

- Northeast – 27%
- Southeast – 18%
- North Central – 23%

- South Central – 11%
- West Coast – 21%

Types of medical plans offered in the United States are as follows:

- Preferred Provider Organization (PPO) – 45%
- Health Maintenance Organization (HMO) – 13%
- Point of Service (POS) – 5%
- Exclusive Provider Organization (EPO) – 4%
- Indemnity – 1%
- High Deductible Health Plan (HDHP) – 31%

Types of dental plans offered in the United States are as follows:

- Dental Preferred Provider Organization (DPPO) – 75%
- Dental Health Maintenance Organization (DHMO) – 16%
- Dental Point of Service (DPOS) – 4%
- Dental Indemnity – 5%
- Dental Discount – 0%
- Dental Reimbursement – 0%

In this year's survey, the average deductible reported in a HDHP/HSA arrangement was \$2,755, up from \$2,162 in 2015 and \$2,087 in 2014. The practice of offering high deductible health plans has grown significantly over the last few years and is expected to continue to grow.

Other employers are just reducing benefit levels overall by increasing employee contributions, deductibles, co-payments, coinsurance, and out-of-pocket maximums. A new trend surfaced in 2012 when several organizations reported a deductible for prescription drugs in addition to the standard medical deductible.

This year's participants reported using the following other cost-saving measures:

- 52% increased employee contribution to premium
- 24% increased prescription co-payment or coinsurance amounts
- 28% increased medical co-payment or coinsurance amounts
- 39% increased deductible amounts
- 39% increased out-of-pocket maximum amounts
- 18% changed the drug formulary
- 10% moved to self-insurance

Cost management strategies such as disease management, health promotion, and wellness programs are being used by many employers to counter increasing health costs. In the 2016 survey, 45% of participating organizations reported their plans as consumer-directed health plans. Consumer-directed health plans are plans that attempt to contain medical benefits costs by empowering consumers to make informed choices regarding the quality and efficiency of their health care. In addition to the consumer-directed health plan

effort, 42% of respondents report introducing new health promotion and wellness programs. Another 21% of respondents report having introduced a disease management program this year. Most employers recognize that knowledge of the marketplace is powerful, and benchmarking one's own health plan costs and practices with other employers in the external marketplace is the first step in evaluating the effectiveness of current and future benefit changes and strategies. Benchmarking employer-provided employee health care benefits is the focus of this survey report. By providing timely and accurate measurement of health care plan costs, we hope that this report will serve as a valuable reference that may be used when considering plans, changes, and strategies for effective benefits management.

## **MEDICAL BENEFITS**

All but one (1) of the seventy-one (71) survey respondents offer at least one medical plan to full-time employees, with Preferred Provider Organization (PPO) plans the most common among all of the four (4) organization sectors surveyed. All plans reported by respondents who offer medical benefits offer a pharmacy prescription drug plan.

Thirty percent (30%) of respondents offer only one (1) medical plan to employees, thirty-eight percent (38%) offer two (2) medical plans, eighteen percent (18%) offer three (3) medical plans, eleven percent (11%) offer four (4) medical plans, and three percent (3%) offer five (5) medical plans to full-time employees. Fifty-six percent (56%) of this year's respondents offer an opt-out for medical and thirty-eight percent (38%) of those respondents offer an opt-out reimburse for opting-out.

Preferred Provider Organizations (PPO) continue to dominate the market, enrolling forty-seven percent (47%) of covered employees in the United States. The percentage of employees covered in other plan types are sixteen percent (16%) of enrollees in Health Maintenance Organization (HMO) plans and five percent (5%) in Point of Service (POS) plans. One percent (1%) participation was reported in Exclusive Provider (EPO) plans and thirty two percent (32%) participation was reported in a High Deductible Health Plan (HDHP) combined with a Health Savings Account. No participation in Indemnity plans was reported.

Preferred Provider Organization (PPO) plans are the most prevalent type of primary medical plan with fifty-seven percent (57%) of the total response. High Deductible Health Plans (HDHP) combined with a Health Savings Account were the second most common type of benefits delivery with nineteen percent (19%) of the response. Health Maintenance Organization (HMO) plans ranked third as the most prevalent type of primary medical plan with fourteen percent (14%) of the response. The average monthly employee cost for Preferred Provider Organization (PPO) plans for employee-only coverage is \$109.91, down thirty-two percent (32%) from \$159.94 in 2015. The average monthly employer cost for Preferred Provider Organization (PPO) plans for employee-only coverage is \$464.17, up seven percent (7%) from \$434.06 from 2015. The employer cost for employee-only coverage for PPO plans equals eighty-one percent (81%) of the total premium cost reported.

Regarding eligibility, eighty-one percent (81%) of respondents report that executives become eligible for health care benefits in one (1) month or less. Eighty-one (81%) of respondents report that exempt employees are eligible following completion of one (1) month or less. Seventy-eight percent (78%) of respondents report that non-exempt employees are eligible following completion of one (1) month or less.



Only seventeen percent (17%) of responding organizations offer medical benefits to retirees while twenty-five percent (25%) of respondents offer medical benefits to part-time employees. Health care organizations are most likely to offer part-time medical and/or dental benefits.

### GENERAL FEATURES OF MEDICAL

The majority of responding organizations provide some form of wellness and/or disease management programs to participants. Eighty-seven percent (87%) of respondents provide an Employee Assistance Plan (EAP) while eighty-nine percent (89%) offer alcohol/substance abuse services provisions. Fifty-five percent (55%) of respondents offer medical benefits to domestic partners.

Forty-seven percent (47%) of this year’s reported medical plans are self-insured. Self-insurance tends to be more popular in large organizations with more than 500 employees.

For actual details and costs, please see the survey report.

### DENTAL/VISION

Dental benefits are offered by ninety-three percent (93%) of responding organizations. In 2016, eighty-four percent (84%) of employees in responding organizations are enrolled in a dental plan, up from seventy-nine percent (79%) of employees in 2015.

Reported 2016 average employer contributions to dental plans increased in 2016 across the board, while employee contribution requirements have remained steady. Tiers representing employer monthly dental contributions to premium over the last three (3) years are:

	2014	2015	2016
Employee Only	\$20.06	\$21.72	\$25.50
Employee + Child	\$35.41	\$37.80	\$44.99
Employee + 1 Adult	\$34.51	\$34.59	\$44.19
Employee + Family	\$50.21	\$55.78	\$65.31

Seventy-seven percent (77%) of organizations providing dental benefits offer only one (1) dental plan. Fifteen percent (15%) of respondents who provide dental coverage offer two (2) dental plans. The Dental Preferred Provider Organization (DPPO) is the most prevalent delivery method for dental (75%). The average employee monthly contribution level for employee-only coverage is \$12.70. The average employee monthly contribution level for employee plus family coverage is \$56.26.

Vision benefits are offered by eighty-seven percent (87%) of respondents, and forty-nine percent (49%) contribute to the cost of this benefit, up from forty-four percent (44%) in 2015. Eighty-seven percent (87%) of organizations offering vision benefits state that dependents are eligible for coverage. In organizations offering vision benefits, twenty-seven percent (27%) offer this benefit as part of the medical plan.

For actual details and costs, please see the survey report.