

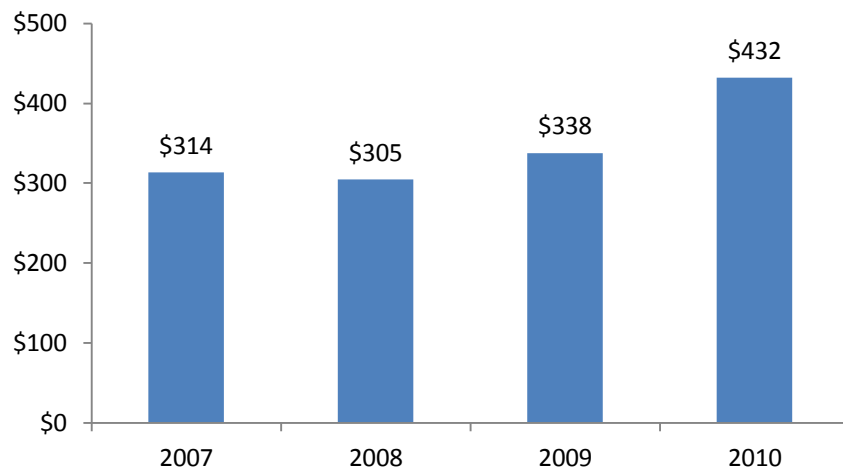
Executive Brief: Health Care Premium Trends Across Plan Types

The SHRM Benchmarking Database provides members with more than 400 metrics based on their organization's industry, employee size, geographic region and more. Questions about this research or how to receive key benchmarking data can be directed to www.shrm.org/benchmarks or 703-535-6366.

Introduction

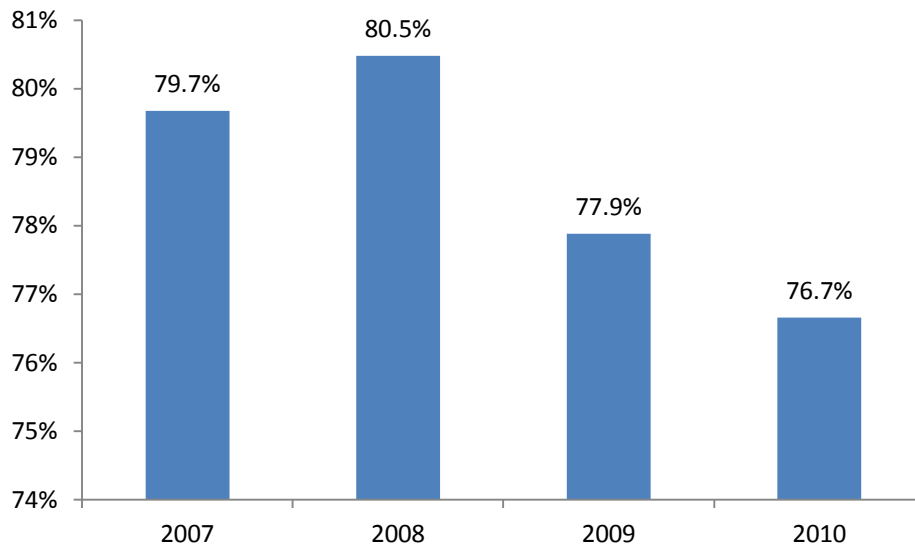
As health care premiums rise, employers must make decisions about employee cost sharing for health care coverage. In its *Employer Health Benefits Annual Survey*, the Kaiser Family Foundation found that average annual premiums for single coverage rose 8% in 2011 compared with 2010.¹ The 2011 premium increase was larger than the 5% increase between 2009 and 2010.² According to a SHRM survey, employers' actual dollar contributions to monthly health care premiums for single coverage have risen 38%, from \$314 to \$432, over the past four years. As seen in Figure 1, the largest increase happened between 2009 and 2010.³ However during this same period, the percentage of the premium employers contributed has fallen 3.8%, from 80% to 77%, as seen in Figure 2. This trend is not expected to end anytime soon, according to the results of the Symposium on Health Care Costs and the Future of U.S. Competitiveness.⁴ Reasons for the expected future increases include an aging population, high end-of-life expenditures and enormous costs of caring for the chronically ill. These data reflect decisions employers must make about how to manage rising health care costs while offering competitive benefits plans.

Figure 1. Employer contribution to monthly health care premium for employee-only coverage for all plan types



Source: 2011-2012 Benefits Benchmarking Database

Figure 2. Percentage of premium employer pays for employee-only coverage for all plan types



Source: 2011-2012 Benefits Benchmarking Database

Although employee benefits are costly—an average of 19% of an employee’s annual salary is spent on voluntary benefits, such as medical plans, prescription coverage, and health savings accounts—they also are a tool to increase job satisfaction and prevent costly turnover.⁵ Employees consistently rank benefits as a large contributor to job satisfaction.⁶ However, these costs must be managed. This article compares cost-sharing trends among the three most popular plan types organizations offer—preferred provider organizations (PPOs), health maintenance organizations (HMOs) and consumer-driven health plans (CDHPs) from 2007 to 2010. To provide accurate cost-sharing comparisons between plan types, these data are based on employee-only coverage.

Preferred Provider Organizations

Preferred provider organizations (PPOs) are formed by an insurance company, an employer or a group of employers that 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. The primary benefit of a PPO plan is that employees can see treatment providers out of network, though usually for an additional cost.

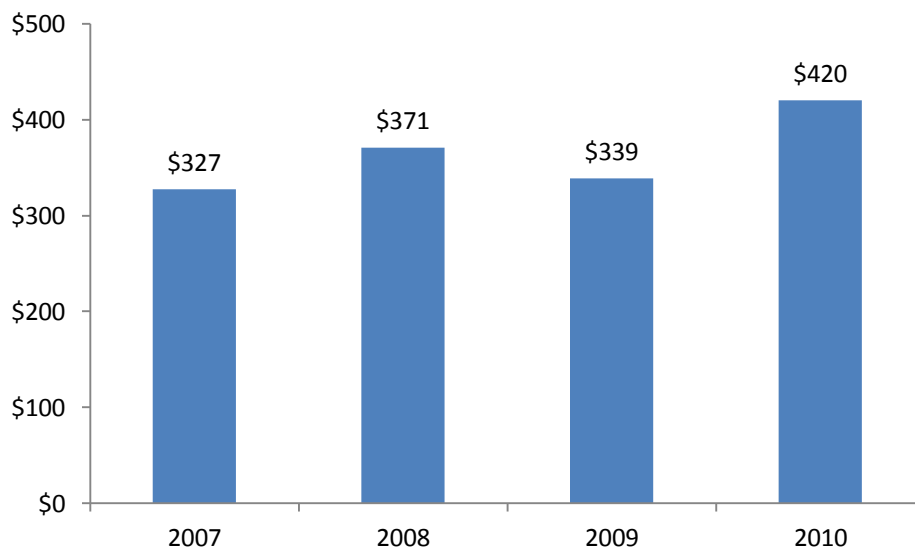
Forty-five percent of organizations offered more than one health care plan in 2010. Larger companies are more likely to offer multiple plan types. Just 8% of organizations with fewer than 250 employees offered three or more plans in 2010 compared with 24% of organizations with 1,000 or more

employees. Larger companies have more purchasing power and therefore can offer more options. PPO plans were both the most common plan organizations offered to employees and the most popular plan in which employees chose to enroll in 2010: 83% of organizations offered PPO plans, and 52% of employees enrolled in them.

As illustrated in Figure 3, employers' contributions to monthly PPO plan premiums increased from \$327 to \$420 between 2007 and 2010. This represents a 28% increase, but it was smaller than the 38% average increase among all plan types. Between 2007 and 2011, organizations' contributions to monthly PPO premiums fell 4.7%, from 79.2% to 75.4% (see Figure 4). This was a steeper fall in the percentage of contribution to the monthly premium than the 3.8% drop across all plan types and may account for the smaller increase in employer actual dollar contribution for PPO plans when compared with all plans.

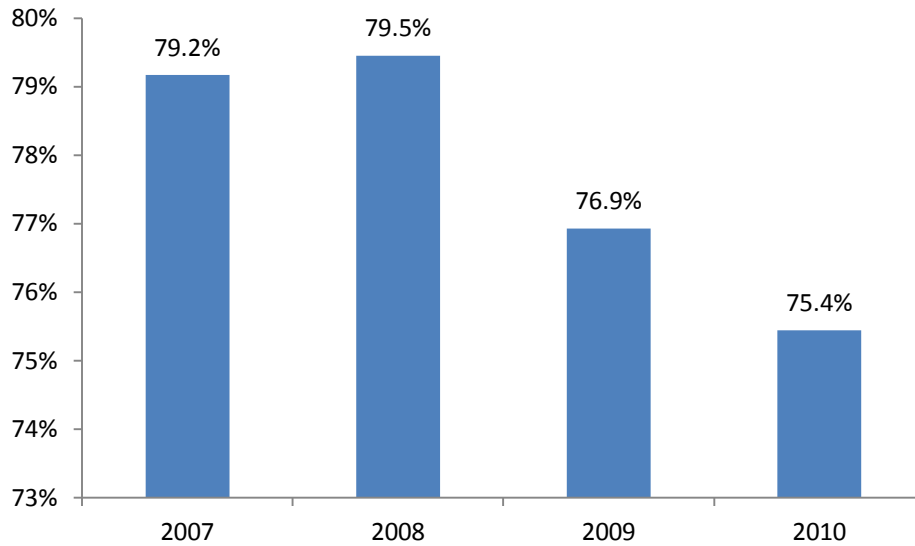
The education, and publishing, broadcasting and other media industries accounted for the largest employer contributions to monthly health care premiums and could be responsible for the average overall increase in PPO premiums. Education environments are typically unionized and often have richer benefits packages in exchange for lower compensation. Publishing, broadcasting and other media, similar to other industries with higher PPO premiums such as finance and insurance, compete for a highly skilled workforce and therefore may offer richer benefits packages to remain competitive from a staffing perspective.

Figure 3. Employer contribution to monthly health care premium for employee-only coverage for PPO plans



Source: 2011-2012 Benefits Benchmarking Database

Figure 4. Percentage of premium employer pays for employee-only coverage for PPO plans



Source: 2011-2012 Benefits Benchmarking Database

Health Maintenance Organizations

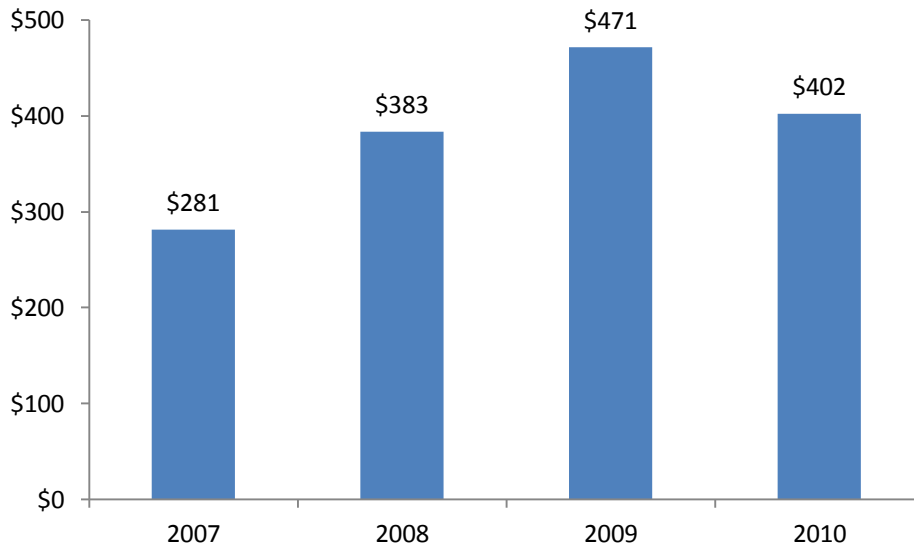
Similar to PPO plans, health maintenance organizations (HMOs), typically referred to as managed care plans, are prepaid medical group practice plans that provide comprehensive predetermined medical care benefits for prenegotiated amounts. Some HMO plans use gatekeepers to ensure that certain medical services are used only when absolutely necessary. HMOs were successful at keeping costs down when employees were restricted to the HMO network. The waiting period for treatment was a drawback for many employees, and as the restrictions to seeing health care providers within the network were loosened, health care premiums increased.

HMO plans were the second most common plan offered by employers and the second most popular plans chosen by employees. HMO plans were offered by 36% of organizations in 2010, and 18% of employees enrolled in HMO plans. Figure 5 shows employer contributions to monthly health care premiums for HMOs increased from \$281 in 2007 to \$402 in 2010. The average monthly contribution for HMO plans was \$402, which is smaller than the average monthly contribution of \$432 across all plan types. However, HMO monthly contributions increased by 43% over the four years being examined, which is greater than the 38% increase seen across all plan types. Figure 6 shows that although employer contributions to monthly HMO premiums fell, they fell at a rate similar to the average of all

plan types. In 2007, employers contributed 80.2% of the HMO monthly premium compared with 78.8% in 2010. This was a 3.1% drop, while the drop across all plan types was 3.8%.

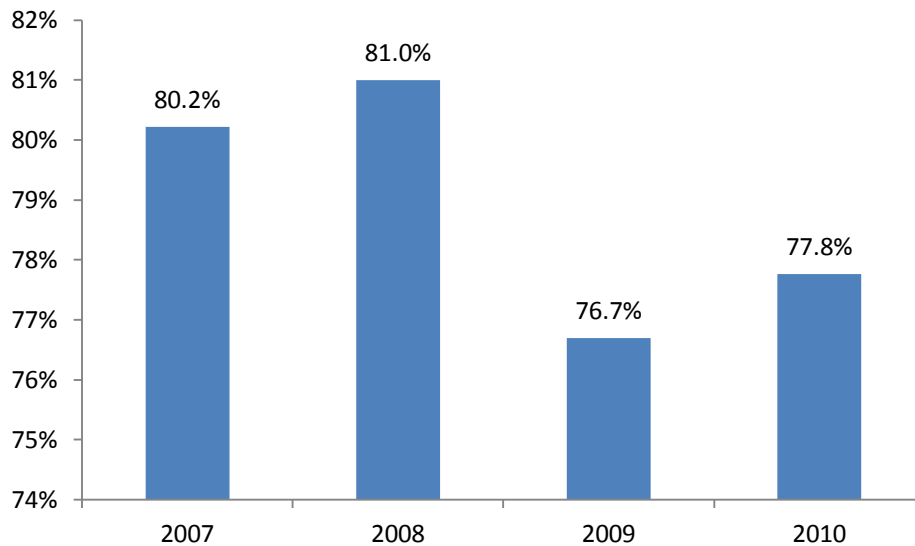
Education, again, was one of the industries that paid the most in monthly premiums for this plan type. However, pharmaceutical and biotechnology had even greater employer premium contributions to HMO plans. These industries require a highly skilled and highly specialized workforce, and therefore, recruitment difficulties may have caused these organizations to offer richer health care plans, contributing to the continued average rise in premiums for HMOs. Despite the weak economy, both industries have forecasted increases in hiring, which could put pressure on employers to offer strong benefits packages to attract top talent.⁷

Figure 5. Employer contribution to monthly health care premium for employee-only coverage for HMO plans



Source: 2011-2012 Benefits Benchmarking Database

Figure 6. Percentage of premium employer pays for employee-only coverage for HMO plans



Source: 2011-2012 Benefits Benchmarking Database

Consumer-Driven Health Plans

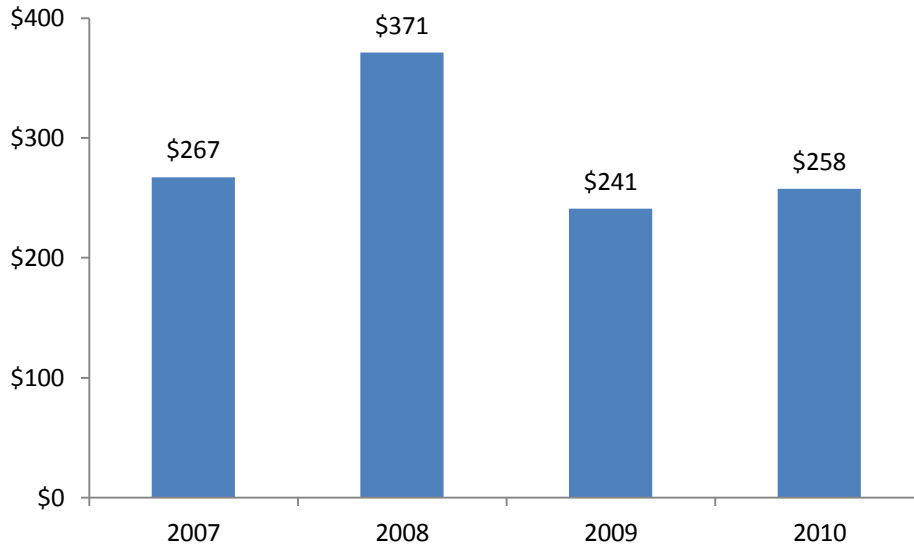
A consumer-driven health care plan (CDHP) is a high-deductible health care plan that is presented along with a tax-advantaged spending account. Presently, two types of plans meet these criteria—health savings accounts (HSAs) and health reimbursement accounts (HRAs). CDHPs can be the most difficult plan to gain employee buy-in. American health care consumers are generally not well informed about how to use the health care system since most have only accessed it through networks. Despite paying more for health care services, the United States has lower health care utilization rates than other countries. Although CDHPs offer the benefit of controlling costs, they also pose the risk of lowering utilization rates further, which can lead to future catastrophic expenses for untreated illness.⁸

CDHP is the only plan type over the past four years to show an overall decrease in employer-paid premiums; however, the year-to-year results are mixed. PPO and HMO plans were by far the most common plan types organizations offered employees. The third most common plan type was CDHPs. Sixteen percent of organizations offered CDHPs, and 6% of employees enrolled in these plans.

As expected, CDHPs also varied significantly in regard to cost sharing when compared to PPO and HMO plans. CDHPs had the lowest employer contribution to the monthly premium in terms of actual dollar amount. However, premiums for CDHPs are generally low because they have high deductibles and more

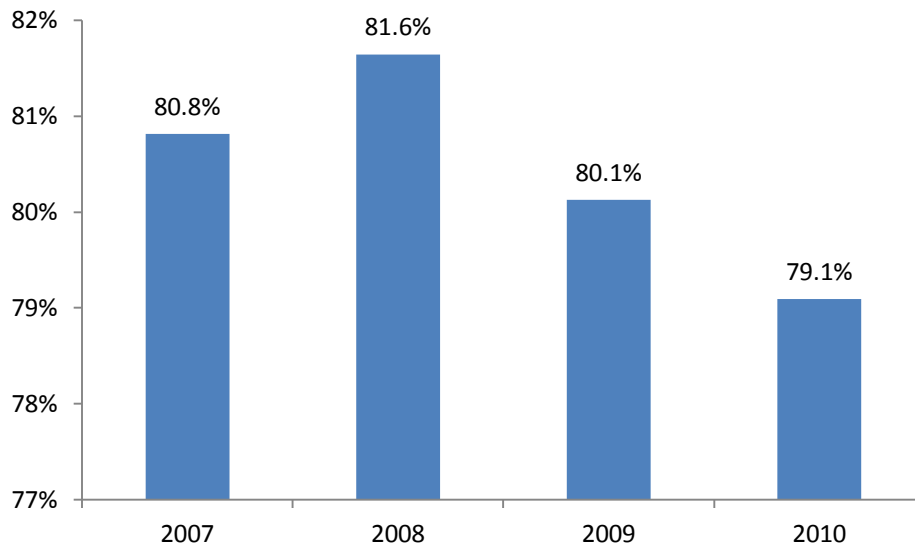
of the cost sharing occurs in how the deductible is funded. CDHPs were the only plan type where the employer contribution to the monthly premium decreased: as illustrated in Figure 7, it fell 3.7%, from \$267 in 2007 to \$258 in 2010. As a percentage, the employer contribution to the monthly premium fell slightly over the same period of time, by 2.7%, from 80.8% in 2007 to 79.1% in 2010, as shown in Figure 8. CDHPs had the largest average percentage of employer contribution to the monthly premium than any other plan. In addition, although employer contributions to the monthly premium as a percentage fell for all plan types, CDHP contributions as a percentage fell the least. This suggests that CDHPs are accomplishing their philosophic goal of motivating employees to be wiser consumers of health care services.

Figure 7. Employer contribution to monthly health care premium for employee-only coverage for CDHPs



Source: 2011-2012 Benefits Benchmarking Database

Figure 8. Percentage of premium employer pays for employee-only coverage for CDHPs



Source: 2011-2012 Benefits Benchmarking Database

Conclusions

Differences in cost sharing among plans reflect the averages of all plan types with one exception—the employer contribution to the monthly health care premium for CDHPs fell. Employer contributions for the monthly premiums for other plans increased even as all plans' employer percentage increased. Experts consider rising health care costs less of a risk to international competitiveness than a burden for small businesses, which generate the majority of jobs in the United States, to remain competitive within their industry.⁹ Managing health care costs is vital for the success of small businesses in particular.

These findings do not necessarily mean that CDHPs are the best managed plans for organizations to offer their employees. Many considerations besides cost control are factored into deciding which plans are the best to offer employee coverage. These considerations include the organization's benefits strategy, the organization's investment in its workforce, employee demographics, employee and organizational values, and competition for attracting and retaining high-performing employees.

Furthermore, this article reported averages for each plan type. There is variability on cost sharing and expenses within each plan; however, the lowest price plan is not necessarily the best option for an organization. Rather, plans should be selected strategically. If a company that needs to hire highly skilled

positions chooses a plan that does not attract the workforce it seeks, it may end up spending more in hiring and lost productivity costs. Plans have to be reviewed and evaluated at an individual basis.

Finally, as seen in the figures, the overall trend has been an increase in premiums and a decrease in the percentage of the employer contribution. However, on a year-to-year basis, there are both increases and decreases. Data for newer plans like CDHPs are limited, so only further tracking in the years ahead could reveal any potential differences. Since no clear trends appear from year to year, it remains to be seen if one plan performs better than any other.

Methodology

The 2011 SHRM Benefits Benchmarking Study was conducted in order to collect metrics about health care, welfare and retirement benefits across various industries. The study collected data on benefits metrics such as employer contribution to monthly health care premium for employee-only coverage, annual out-of-network deductible for employee-only coverage, employer contribution to health savings account, prescription drug co-pay amounts, and 401(k) match percentage. In addition, organizational data, such as employee size and geographic region, were obtained. Data were collected for 2010, along with expectations for hiring and revenue change in 2011. 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 U.S. and international SHRM members who are experts in the field of benefits management.

The survey was fielded in February 2011 to 13,000 randomly selected SHRM members who were HR managers, assistant or associate directors, directors, assistant or associate vice presidents, vice presidents, or presidents. 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. Of these, 2,558 senior HR professionals responded on behalf of their organizations, yielding a response rate of 20%. The survey was accessible for a period of eight weeks.

This article was prepared by Andrew Mariotti, strategic research analyst at SHRM.

Endnotes

¹ Kaiser Family Foundation. (2011). *Employee health benefits: 2011 summary of findings*. Retrieved December 7, 2011, from <http://ehbs.kff.org/pdf/8226.pdf>.

² Ibid.

³ SHRM 2011-2012 Health Care Benefits Benchmarking Database

⁴ Society for Human Resource Management. (2006). *The SHRM Symposium on Health Care Costs and the Future of U.S. Competitiveness*. Alexandria, VA: SHRM.

⁵ Society for Human Resource Management. (2011). *2011 employee benefits: A research report by SHRM*. Alexandria, VA: SHRM.

⁶ Society for Human Resource Management. (2011). *2011 employee job satisfaction and engagement: A survey report by SHRM*. Alexandria, VA: SHRM

⁷ SHRM 2011-2012 Human Capital Benchmarking Database.

⁸ Society for Human Resource Management. (2006). *The SHRM Symposium on Health Care Costs and the Future of U.S. Competitiveness*. Alexandria, VA: SHRM.

⁹ Ibid.

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