

# EMPAQ®

## Data Dictionary



National  
Business  
Group on  
Health

EMPAQ®

Employer Measures of Productivity, Absence and Quality™

## Table of Contents

---

<b>Demographic Information</b>	<b>3</b>
<b>Short-Term Disability (STD) Metrics and Data Elements</b>	<b>6</b>
<b>Workers' Compensation (WC) Metrics and Data Elements</b>	<b>15</b>
<b>Long-Term Disability (LTD) Metrics and Data Elements</b>	<b>24</b>
<b>Family Medical Leave (FMLA) Metrics and Data Elements</b>	<b>30</b>
<b>Group Health (GH) Metrics and Data Elements</b>	<b>33</b>
<b>Incidental Absence (IA) and Total Absence (TA) Metrics and Data Elements</b>	<b>46</b>
<b>Employee Assistance Program (EAP) Metrics and Data Elements</b>	<b>48</b>
<b>Health Management Program (HM) Metrics and Data Elements</b>	<b>51</b>

---

<b>Index</b>	<b>54</b>
<b>About the National Business Group on Health</b>	<b>57</b>
<b>About the Institute for Health, Productivity and Human Capital (IHPHC)</b>	<b>57</b>

## Demographic Information (Company Overview)

### Demographic Definitions:

The following definitions provide background for the Demographic Metrics:

**Average Size of Workforce:** The “average size of workforce” is the number of active employees plus any on leave who are still benefit eligible at mid-month (or mid-quarter) during the reporting period, summed, and then divided by the total number of months (or quarters) during the reporting period.

Example: 
$$\frac{10,000 (Q1) + 10,000 (Q2) + 10,000 (Q3) + 10,000 (Q4)}{4}$$

This information can be obtained from an HRIS system, a payroll system, a Department of Labor filing, or an eligibility vendor.

**Employees – Active:** An employee who works for the employer on a regular basis in the usual schedule of the employer’s business.

**Employees – Covered:** An employee who is eligible to receive benefits under a designated plan and is enrolled (or participating) in that particular benefit plan. A health care plan may refer to a covered employee as the subscriber, contract holder or cardholder.

**Employees – Eligible:** An employee who is entitled to receive benefits under a designated plan.

**Full-Time Equivalent:** The number of full-time equivalent jobs, defined as total hours worked divided by average annual hours worked in full-time jobs.

### Demographic Metrics:

Provide your company’s responses to the following Demographic metrics, using the EMPAQ® Data Submission Tool. For your convenience, write your answer in the boxes provided below as you are gathering your data. Then log onto the EMPAQ® website ([www.empaq.org](http://www.empaq.org)) to provide your company’s data.

**Note:** If your company and/or its suppliers send claims level data for other programs (such as STD), your company needs to complete the Demographics Metrics in order to produce valid benchmarks.

**Company Size:** The total number of full-time employees that work for a company during the reporting period.

Your Company’s  
Response:

---

## **Demographic Metrics (continued):**

**NAICS Code (2-digit or 4-digit):** The North American Industry Classification System (NAICS) is the standard used by Federal statistical agencies to classify business establishments for the purpose of collecting, analyzing, and publishing statistical data related to the U.S. business economy. NAICS is a two- through six-digit hierarchical classification code system, offering five levels of detail. Each digit in the code is part of a series of progressively narrower categories, the more digits in the code signify greater classification detail. **EMPAQ® users must select a 2- or 4-digit NAICS code to assign a company to an industry group for benchmarking. 4-digit codes are recommended.**

Your Company's  
Response:

---

Please see the official 2007 U.S. NAICS Manual, which includes codes and definitions for each industry, background information, and a comprehensive index for more information. The NAICS Manual is hosted on the EMPAQ® website at [www.empaq.org](http://www.empaq.org).

**SIC Code:** The Standard Industrial Classification (SIC) was a standard used by the U.S. government for classifying industries. Since 1997, SIC has been slowly phased out and will be fully replaced by the North American Industry Classification System (NAICS). EMPAQ® will accept SIC codes but participants should be cautioned that they will be expected to assist in SIC to NAICS cross-walking if there is not a 1:1 match.

Your Company's  
Response:

Provide NAICS Code

---

**Employees – Full-Time Salaried Exempt:** The number of “white collar” workers who are not covered by the Fair Labor Standards Act of 1938 (applies to overtime and other work regulations). Note: An exempt employee is generally defined in the law as “any employee employed in a bona fide executive, administrative, or professional capacity.” (Fair Labor Standards Act 29 U.S. C. § 213(a)(1).)

Your Company's  
Response:

---

**Employees – Full-Time Salaried Non-Exempt:** Salaried non-exempt employees are employees who, because of the type of duties performed, the usual level of decision making authority, and the method of compensation, are subject to all provisions of the Fair Labor Standards Act of 1938 (FLSA) including the payment of overtime and other work regulations. Non-exempt employees are normally required to account for hours and fractional hours worked.

Your Company's  
Response:

---

**Employees – Full-Time Hourly:** An employee that works 32-40 hours per week (based on the employer's schedule for full-time status), is paid based on an hourly rate and is covered by the Fair Labor Standards Act of 1938 (applies to minimum wage, overtime and other work regulations).

Your Company's  
Response:

---

**Employees – Part-Time:** An employee that is working between 1 and 34 hours per week or a work schedule as defined by the employer that encompasses fewer hours than the standard full-time schedule, typically with pro-rated salary, benefits and career advancement.

Your Company's  
Response:

---

**Demographic Metrics (continued):**

**Age Breakdown – Under Age 30 (%)**: The percentage of the average size of workforce that is equal to or less than 30 years old. Indicate the number as a whole number (i.e., 10 for 10%) rather than a decimal (i.e., 0.10).

Your Company's  
Response:

\_\_\_\_\_

**Age Breakdown – Over Age 55 (%)**: The percentage of the average size of workforce that is equal to and greater than 55 years old. Indicate the number as a whole number (i.e., 10 for 10%) rather than a decimal (i.e., 0.10).

Your Company's  
Response:

\_\_\_\_\_

**Length of Employment – Less Than 1 Year (%)**: The percentage of the average size of workforce whose length of employment is equal to or less than one year. Indicate the number as a whole number (i.e., 10 for 10%) rather than a decimal (i.e., 0.10).

Your Company's  
Response:

\_\_\_\_\_

**Length of Employment – More Than 10 Years (%)**: The percentage of the average size of workforce whose length of employment is equal to or more than ten years. Indicate the number as a whole number (i.e., 10 for 10%) rather than a decimal (i.e., 0.10).

Your Company's  
Response:

\_\_\_\_\_

**Population Female (%)**: The percentage of the average size of workforce who are female. Indicate the number as a whole number (i.e., 10 for 10%) rather than a decimal (i.e., 0.10).

Your Company's  
Response:

\_\_\_\_\_

**Population Unionized (%)**: The percentage of the average size of workforce who are covered under a collective bargaining agreement. Indicate the number as a whole number (i.e., 10 for 10%) rather than a decimal (i.e., 0.10).

Your Company's  
Response:

\_\_\_\_\_

**Total Payroll**: The aggregate gross wages for all of an employer's U.S. employees, including those not covered by the employer's benefit programs.

This information is the amount indicated on the W-2 (the dollar amount paid for employee payroll wages, including base pay, shift differential, overtime, bonuses, and paid sales commissions.)

Your Company's  
Response:

\_\_\_\_\_

# Short-Term Disability (STD) Metrics and Data Elements

## STD Headcount Chart:

The following chart provides assistance in determining whether to include certain individuals in the STD headcount metric:

Metric	Eligible Employees (but not enrolled in STD)	Employees Enrolled in STD	Employees on STD
Average Number of Employees Covered under STD Plan		X	X

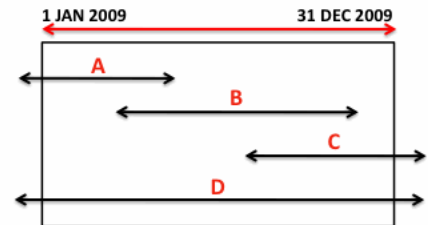
## STD Definitions:

The following definitions provide background for calculating the STD headcount and cost metrics:

**Active Claim:** Synonymous with **Open Claim**—Refers to a claim which has not been settled, with an expectation that further payments will be made. Most commonly referenced in metrics for disability programs such as: Short-Term Disability, Long-Term Disability and Workers' Compensation.

The following categories are available for **Active Claims** in the reporting period:

- Claims incurred in the prior period, and paid and closed in current period (A)
- Opened and closed during the current period (B)
- Opened in the current period, and continued into the subsequent period (C)
- Opened in the prior period, remained active in current period, and continued into the subsequent period (D)



**Approved Claim:** The claims that have been reviewed for benefit determination and payments have been approved under the plan provisions. Most commonly referenced in metrics for disability programs such as: Short-Term Disability, Long-Term Disability and Workers' Compensation.

**Closed Claim:** The claims that have been closed during the reporting period based on either a full return to work or an expiration of benefits. A **Closed Claim** means that there are no more payments to be made under the plan provisions

## **STD Definitions (continued):**

**New Claim:** Refers to a newly received claim that has been reported for the determination of benefits under the plan provisions during the reporting period. **New Claims** are opened when:

1. The employee has not previously experienced a recorded injury or illness of the same type that affects the same part of the body; or
2. The employee previously experienced a recorded injury or illness of the same type that affected the same part of the body but had recovered.

Most commonly referenced in metrics for disability programs such as: Short-Term Disability, Long-Term Disability and Workers' Compensation.

**Return to Work (RTW):** A claimant returns to the company in partial duty, temporary duty or full-time, regular job. The claimant is no longer fully disabled and unable to perform some duty/job at the work location. Once an employee has returned to work in some capacity, chances are good that the Workers' Compensation/disability benefits will eventually end.

## **Claims Cost Category**

**Provide your company's responses to the following STD Metrics, using the EMPAQ® Data Submission Tool. For your convenience, write your answer in the boxes provided below as you are gathering your data. Then log onto the EMPAQ® website ([www.empaq.org](http://www.empaq.org)) to provide your company's data.**

**Average Number of Employees Covered Under STD Plan:** The average number of covered or enrolled employees (not the eligible employees) in the STD plan.

The average number of employees is obtained by dividing the sum-total of the covered population at the mid-point of each month or quarter for the period being measured, by the number of months (12) or quarters (4) within that time period.

Your Company's  
Response:

Note:

- If a plan is contributory, not all eligible employees will enroll.
- If the plan has an employer paid base with voluntary buy up options, all employees covered by the base plan should be counted.

**Total Number of New STD Claims:** The total number of new, approved claims with dates of disability in the reporting period.

Exclude claims in which STD benefits supplement WC benefits. (These claims will be counted in the WC data.) If the employer has a salary continuation program, include those claims in which the employer's salary continuance program requires a medical certification. Exclude statutory disability claims to avoid double-counting.

Your Company's  
Response:

## Claims Cost Category (continued)

**Total Benefits Paid:** The STD payments made for active claims during the reporting period, even if the claim originated in an earlier year and/or continued into a following year.

Types of payments to consider include:

- STD benefits paid, net of any offsets, such as WC payments.
- Only benefits paid after any elimination period. If the elimination period is paid by a program other than STD, exclude the waiting period pay from the Total Benefits Paid. If the elimination period is reclassified as STD time and not incidental absence, then include these reclassified days.
- The entire cost of relapse claims, as dictated by plan design - both the initial period and the second (or more) relapse periods.
- Any statutory disability claims paid (or premiums if fully-insured).
- Only supplemental payments for any claims that were determined to be Workers' Compensation indemnity claims.
- The portion of the premium used to pay wage replacement for claims (estimated if necessary), if the plan is fully-insured.

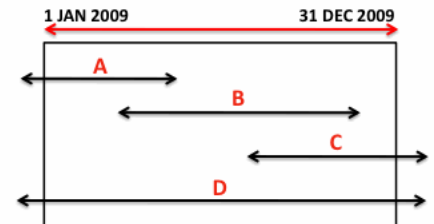
Your Company's  
Response:

---

**Total Number of Active STD Claims:** The total number of STD claims that were ever active (eligible for payments) during the reporting period.

Include the following types:

- Claims incurred in the prior period, paid and closed in current period. (A)
- Opened and closed during the current period. (B)
- Opened in the current period, continued into the subsequent period. (C)
- Opened in the prior period, and remained active in current period, and continued into the subsequent period. (D)



Exclude the following types:

- Denied or pending STD claims.
- Any claims that were initially classified as STD and then reclassified as WC claims.
- Any STD claims that solely provide supplemental payments to a concurrent WC claim.
- Statutory disability claims to avoid double-counting.

Your Company's  
Response:

---

## Claims Cost Category (continued)

**Total Number of Lost Workdays:** The total lost workdays attributable to active STD claims during the reporting period. This is the number of workdays for which employees, after completing the benefit **Elimination Period**, received benefit income from STD claims.

Your Company's  
Response:

---

If an administrative system tracks calendar durations of absence, estimate lost workdays by multiplying the total number of elapsed (calendar days) absent by 5/7 and truncate the final result to adjust for a normal workweek.

Include:

- Partial lost workdays should be summed into full-day equivalents and included in the total.

Exclude:

- Any days before the STD benefit effective date that are part of the initial elimination period.
- Days while the employee is still absent, but the STD claim has ended.
- Any lost workdays associated with a state-mandated or statutory plan.
- Days paid under LTD benefits.
- Days reported as paid under WC claims, where employees are only receiving supplemental STD benefits in addition to WC benefits. If the WC claim is closed, but the individual continues to receive STD benefits, the STD workdays incurred after the WC claim closes would be counted as STD lost workdays.

Include only authorized/paid period days. If a case is closed, and subsequently reopened due to relapse based on a client's plan parameters, then the additional authorized/paid days of the new period is included but not the days in between RTW and going back out on an approved disability.

**Lost Calendar Days Associated with Closed STD Claims:** The number of calendar days lost to closed STD claims. This is the amount of time elapsed between the date an employee becomes disabled (first day of absence) and the date STD benefits ended. Intermittent STD days should be totaled into whole days if they are part of the same claim. Exclude any lost workdays associated with a statutory disability plan to avoid double-counting.

The count of lost calendar days includes any time intervals for claims that are closed within the current reporting period. This includes:

- The benefit elimination period.
- Periods of absence covered by STD prior to the reporting period.
- Periods of absence covered by STD within the reporting period.

Your Company's  
Response:

---

The end date of a closed claim is defined as the point in time when the employee ceases to be eligible for benefits for one of several reasons:

- Employee returns to work either full time/full duty or as part of a transition work program and is no longer receiving STD benefits.
- Claim is settled.
- Claim is terminated because the employee is no longer disabled.
- Employee dies.
- Benefit end date is reached (i.e., 180 days per the STD plan design).

## Claims Cost Category (continued)

**Lost Calendar Days Associated with Closed STD Claims:** *(continued)* Include only authorized/paid period days. If a case is closed, and subsequently reopened due to relapse based on a client's plan parameters, then the additional authorized/paid days of the new period is included but not the days in between RTW and going back out on an approved disability.

**Total Benefits Paid for Closed STD Claims:** The claim costs for all payments made throughout the life of the claim, for any claim that closed in the reporting period. These are claims that were opened in prior years (as long as they closed in the current year). Exclude claims opened in the current period that are not closed by the period end.

Your Company's  
Response:

---

Include the following:

- STD benefits paid, net of any offsets, such as WC payments but including supplemental. STD benefits paid on top of WC claims.
- Only benefits paid after any elimination period.
- Any statutory disability claims paid (or premiums if fully-insured).
- Only supplemental payments for any claims that were determined to be WC indemnity claims.
- If the plan is fully-insured, only the portion of the premium used to pay wage replacement for claims (estimated if necessary) should be counted, not the portion used for plan administration and carrier retention charges.

**Total Number of Closed STD Claims:** The number of claims that closed during the reporting period, even if they were opened in a previous period. Exclude claims where lost time was included under a WC program and any statutory disability claims (to avoid double-counting).

Your Company's  
Response:

---

Include the following claims that:

- Transition to LTD benefits after STD benefits are exhausted.
- The employer's salary continuance program requires a medical certification.

The end date of a closed claim is defined as the point in time when the employee ceases to be eligible for benefits for one of several reasons:

- Employee returns to work either full time/full duty or as part of a transitional work program and is no longer receiving STD benefits.
- Claim is settled.
- Claim is terminated because the employee is no longer disabled.
- Employee dies.
- Benefit end date is reached (i.e., 180 days per the STD plan design).

**Total Number of New STD Maternity Claims:** The total number of approved STD claims that are maternity-related (normal and/or with complications) that opened within the reporting period.

Your Company's  
Response:

---

## **Return-to-Work (RTW) Category**

Provide your company's responses to the following STD Metrics, using the EMPAQ® Data Submission Tool. For your convenience, write your answer in the boxes provided below as you are gathering your data. Then log onto the EMPAQ® website ([www.empaq.org](http://www.empaq.org)) to provide your company's data.

**Total Number of Claims on RTW Transitional Duty:** The total number of claims in which an employee previously on STD has returned to work (RTW) with reduced hours or in a restricted capacity.

This includes the following work categories:

- Full-Time, Restricted, Permanent;
- Full-Time Restricted, Temporary;
- Reduced Hours, Restricted, Permanent; and
- Reduced Hours, Restricted, Temporary.

Your Company's  
Response:

---

Include claims where an employee returned to work in a prior period, but continues on restricted duty during the current reporting period. Exclude claims for statutory disability plan to avoid double-counting.

**Total Number of Workdays with Employees on RTW Transitional Duty:** The workdays in the reporting period where an employee has worked in any capacity other than full-time unrestricted (i.e., is on restrictions). Exclude any lost workdays associated with a statutory disability plan to avoid double-counting.

This includes the following work categories:

- Full-Time, Restricted, Permanent;
- Full-Time Restricted, Temporary;
- Reduced Hours, Restricted, Permanent; and
- Reduced Hours, Restricted, Temporary.

Your Company's  
Response:

---

Include workdays for a claim that was closed in a prior period (with the employee still on restricted duty in the current reporting period).

## **Major Diagnostic Categories (Codes 0-25, Version 25)**

Provide your company's responses to the following STD metrics, using the EMPAQ® Data Submission Tool. For your convenience, write your answer in the boxes provided below as you are gathering your data. Then log onto the EMPAQ® website ([www.empaq.org](http://www.empaq.org)) to provide your company's data.

**Major Diagnostic Category (MDC) Codes:** MDC codes group the principal diagnoses for all diseases and medical conditions into 26 mutually exclusive diagnosis areas (codes 0-25). In general, an MDC corresponds to a single organ system or etiology and is roughly associated with a medical specialty.

## **Major Diagnostic Categories (continued)**

Data is collected by MDC code for active employees only in the following areas:

- Total Number of Claims: The number of ever active STD claims corresponding to each MDC classification, for this reporting period.
- Total Lost Workdays: The number of lost workdays (attributable to STD) corresponding to each MDC classification, for this reporting period.
- Total Claims Cost: The total STD claims costs corresponding to each MDC classification, for this reporting period. Include costs for all claims that were ever active during this time.

<b>MDC</b>	<b>Total Number of Claims</b>	<b>Total Claims Cost</b>	<b>Total Lost Workdays</b>
0			
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			
13			
14			
15			
16			
17			
18			
19			
20			
21			
22			
23			
24			
25			

## PLAN DESIGN ELEMENTS: SHORT-TERM DISABILITY (STD)

Provide your company's responses to the following STD plan design elements, using the EMPAQ® Data Submission Tool. For your convenience, write your answer in the boxes provided below as you are gathering your data. Then log onto the EMPAQ® website ([www.empaq.org](http://www.empaq.org)) to provide your company's data.

**Cost Sharing Percentage:** The proportion of the cost of coverage for which the worker is responsible. Answer Tiered Percentage, Flat Percentage, Non-contributory, or Other.

Cost-sharing can usually be classified as:

- Tiered Percentage (Cost of coverage based on employee's length of service or another factor),
- Flat Percentage (Employee contributes X% of the cost of coverage),
- Non-contributory (i.e., fully employer paid), or
- Other.

Cost Sharing Percentage	Answers
Select the one that best applies for your company's STD plan:	<ul style="list-style-type: none"> <li>• Tiered percentage;</li> <li>• Flat percentage;</li> <li>• Non-contributory; or</li> <li>• Other</li> </ul>

**Definition of Disability:** A condition of the STD plan that classifies an employee as being unable to work. Answer "Own Occupation", "Any Occupation" or Other.

Use the following to assist in determining your plan's **Definition of Disability:**

- "Own Occupation" which is a disability that renders the employee unable to perform meaningful and substantial duties associated with his/her pre-injury/illness occupation.
- "Any Occupation" which is a disability that renders the employee unable to perform any occupation/job, any offered work, or any offered task he/she is suited for by way of training, education and experience.

Definition of Disability	Answers
Select the one that best applies for your company's STD plan:	<ul style="list-style-type: none"> <li>• Own Occupation;</li> <li>• Any Occupation; or</li> <li>• Other</li> </ul>

**Elimination Period:** The length of time an employee must be disabled before he/she receives STD wage replacement income. The period is typically expressed in number of days. Answer 1<sup>st</sup> day of disability, 1<sup>st</sup> day if hospitalized and 8<sup>th</sup> calendar day for other conditions, 7 calendar days, or other.

Typical elimination periods include:

- 1st day of disability (no elimination period),
- 1st day if hospitalized and 8th calendar day for other conditions (no elimination period if hospitalized on 1<sup>st</sup> day of disability; otherwise, 7 calendar day elimination period for non-hospitalized disabilities), and
- 7 calendar days (elimination period of 7 calendar days for all disabilities).

PLAN DESIGN ELEMENTS: STD (continued)

Elimination Period	Answers
Select the one that best applies for your company's STD plan:	<ul style="list-style-type: none"> <li>▪ 1<sup>st</sup> day of disability;</li> <li>▪ 1<sup>st</sup> day if hospitalized/8<sup>th</sup> calendar day for other conditions;</li> <li>▪ 7 calendar days; or</li> <li>▪ Other</li> </ul>

**Maximum Benefit Period:** The cap on the length of time a disabled employee is eligible to receive STD income. Typical periods include 90 days, 180 days, 1 year, and other. Answer 1 year, 180 days, 90 days, or other.

Maximum Benefit Period	Answers
Select the one that best applies for your company's STD plan:	<ul style="list-style-type: none"> <li>▪ 1 year;</li> <li>▪ 180 days;</li> <li>▪ 90 days; or</li> <li>▪ Other</li> </ul>

**Wage Replacement Structure:** The percentage of a disabled employee's regular wage that can be replaced with STD income. This percentage is determined usually as a flat percentage (such as 70% wage replacement) or a tiered percentage (based on length of service or other factors). Answer flat percentage or tiered percentage.

Wage Replacement Structure	Answers
Select the one that best applies for your company's STD plan:	<ul style="list-style-type: none"> <li>▪ Flat percentage; or</li> <li>▪ Tiered percentage</li> </ul>

**STD Offset by WC:** Source of disability-related salary compensation from Workers' Compensation (WC) that reduces STD wage replacement payments. Answer Yes or No.

STD Offset by WC	Answers
Is your company's STD plan offset by WC?	Yes or No

**STD Offset by Statutory STD:** Source of disability-related salary compensation statutory STD that reduces STD wage replacement payments. For companies in California, Hawaii, New Jersey, New York, Puerto Rico, and Rhode Island, statutory STD is called state-mandated STD. Answer Yes or No.

STD Offset by Statutory STD	Answers
Is your company's STD plan offset by Statutory STD?	Yes or No

**STD Offset by Other Sources:** Other sources of disability-related salary compensation (not Worker's compensation or statutory STD) that reduce STD wage replacement payments. Answer Yes or No.

STD Offset by Other Sources	Answers
Is your company's STD plan offset by other sources?	Yes or No

## Workers' Compensation (WC) Metrics and Data Elements

### WC Metrics Chart:

The following chart provides assistance in determining whether to include certain WC expenses in the WC cost metrics:

EMPAQ® metrics defined for Workers' Compensation include all of items in the following grid (except where noted):

Metric	WC Indemnity-Wage Replacement	WC Indemnity-Related Medical	WC Medical-Only Cases	WC - Temporary Total Disability Only	Total WC
1. Cost per FTE	X	X	X	n/a	X
2. Cost per Active Claim	X	X	X	n/a	X
3. Lost TTD Workdays per 100 FTE	n/a	n/a	n/a	X	n/a
4. Annual Claim Incidence	X	n/a	X	n/a	X
5. New Indemnity Claim Percentage	X	n/a	n/a	n/a	n/a
6. Cost per Closed Claim	X	X	X	n/a	X
7. Lost TTD Workdays per Closed TTD Claim	n/a	n/a	n/a	X	n/a

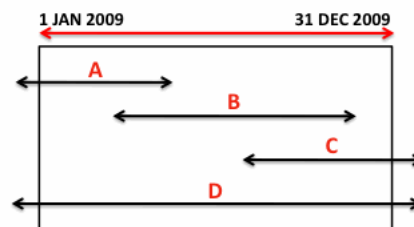
## WC Definitions:

The following definitions provide background for calculating the WC headcount and cost metrics:

**Active Claim:** Synonymous with **Open Claim**—Refers to a claim which has not been settled, with an expectation that further payments will be made. Most commonly referenced in metrics for disability programs such as: Short-term Disability, Long-Term Disability and Workers' Compensation.

The following categories are available for **Active Claims** in the reporting period:

- Claims incurred in the prior period, and paid and closed in current period (A)
- Opened and closed during the current period (B)
- Opened in the current period, and continued into the subsequent period (C)
- Opened in the prior period, remained active in current period, and continued into the subsequent period (D)



**Approved Claim:** The claims that have been reviewed for benefit determination and payments have been approved under the plan provisions. Most commonly referenced in metrics for disability programs such as: Short-term Disability, Long-Term Disability and Workers' Compensation.

**Closed Claim:** The claims that have been closed during the reporting period based on either a full return to work or an expiration of benefits. A **Closed Claim** means that there are no more payments to be made under the plan provisions.

**Indemnity Claims:** This refers to work-related injuries or illnesses involving missed work time. Costs include both medical care and wage replacement. Note: A claim may start out as medical-only (the employee did not initially miss work) and later become an **Indemnity Claim** if the employee has lost time due to the work-related illness/injury. Once an employee loses time from work, the claim is classified as an **Indemnity Claim**. Within the category of **Indemnity Claims**, there are four different types of lost time claims.

- Temporary Total Disability (TTD)
- Temporary Partial Disability (TPD)
- Permanent Total Disability (PTD)
- Permanent Partial Disability (PPD)

Note: Indemnity claims should not include settlement costs. Workers' Compensation Settlement Costs are collected separately from the Total Indemnity Costs for Indemnity Claims.

**Medical-Only Claims:** This refers to work-related injuries or illnesses involving no missed worked during the life of the claim. Medical care constitutes the primary costs.

## **WC Definitions (continued):**

**New Claim:** This refers to a newly received claim that has been reported for the determination of benefits under the plan provisions during the reporting period. **New Claims** are opened when:

- The employee has not previously experienced a recorded injury or illness of the same type that affects the same part of the body; or
- The employee previously experienced a recorded injury or illness of the same type that affected the same part of the body but had recovered.

Most commonly referenced in metrics for disability programs such as: Short-term Disability, Long-Term Disability and Workers' Compensation.

**Return to Work (RTW):** A claimant returns to the company in partial duty, temporary duty or full-time, regular job. The claimant is no longer fully disabled and unable to perform some duty/job at the work location. Once an employee has returned to work in some capacity, changes are good that the Workers' Compensation/disability benefits will eventually end.

**Temporary Total Disability (TTD):** A type of Workers' Compensation claim in which the worker is completely disabled for a temporary period of time.

## **Cost Per FTE Category:**

Provide your company's responses to the following WC cost metrics, using the EMPAQ Data Submission Tool. For your convenience, write your answer in the boxes provided below as you are gathering your data. Then log onto the EMPAQ website ([www.empaq.org](http://www.empaq.org)) to provide your company's data.

**Total Number of FTEs Covered for WC:** The total number of full-time equivalent (FTE) employees covered by Workers' Compensation, even if they do not work a standard 8-hour workday. The definition of FTE accounts for the variety of employee types within a company, including part-time workers, those who job share, those with over-time, and those who no longer work for a company.

To calculate the number of FTEs, divide the total number of hours worked by FTEs covered for WC by the number of hours in a standard work year or 2080 hours.

Then take the number of FTEs at the mid-month (or mid-quarter) during the reporting period, summed and then divided by the total number of months (or quarters) during the reporting period.

Example: 
$$\frac{10,000 (Q1) + 10,000 (Q2) + 10,000 (Q3) + 10,000 (Q4)}{4}$$

**Average Employee Concentration by State:** The average size of a workforce employed in a specific U.S. state. Note: This information should only be reported if WC data are submitted by state (rather than on a national level).

Your Company's  
Response:

---

Your Company's  
Response:

---

**Total Indemnity Costs for Indemnity Claims:** The sum of the indemnity payments made during the reporting period for Workers' Compensation active indemnity claims.

Your Company's Response:

Indemnity costs include wage replacement benefit payments (TTD, TPD, PTD, and PPD) under each state's statutory regulations during the reporting period (and not over the life of the claim). Costs for vocational rehabilitation (VR) and death benefits are included; however, supplemental STD payments and settlement costs are not included.

**Total Medical Costs for Indemnity Claims:** The total dollar amount paid for the medical payments of active indemnity claims (claims that had lost time) during the reporting period. If the employee has returned to work and is still receiving medical payments, those payments should be included as well.

Your Company's Response:

Includes claims receiving the following types of indemnity-related payments: wage replacement (TTD, TPD, PTD, and PPD), vocational rehabilitation (VR), and death benefits.

**Total Medical Costs for Medical-Only Claims:** The sum of the medical payment costs paid during the reporting period for Workers' Compensation active medical-only claims (claims that had no lost work time.)

Your Company's Response:

### **Claim Incidence Category:**

Provide your company's responses to the following WC Incidence Metrics, using the EMPAQ® Data Submission Tool. For your convenience, write your answer in the boxes provided below as you are gathering your data. Then log onto the EMPAQ® website ([www.empaq.org](http://www.empaq.org)) to provide your company's data.

**Total Number of New WC Indemnity Claims:** The number of newly incurred and approved indemnity (wage-replacement) claims for the reporting period. Include those claims that were approved and:

Your Company's Response:

- Opened and closed during the current period; or
- Opened in the current period, and continued into the subsequent period.
- Cover the following "Indemnity-related" benefits: all Wage replacement costs (Temporary Total Disability, Temporary Partial Disability, Permanent Total Disability, and Permanent Partial Disability), vocational rehabilitation, and death benefits.

**Total Number of New WC Medical-Only Claims:** The number of newly incurred and approved Workers' Compensation claims for payment of medical-only benefits during the reporting period. Include those claims closed during the reporting period and those that closed in a subsequent period.

Your Company's Response:

## **Cost per Active Claim Category:**

Provide your company's responses to the following WC cost metrics, using the EMPAQ® Data Submission Tool. For your convenience, write your answer in the boxes provided below as you are gathering your data. Then log onto the EMPAQ® website ([www.empaq.org](http://www.empaq.org)) to provide your company's data.

**Total Active Claim Costs:** Total of all active claims payments paid out during the reporting period (medical payments from medical-only claims plus indemnity-related payments from indemnity claims PLUS medical payments indemnity claims). This includes all claims that were ever active, even for those opened in prior years and/or continuing into the future. Workers' Compensation payments for this data element include:

- Workers' Compensation indemnity income (i.e., wage replacement payments).
- Workers' Compensation death benefit payments.
- Workers' Compensation indemnity-related medical payments.
- Workers' Compensation medical-only (payments for cases with no lost time).
- Workers' Compensation settlement costs.
- Workers' Compensation expense payments associated with the individual claim (i.e., vocational rehab, legal, transcription fees, or investigative fees).
- Total Workers' Compensation payments.

Your Company's  
Response:

**Total Number of Active WC Indemnity Claims:** Total number of active Workers' Compensation indemnity claims that received a payment during the reporting period, regardless of when the claim was initially incurred or opened.

Note: If a WC claim received an indemnity payment at any time in the claim cycle, it is considered an indemnity claim even if only medical benefits were paid during the reporting period.

Your Company's  
Response:

Include claims that cover the following "Indemnity-related" benefits: all Wage replacement costs (Temporary Total Disability, Temporary Partial Disability, Permanent Total Disability, and Permanent Partial Disability), vocational rehabilitation, and death benefits.

**Total Number of Active WC Medical-Only Claims:** Total number of active Workers' Compensation claims for which only medical benefits were paid during the reporting period. These claims include those, which have never received an indemnity payment, regardless of when the claim was initially incurred or opened

Your Company's  
Response:

## **Cost per Active Claim Category (continued):**

**Total Number of Active WC Claims:** Total of all claims that were "ever active" (eligible for payments and where injury was incurred) during the reporting period. This number is the total of all active indemnity and medical-only claims.

- Exclude all denied or pended WC claims.
- Include all claims that were active in the time period, including those that opened in a previous period and/or continued into a following period.

Your Company's  
Response:

---

**Total Number of Active TTD Claims:** The number of ever active Workers' Compensation claims for which temporary total disability (TTD) benefits were paid during the reporting period, regardless of date incurred or closed.

Your Company's  
Response:

---

## **Cost Per Closed Claim Category:**

Provide your company's responses to the following WC cost metrics, using the EMPAQ<sup>®</sup> Data Submission Tool. For your convenience, write your answer in the boxes provided below as you are gathering your data. Then log onto the EMPAQ<sup>®</sup> website ([www.empaq.org](http://www.empaq.org)) to provide your company's data.

**Total Costs of Closed Claims:** The total cost for claims closed during the reporting period, including all costs that were incurred throughout the life of a claim (even for claims opened in a previous reporting period.)

This cost will capture all costs incurred from the date of injury through the closure of the claim, including:

- Workers' Compensation indemnity income (i.e., wage replacement payments);
- Workers' Compensation death benefit payments;
- Workers' Compensation indemnity-related medical payments;
- Workers' Compensation medical-only (payments for cases with no lost time);
- Workers' Compensation settlement costs; and
- Workers' Compensation expense payments (such as fees for transcriptions and outside investigators, legal costs not related to settlement, etc.)

Your Company's  
Response:

---

**Total Number of Closed Claims:** The total number of claims closed during the reporting period based on closed claim date, including all claim categories, regardless of when the claim was initially opened (e.g., even if they were opened in a previous period.)

Your Company's  
Response:

---

**Total Indemnity Costs of Closed Indemnity Claims:** The dollar amount paid for all indemnity-related payments of Workers' Compensation claims that closed in the reporting period, regardless of the year paid. \_Also includes the following types of indemnity-related claims payments: wage replacement (for TTD, TPD, PTB, or PPD), vocational rehabilitation, and death benefits.

Your Company's  
Response:

---

**Cost Per Closed Claim Category (continued):**

**Total Medical Costs of Closed Indemnity Claims:** The sum of the medical payments made during the life of the claim for indemnity claims closed during the reporting period, regardless of the year paid. Includes medical payments associated with claims receiving the following types of indemnity-related payments: wage replacement (for TTD, TPD, PTD, and PPD), vocational rehabilitation, and death benefits.

Your Company's  
Response:

\_\_\_\_\_

**Total Number of Closed Indemnity Claims:** The number of Workers' Compensation indemnity claims that closed during the reporting period, regardless of when the claim was initially opened. If a WC claim received an indemnity payment at any time in the claim cycle, it is considered an indemnity claim.

Your Company's  
Response:

\_\_\_\_\_

Includes claims receiving the following types of indemnity-related payments: wage replacement (including TTD, TPD, PTD, PPD), vocational rehabilitation, and death benefits.

**Total Medical Costs of Closed Medical-Only Claims:** The sum of the medical payments made during the life of the claim for Workers' Compensation medical-only claims closed during the reporting period, regardless of the year paid.

Your Company's  
Response:

\_\_\_\_\_

**Total Number of Closed Medical-Only Claims:** The number of Workers' Compensation claims closed during the reporting period (and for which only medical benefits were paid during the life of the claim), regardless of when the claim was initially incurred or opened.

Your Company's  
Response:

\_\_\_\_\_

**WC Settlement Costs:** The additional costs negotiated to resolve or "settle" a Workers' Compensation claim.

Your Company's  
Response:

\_\_\_\_\_

## **Lost Time Category**

Provide your company's responses to the following WC lost time metrics, using the EMPAQ® Data Submission Tool. For your convenience, write your answer in the boxes provided below as you are gathering your data. Then log onto the EMPAQ® website ([www.empaq.org](http://www.empaq.org)) to provide your company's data.

**Total Number of Lost Workdays for TTD Claims:** The total number of lost workdays associated with all temporary total disability (TTD) claims during the reporting period. If there is an elimination period required before the TTD benefits are payable, exclude the elimination period days in the count.

Your Company's  
Response:

Note: Some STD plans supplement the statutory Workers' Compensation wage replacement benefits.

- In this situation, the lost workdays should only be counted once as Workers' Compensation days.
- If an employee has an approved Workers' Compensation indemnity claim that is supplemented by STD benefits, his lost workdays should only be attributed to the Workers' Compensation claim.
- If the Workers' Compensation claim is closed, but the individual continues to receive STD benefits, the STD workdays incurred after the claim closes would be counted as STD lost workdays.

**Total Number of Lost Workdays from Date of Injury for Closed TTD Claims:** The total of all lost temporary total disability (TTD) workdays for claims closed during the reporting period based on closed claim date. Include all lost workdays from the date of injury (regardless of year incurred) through the date the claim closed.

Your Company's  
Response:

**Total Number of Closed TTD Claims:** The number of closed Workers' Compensation claims for which temporary total disability (TTD) benefits were paid during the reporting period based on closed claim date, regardless of when the claim was initially opened.

Your Company's  
Response:

## **Return-to-Work (RTW) Category**

Provide your company's responses to the following WC RTW metrics, using the EMPAQ® Data Submission Tool. For your convenience, write your answer in the boxes provided below as you are gathering your data. Then log onto the EMPAQ® website ([www.empaq.org](http://www.empaq.org)) to provide your company's data.

**Total Number of Claims RTW Transitional Duty:** The number of temporary total disability (TTD) claims where an employee has returned to work (RTW) in a reduced-hours or restricted capacity. This includes anyone who returned to work on transitional duty from a TTD claim anytime in the reporting period, irrespective of the claim origination date.

Exclude claims where an employee returned to work in a prior period, but the employee is still on restricted duty in the current reporting period.

Include any claims in the following categories:

- Full-Time, Restricted, Permanent
- Full-Time, Restricted, Temporary
- Reduced Hours, Restricted, Permanent
- Reduced Hours, Restricted, Temporary

Your Company's  
Response:

---

**Total Number of Transitional Duty Workdays:** The total number of transitional workdays during the reporting period associated with active temporary total disability (TTD) claim when an employee returns to work in a "transitional capacity" (any case in which an employee who has returned to work in any capacity other than full-time, unrestricted).

Include claims that were closed in a prior period, with the employee still on restricted duty in the current reporting period.

For transitional duty workdays that involve reduced hours, count each partial day as one day in the total.

Your Company's  
Response:

---

# Long-Term Disability (LTD) Metrics and Data Elements

## LTD Headcount Metrics Chart:

The following chart provides assistance in determining whether to include certain individuals in the LTD headcount metric:

Metric	Eligible Employees (but not enrolled in LTD)	Employees Enrolled in LTD	Employees on LTD
Average Number of Employees Covered under LTD Plan		X	X

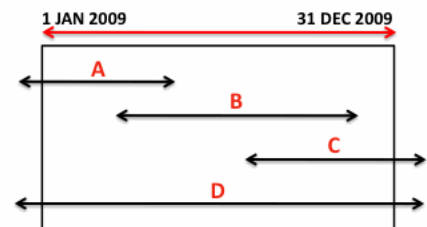
## LTD Definitions:

The following definitions provide background for calculating the LTD headcount and cost metrics:

**Active Claim:** Synonymous with **Open Claim**—Refers to a claim which has not been settled, with an expectation that further payments will be made. Most commonly referenced in metrics for disability programs such as: Short-term Disability, Long-Term Disability and Workers' Compensation.

The following categories are available for **Active Claims** in the reporting period:

- Claims incurred in the prior period, and paid and closed in current period (A)
- Opened and closed during the current period (B)
- Opened in the current period, and continued into the subsequent period (C)
- Opened in the prior period, remained active in current period, and continued into the subsequent period (D)



**Approved Claim:** The claims that have been reviewed for benefit determination and payments have been approved under the plan provisions. Most commonly referenced in metrics for disability programs such as: Short-term Disability, Long-Term Disability and Workers' Compensation.

**Closed Claim:** The claims that have been closed during the reporting period based on either a full return to work or an expiration of benefits. A **Closed Claim** means that there are no more payments to be made under the plan provisions.

## **LTD Definitions (continued):**

**New Claim:** Refers to a newly received claim that has been reported for the determination of benefits under the plan provisions during the reporting period. **New Claims** are opened when:

- The employee has not previously experienced a recorded injury or illness of the same type that affects the same part of the body; or
- The employee previously experienced a recorded injury or illness of the same type that affected the same part of the body but had recovered.

Most commonly referenced in metrics for disability programs such as: Short-term Disability, Long-Term Disability and Workers' Compensation.

## **Claims Cost Category:**

Provide your company's responses to the following LTD cost metrics, using the EMPAQ® Data Submission Tool. For your convenience, write your answer in the boxes provided below as you are gathering your data. Then log onto the EMPAQ® website ([www.empaq.org](http://www.empaq.org)) to provide your company's data.

**Average Number of Employees Covered under LTD Plan:** The average number of employees who were covered by or enrolled in LTD during the year. Include any employee who has any type of coverage (such as basic coverage and buy-up coverage.)

Exclude employees who:

- Have not satisfied an eligibility waiting period;
- Do not work the minimum required number of hours per week; and
- Were eligible but declined coverage.

Your Company's  
Response:

---

**Total Number of New LTD Claims:** Total number of all new, approved LTD claims during the reporting period, even if they run concurrently with Workers' Compensation or disability pension/retirement benefits.

Your Company's  
Response:

---

**Total LTD Benefits Paid:** The sum of all LTD payments. Report net paid wage replacement costs (i.e., subtract out offsets for SSDI or Social Security Disability Insurance, Workers' Compensation or pension plans).

Include:

- Paid wage replacement (paid claims);
- Reserves for incurred and unreported claims;
- Administrative fees and/or premiums (depending on insured versus self-insured status); and
- The portion of the premium that is for wage replacement benefits if the plan is fully insured. (Do not include the premium component that equates to administrative or retention fees).

Your Company's  
Response:

---

Note: Only the wage replacement dollars paid in the reporting period are used, even though that may involve excluding other types of costs for these claims.

## Claims Cost Category (continued):

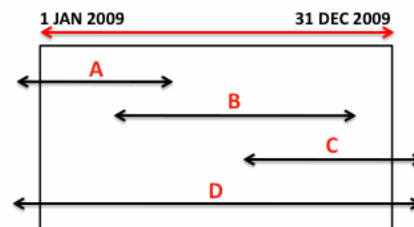
**Total Number of Open LTD Claims:** All LTD claims that were active for at least some part of the reporting period, regardless of the year the claim was opened. Includes "zero balance" cases in which no LTD benefits were paid due to offsets from other income sources.

Your Company's  
Response:

---

Include the following types of claims:

- Incurred in a prior period, and paid and closed in current period (A);
- Opened and closed during the current period (B);
- Opened in the current period, and continued into the subsequent period (C); and
- Opened in a prior period, remained active in current period, and continued into the subsequent period (D).



## Major Diagnostic Categories (Codes 0-25, Version 25)

Provide your company's responses to the following GH metrics, using the EMPAQ<sup>®</sup> Data Submission Tool. For your convenience, write your answer in the boxes provided below as you are gathering your data. Then log onto the EMPAQ<sup>®</sup> website ([www.empaq.org](http://www.empaq.org)) to provide your company's data.

**Major Diagnostic Category (MDC) Codes:** Major Diagnostic Category (MDC) codes group the principal diagnoses for all diseases and medical conditions into 26 mutually exclusive diagnosis areas (codes 0-25). In general, an MDC corresponds to a single organ system or etiology and is roughly associated with a medical specialty.

Data is collected by MDC code for the following areas:

- Total Number of Claims: The number of ever active LTD claims corresponding to each MDC classification for this reporting period.
- Total Lost Workdays: The number of lost workdays (attributable to LTD) corresponding to each MDC classification for this reporting period.
- Total Claims Cost: The total LTD claims costs corresponding to each MDC classification for this reporting period. Include costs for all claims that were ever active during this time.

**Major Diagnostic Categories: (continued)**

<b>MDC</b>	<b>Total Number of Claims</b>	<b>Total Claims Cost</b>	<b>Total Lost Workdays</b>
0			
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			
13			
14			
15			
16			
17			
18			
19			
20			
21			
22			
23			
24			
25			

## PLAN DESIGN ELEMENTS: LONG-TERM DISABILITY (LTD)

Provide your company's responses to the following LTD plan design elements, using the EMPAQ® Data Submission Tool. For your convenience, write your answer in the boxes provided below as you are gathering your data. Then log onto the EMPAQ® website ([www.empaq.org](http://www.empaq.org)) to provide your company's data.

**Cost Sharing Percentage:** The proportion of the cost of coverage for which the worker is responsible. Answer Tiered Percentage, Flat Percentage, Non-contributory, or Other.

Cost-sharing can usually be classified as:

- Tiered Percentage (Cost of coverage based on employee's length of service or another factor),
- Flat Percentage (Employee contributes X% of the cost of coverage),
- Non-contributory (i.e., fully employer paid), or
- Other.

Cost Sharing Percentage	Answers
Select the one that best applies for your company's LTD plan:	<ul style="list-style-type: none"><li>▪ Tiered percentage;</li><li>▪ Flat percentage;</li><li>▪ Non-contributory; or</li><li>▪ Other</li></ul>

**Definition of Disability:** A condition of the LTD plan that classifies an employee as being unable to work. The conditions are defined as either own occupation or any occupation.

Own occupation is a disability that renders the employee unable to perform meaningful and substantial duties associated with his/her pre-injury/illness occupation.

Any occupation is a disability that renders the employee unable to perform any occupation/job, any offered work, or any offered task he/she is suited for by way of training, education and experience. Answer Own Occupation, Other Occupation or other.

Definition of Disability	Answers
Select the one that best applies for your company's LTD plan:	<ul style="list-style-type: none"><li>▪ Own Occupation;</li><li>▪ Any Occupation; or</li><li>▪ Other</li></ul>

**Elimination Period:** The length of time an employee must be disabled before he/she receives LTD wage replacement income. The period is typically expressed in number of calendar days or number of weeks. Answer 180 days, 52 weeks, 90 days, or other.

Elimination Period	Answers
Select the one that best applies for your company's LTD plan:	<ul style="list-style-type: none"><li>▪ 180 days;</li><li>▪ 52 weeks;</li><li>▪ 90 days; or</li><li>▪ Other</li></ul>

## PLAN DESIGN ELEMENTS: LTD (continued)

**Maximum Benefit Period:** The cap on the length of time a disabled employee is eligible to receive LTD income. The usual definitions of maximum benefit period include age 65 (including a schedule for a fixed number of years if disability occurs after a certain age, such as age 60 or 62), a fixed number of years, or another definition. Answer “Age 65”, Fixed # of years or other.

Maximum Benefit Period	Answers
Select the one that best applies for your company’s LTD plan:	<ul style="list-style-type: none"> <li>▪ Age 65;</li> <li>▪ Fixed # of years; or</li> <li>▪ Other</li> </ul>

**Wage Replacement Structure:** A condition of the LTD plan that sets the percentage of a disability employee’s regular wage that can be supplemented with LTD income. This percentage is determined usually as a flat percentage or a tiered percentage. Answer flat percentage or tiered percentage.

Wage Replacement Structure	Answers
Select the one that best applies for your company’s LTD plan:	<ul style="list-style-type: none"> <li>▪ Flat percentage; or</li> <li>▪ Tiered percentage</li> </ul>

**Maximum Duration for Mental/Nervous Disabilities:** The cap expressed as a number of months (if any) on the length of time a disabled employee is eligible to receive LTD wage replacement income for mental/nervous (behavioral health) disabilities. Answer 1 year, 24 months, 65 years old, or other.

Maximum Duration for Mental/Nervous Disabilities	Answers
Select the one that best applies for your company’s LTD plan:	<ul style="list-style-type: none"> <li>▪ 1 year;</li> <li>▪ 24 months;</li> <li>▪ 65 years old; or</li> <li>▪ Other</li> </ul>

**LTD Offset by Social Security Employee Benefits Only:** Whether or not an employee’s social security disability income (SSDI) reduces the LTD wage replacement income under the LTD plan. Answer Yes or No.

LTD Offset by Social Security Employee Benefits Only	Answers
Is your company’s LTD plan offset by Social Security Employee Benefits only?	Yes or No

**LTD Offset by Social Security Family Benefits:** Whether or not social security disability income (SSDI) from an employee’s family reduces the LTD wage replacement income under the LTD plan. Answer Yes or No.

LTD Offset by Social Security Family Benefits	Answers
Is your company’s LTD plan offset by Social Security Family Benefits?	Yes or No

# Family Medical Leave (FMLA) Metrics and Data Elements

## FMLA Definition:

The following definition provides background for calculating the FMLA headcount and cost metrics:

**Non-Concurrent:** FMLA non-concurrent claims are any FMLA claims that do *not* run concurrently with STD and/or Workers' Compensation. However, a "non-concurrent" FMLA claim can be considered under your organization's policy for incidental sick leave (paid or unpaid) and/or vacation/paid time off (PTO). The non-concurrent FMLA metrics will include all FMLA non-concurrent claims and/or workdays regardless of whether they were paid or unpaid.

## FMLA Cost Category:

Provide your company's responses to the following FMLA cost metrics, using the EMPAQ® Data Submission Tool. For your convenience, write your answer in the boxes provided below as you are gathering your data. Then log onto the EMPAQ® website ([www.empaq.org](http://www.empaq.org)) to provide your company's data.

**Average Number of Employees Eligible for FMLA:** Average number of FMLA-covered employees. Employees must have worked for the organization at least one year and have actually worked at least 1,250 hours within the previous 12 months. For those employees in a state with a state-mandated leave, include those employees covered by state programs who may not yet be eligible for federal FMLA coverage.

Your Company's  
Response:

\_\_\_\_\_

**Total Number of FMLA Claims:** Number of all approved claims, including those for employees working a reduced schedule and/or any claims that are approved for state FMLA leave even if they do not qualify for federal FMLA.

The total number of FMLA claims includes:

- Continuous and intermittent claims;
- Non-concurrent FMLA claims (including those that may be paid under an incidental sick leave or vacation/PTO policy);
- All approved STD and WC claims that ran concurrent with FMLA;
- Denied STD or WC claims that were approved for FMLA; and
- Partially denied STD or WC claims approved for FMLA.

Your Company's  
Response:

\_\_\_\_\_

For these partially denied claims, count the portion running concurrently with STD or WC as a concurrent claim, and count the continually approved FMLA portion beyond the STD/WC approved status as a non-concurrent claim. Typically, this type of FMLA absence is viewed as two FMLA claims: one concurrent and one non-concurrent.

## **FMLA Cost Category (continued):**

**Total Number of FMLA Lost Workdays:** The number of FMLA intermittent days and FMLA continuous days, including concurrent and non-concurrent claims. Convert intermittent/partial days and hours into full day equivalents.

Include days lost for:

- Federal and state mandated FMLA programs.
- Active FMLA claims opened during a prior year.
- All lost workdays for approved STD and WC claims that ran concurrent with FMLA. Include the lost workdays associated with any elimination period prior to the approved STD or Workers' Compensation benefit effective date.
- Denied STD or WC claims approved for FMLA.
- Partially denied STD or WC claims approved for FMLA.
- Non-concurrent FMLA claims including those that may be paid under an incidental sick leave or vacation/PTO policy.

Your Company's  
Response:

Do not include supplemental FMLA leave programs provided by the employer or STD/WC lost workdays if FMLA was exhausted.

**Total Number of Non-Concurrent FMLA Claims:** The total number of non-concurrent claims during a given period, including claims for leaves starting in a prior period or continuing into a subsequent period. A non-concurrent claim is an approved FMLA claim that does *not* run concurrently with STD and/or WC.

A concurrent claim is an approved claim that runs concurrently with approved STD and/or WC claims. To ensure that time off is not double-counted between programs, concurrent claims and/or lost workdays are only counted in the FMLA concurrent claim metrics and are *excluded* from any non-concurrent FMLA metric.

If an approved FMLA concurrent claim that is tied to an STD or WC claim includes a waiting period before the STD or WC benefits begin, then the waiting period days are considered part of the FMLA concurrent claim.

Note: A claim may have STD or WC benefits that are concurrent with FMLA for only portion of the claim.

Your Company's  
Response:

## **FMLA Cost Category (continued):**

**Total Number of Non-Concurrent FMLA Lost Workdays:** The total number of lost workdays for non-concurrent FMLA claims occurring during the given period. A non-concurrent claim is an approved FMLA claim that does *not* run concurrently with STD and/or WC. All lost workdays that occurred during the reporting period should be counted, even for FMLA leaves starting in a prior period or continuing into a subsequent period. Include both intermittent and continuous leaves. Convert intermittent partial days and hours into full day equivalents.

Include days lost due to:

- Federal and state mandated FMLA programs.
- Active FMLA claims opened during a prior year, including lost workdays for the current reporting period only.
- Continuous and intermittent lost workdays for non-concurrent FMLA claims.
- Denied STD or WC claims approved for FMLA.
- Any lost workdays associated with a partially denied STD or WC claim approved for FMLA for those days continuing beyond the denied STD/WC date.

Do not include claims from employer-supplied supplemental FMLA leave programs or STD/WC lost workdays if FMLA was exhausted.

A concurrent claim is an approved claim that runs concurrently with approved STD and/or WC claims. To ensure that time off is not double-counted between programs, concurrent claims and/or lost workdays are only counted in the FMLA concurrent claim metrics and are *excluded* from any non-concurrent FMLA metric.

If an approved FMLA concurrent claim that is tied to an STD or WC claim includes a waiting period before the STD or WC benefits begin, then the waiting period days are considered part of the FMLA concurrent claim.

Note: A claim may have STD or WC benefits that are concurrent with FMLA for only portion of the claim.

Your Company's  
Response:

---

# Group Health (GH) Metrics and Data Elements

## Group Health Headcount and Cost Metrics Chart:

The following chart provides assistance in determining whether to include certain individuals in the GH headcount and cost metrics:

Metric	Active Employees	Non-Active Employees (i.e., on leave)	Retirees	Spouses and Dependent Children	Surviving Spouses
Average Active Headcount	X	X			
Average Number of Group Health Covered Employees	X	X			
Average Number of Medical Plan Covered Employees	X	X			
Average Number of Behavioral Health Covered Employees (if separate)	X	X			
Average Number of Pharmacy Plan Covered Employees	X	X			
Average Number of Covered Subscribers for Group Health	X	X	X		X
Average Number of Covered Lives for Group Health	X	X	X	X	X
Group Health Employee Contributions	X	X			
Total Group Health Subscribers' Contributions	X	X	X	X	X
Medical Program Costs Paid by Employer for Covered Employees Including Behavioral Health	X	X			
Medical Program Costs Paid by Employer for Covered Lives Including Behavioral Health	X	X	X	X	X
Behavioral Health Program Costs for Covered Employees (if separate)	X	X			
Behavioral Health Program Costs for Covered Lives (if separate)	X	X	X	X	X
Pharmacy Program Costs Paid by Employer for Covered Employees	X	X			
Pharmacy Program Costs Paid by Employer for Covered Lives	X	X	X	X	X
Total Dental Health Program Costs for Covered Employees	X	X			
Total Dental Health Program Costs for Covered Lives	X	X	X	X	X
Dental Health Employee Contributions	X	X			
Average Number of Covered Subscribers for Dental Health	X	X	X		X

## **Group Health Definitions:**

**The following definitions provide background for calculating the GH headcount and cost metrics:**

**Healthcare Reimbursement Account (HRA):** An employer-established account that provides non-taxed funds that employees can use for qualified medical expenses. The account balance may roll over but is not portable (that is, it does not follow the individual if he/she leaves the company). The HRA should not be confused with a Flexible Spending Account (FSA). (Refer to IRS Publication 969 for more information.)

**Health Savings Account (HSA):** A tax-exempt account owned by individuals and used to pay or reimburse for current and future qualified medical expenses. Remaining account balance at the end of the year rolls over to following year and is portable (follows the individual when changing employers or leaving the work force). (Refer to IRS Publication 969 for more information.)

**Surviving Spouse:** A widower or widow of an employee or retiree. A **Surviving Spouse** may have eligibility to continue health care coverage as a Subscriber in an employer's health care plan. Consult your health care plan's Summary Plan Description (SPD) to confirm if the health care plan covers **Surviving Spouses**.

## Covered Population Category

Provide your company's responses to the following GH headcount metrics, using the EMPAQ® Data Submission Tool. For your convenience, write your answer in the boxes provided below as you are gathering your data. Then log onto the EMPAQ® website ([www.empaq.org](http://www.empaq.org)) to provide your company's data.

**Average Active Headcount:** The number of the active U.S. employees, plus any on leave at the mid-month (or mid-quarter) during the reporting period, summed and then divided by the total number of months (or quarters) during the reporting period. Note: This is not the count of covered (enrolled) employees. Do not include retirees, surviving spouses or spouses and dependent children.

Your Company's  
Response:

Example: 
$$\frac{10,000 (Q1) + 10,000 (Q2) + 10,000 (Q3) + 10,000 (Q4)}{4}$$

**Average Number of Group Health Covered Employees:** The average number of covered (enrolled) active employees and employees on leave, not the number of eligible employees. "Covered" refers specifically to the subset of eligible employees who are enrolled in group health benefits. Do not include retirees, surviving spouses, or spouses and dependent children. Note: if a plan is contributory, not all eligible employees will enroll.

Your Company's  
Response:

The average number of covered employees is the number of enrolled employees plus any on leave who are still benefit eligible at mid-month (or mid-quarter) during the reporting period, summed, and then divided by the total number of months (or quarters) during the reporting period.

Example: 
$$\frac{10,000 (Q1) + 10,000 (Q2) + 10,000 (Q3) + 10,000 (Q4)}{4}$$

**Average Number of Medical Plan Covered Employees:** The average number of active employees and employees on leave covered by the medical plan, not necessarily eligible employees. It does not include retirees, surviving spouses or spouses and dependent children.

Your Company's  
Response:

The average number of employees covered by or enrolled in the plan should be obtained by dividing the sum-total of the covered population at the mid-point of each month or quarter for the reporting period being measured, by the number of months (12) or quarters (4) within that time period.

## **Covered Population Category (continued)**

### **Average Number of Behavioral Health Covered Employees (if separate):**

The average number of active employees and employees on leave who are covered/enrolled for behavioral health, not necessarily eligible employees; does not include retirees, surviving spouses or spouses and dependent children. If the behavioral health costs are covered under the Medical Program Costs, do not submit data for this data element. Only include the average number of active employees under the Average Number of Medical Plan Covered Employees to avoid double-counting.

Your Company's  
Response:

---

The average number of employees covered/enrolled by the plan should be obtained by dividing the sum-total of the covered population at the mid-point of each month or quarter for the reporting period being measured, by the number of months (12) or quarters (4) within that time period.

**Average Number of Pharmacy Plan Covered Employees:** The average number of active employees and employees on leave covered by the pharmacy plan, not necessarily eligible employees. It does not include retirees, surviving spouses or spouses and dependent children.

Your Company's  
Response:

---

The average number of employees covered/enrolled by the plan should be obtained by dividing the sum-total of the covered population at the mid-point of each month or quarter for the reporting period being measured, by the number of months (12) or quarters (4) within that time period.

**Average Number of Covered Subscribers for Group Health:** The average number of group health insurance subscribers covered by the employer—not the number of covered employees. This number should include subscribers such as active employees (including employees on leave), retirees, and surviving spouses.

Your Company's  
Response:

---

**Average Number of Covered Lives for Group Health:** The average number of covered (or enrolled) employees. (This is a subset of all eligible employees.). It includes active employees, employees on leave, retirees, surviving spouses, and spouses and dependent children.

Your Company's  
Response:

---

## Group Health Cost Category

Provide your company's responses to the following GH cost metrics, using the EMPAQ® Data Submission Tool. For your convenience, write your answer in the boxes provided below as you are gathering your data. Then log onto the EMPAQ® website ([www.empaq.org](http://www.empaq.org)) to provide your company's data.

**Group Health Employee Contributions:** Employees' costs for insurance premiums or self-insured premium equivalents, for active employees and employees on leave only. Do not include deductibles and co-payments.

Your Company's  
Response:

---

**Total Group Health Subscribers' Contributions:** The total of group health contributions from active employees, employees on leave, retirees, surviving spouses, and spouses and dependent children. These costs are the yearly contributions from group health premiums and do not include any copays or deductibles.

Your Company's  
Response:

---

**Medical Program Costs Paid by Employer for Covered Employees Including Behavioral Health:** Cost paid by the employer to cover the medical program, for active employees (including employees on leave). Include costs for behavioral health. (Do not include any costs for covered dependents.)

Your Company's  
Response:

---

Includes employer contributions made to Health Savings Accounts (HSAs) and Healthcare Reimbursement Accounts (HRAs). (**Note:** Do not include employee contributions made to HSAs. Do not include any costs for covered dependents.)

- For Fully-Insured Plans, the Program Costs = Premiums paid by the employer
- For Self-Insured Plans, the Program Costs = Claims paid + ASO/TPA fees.

**Medical Program Costs Paid by Employer for Covered Lives Including Behavioral Health:** Cost paid by the employer to cover the medical program, for active employees (including employees on leave), retirees, surviving spouses, and spouses and dependent children. Include costs for behavioral health.

Your Company's  
Response:

---

Includes employer contributions made to Health Savings Accounts (HSAs) and Healthcare Reimbursement Accounts (HRAs). (**Note:** Do not include employee contributions made to HSAs.)

- For Fully-Insured Plans, the Program Costs = Premiums paid by the employer
- For Self-Insured Plans, the Program Costs = Claims paid + ASO/TPA fees.

## **Group Health Cost Category (continued)**

**Behavioral Health Program Costs for Covered Employees (if separate):** Program costs for care received under the behavioral health benefit for active employees and employees on leave minus employee contributions. (Do not include any costs for covered dependents.) If the behavioral health costs are covered under the Medical Program Costs, do not submit data for the behavioral health costs in this metric. Only include the behavioral health costs under the Medical Program Costs to avoid double-counting.

Your Company's  
Response:

---

**Behavioral Health Program Costs for Covered Lives (if separate):** Program costs for care received under the behavioral health benefit for active employees (including employees on leave), retirees, surviving spouses, and spouses and dependent children. (Do not include employee contributions.) If the behavioral health costs are covered under the Medical Program Costs, do not submit data for the behavioral health costs in this metric. Only include the behavioral health costs under the Medical Program Costs to avoid double-counting.

Your Company's  
Response:

---

**Pharmacy Program Costs Paid by Employer for Covered Employees:** Cost paid by the employer to cover the pharmacy program for active employees and employees on leave. (Do not include any costs for covered dependents.)

Your Company's  
Response:

---

**Pharmacy Program Costs Paid by Employer for Covered Lives:** Cost paid by the employer to cover the pharmacy program for active employees (including employees on leave), retirees, surviving spouses, and spouses and covered dependents.

Your Company's  
Response:

---

## **Dental Health Costs Category**

Provide your company's responses to the following GH cost metrics, using the EMPAQ<sup>®</sup> Data Submission Tool. For your convenience, write your answer in the boxes provided below as you are gathering your data. Then log onto the EMPAQ<sup>®</sup> website ([www.empaq.org](http://www.empaq.org)) to provide your company's data.

**Total Dental Health Program Costs for Covered Employees:** The total costs paid by the employer to cover the dental program for active employees and employees on leave. It includes employee contributions (if any). Do not include any costs for covered dependents.

- For Fully-Insured Plans, the Program Costs = Premiums paid by the employer
- For Self-Insured Plans, the Program Costs = Claims paid + ASO/TPA fees.

Your Company's  
Response:

---

## **Dental Health Costs Category (continued)**

**Total Dental Health Program Costs for Covered Lives:** The total costs paid by the employer to cover the dental program for active employees (including employees on leave), retirees, surviving spouses, and spouses and dependent children. It includes employee contributions (if any).

- For Fully-Insured Plans, the Program Costs = Premiums paid by the employer
- For Self-Insured Plans, the Program Costs = Claims paid + ASO/TPA fees.

Your Company's  
Response:

---

**Dental Health Employee Contributions:** The employee's portion of insurance premiums or self-insured premium equivalents, for active employees and employees on leave.

Your Company's  
Response:

---

**Average Number of Covered Subscribers for Dental Health:** The average number of dental health subscribers covered by the employer during the reporting period. It includes active employees, employees on leave, retirees, and surviving spouses,

Your Company's  
Response:

---

## **Major Diagnostic Categories (Codes 0-25, Version 25)**

Provide your company's responses to the following GH metrics, using the EMPAQ® Data Submission Tool. For your convenience, write your answer in the boxes provided below as you are gathering your data. Then log onto the EMPAQ® website ([www.empaq.org](http://www.empaq.org)) to provide your company's data.

**Major Diagnostic Category (MDC) Codes:** Major Diagnostic Category (MDC) codes group the principal diagnoses for all diseases and medical conditions into 26 mutually exclusive diagnosis areas (codes 0-25). In general, an MDC corresponds to a single organ system or etiology and is roughly associated with a medical specialty.

Data is collected by MDC code for active employees only in the following areas:

- Total Number of Claims: The number of active GH claims corresponding to each MDC classification, for this reporting period.
- Total Number of Unique Individuals: The number of unique individuals with GH claims that correspond to each MDC classification, for this reporting period.
- Total Claims Cost: The total GH claims costs corresponding to each MDC classification, for this reporting period.

## Major Diagnostic Categories (GH)

<b>MDC</b>	<b>Total Number of Claims</b>	<b>Total Claims Cost</b>	<b>Total Number of Unique Individuals</b>
0			
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			
13			
14			
15			
16			
17			
18			
19			
20			
21			
22			
23			
24			
25			

## PLAN DESIGN ELEMENTS: MEDICAL

Provide your company's responses to the following GH plan design elements, using the EMPAQ® Data Submission Tool. For your convenience, write your answer in the boxes provided below as you are gathering your data. Then log onto the EMPAQ® website ([www.empaq.org](http://www.empaq.org)) to provide your company's data.

**Finance Structure of Company's Health Insurance Plan(s):** The type of financial structure that describes the employer's health plans. For each of your top three (3) plans, select the one that applies:

- 100% Fully-insured
- 100% Self-insured
- Combination of fully-insured and self-insured plans
  - a. % Enrolled under Fully-Insured
  - b. % Enrolled under Self-Insured

Financial Structure	Medical Plan #1	Medical Plan #2	Medical Plan #3
Select one that applies:	100% Fully-insured	100% Fully-insured	100% Fully-insured
	100% self-insured	100% self-insured	100% self-insured
	Combination of Fully-insured and Self-insured	Combination of Fully-insured and Self-insured	Combination of fully-insured and Self-insured
If a combination, enter % enrolled under Fully-insured	%	%	%
If a combination, enter % enrolled under Self-insured	%	%	%

**Plan Administrative Type:** The different plan administrations offered by the employer. Indicate the percent of eligible employees who are enrolled in each of the plan type below. The choices include:

- *Indemnity:* An indemnity plan, also referred to as a traditional plan or fee-for-service plan, reimburses a covered individual for medical expenses regardless of who provides the service, although in some cases reimbursement amounts may be limited.
- *HMO:* Health Maintenance Organizations provide medical treatment on a prepaid basis, which means that HMO members pay a fixed monthly fee, regardless of how much medical care is needed in a given month. HMO members must utilize participating providers and typically must choose a primary care provider.
- *PPO:* Sometimes called a "participating provider organization" or "preferred provider option." A PPO is comprised of a group of doctors and/or hospitals that provides medical service only to a specific group or association. The PPO may be sponsored by a particular insurance company, by one or more employers, or by some other type of organization. Benefits are often provided at a reduced cost to the participant if they utilize a PPO provider.

## PLAN DESIGN ELEMENTS: MEDICAL

### **Plan Administrative Type** (continued)

- *POS*: A type of managed healthcare system that combines characteristics of the HMO and the PPO. An individual covered by a POS (or point-of-service) plan may pay no deductible and usually pays only a minimal copay when a healthcare provider within the network is used. The individual typically must choose a primary care physician who is responsible for all referrals within the POS network. The individual has the option of “opting-out” of the network at the “point-of-service” usually at a lower reimbursement level. This “out-of-network coverage” is subject to reasonable and customary limits.
- *Consumer-Directed Health Plan*: A consumer-driven health plan is a high deductible health plan accompanied by a consumer-controlled savings account for health care, which can be in the form of either a healthcare reimbursement arrangement (HRA) or a health savings account (HSA).

Indicate the percent of eligible employees who are enrolled in each of the plan types below for your top three plans:

Plan Types	Medical Plan #1	Medical Plan #2	Medical Plan #3
Indemnity	%	%	%
HMO	%	%	%
PPO	%	%	%
POS	%	%	%
CDHP	%	%	%

**Healthcare Reimbursement Account (HRA)**: Does the medical plan include a Healthcare Reimbursement Account? The HRA (Healthcare Reimbursement Account or Healthcare Reimbursement Agreement) is an employer-established account that provides non-taxed funds that employees can use for medical expenses. Account balance may roll over but is not portable (that is, does not follow the individual if he/she leaves the company). Should not be confused with a flexible spending account. Answer Yes or No.

HRA	Medical Plan #1	Medical Plan #2	Medical Plan #3
Include a healthcare reimbursement account?	Yes or No	Yes or No	Yes or No

**Health Savings Account (HSA)**: Does the medical plan include a Health Savings Account? The HSA is a tax-deferred account owned by individuals and used to pay for current and future out-of-pocket health care expenses. Remaining account balance at the end of the year rolls over to following year and is portable (follows the individual). Answer Yes or No.

HSA	Medical Plan #1	Medical Plan #2	Medical Plan #3
Include a health savings account?	Yes or No	Yes or No	Yes or No

**PLAN DESIGN ELEMENTS: MEDICAL (continued)**

**Medical Plan Deductibles:** Report the medical plan’s annual deductible (if any) for an individual and/or a family. (If the medical plan has a deductible for two-party coverage, do not provide this information.) Answer for each of your top three (3) medical plans:

Coverage Type	Medical Plan #1: Annual Deductible	Medical Plan #2: Annual Deductible	Medical Plan #3: Annual Deductible
Single (or Individual)	\$	\$	\$
Family	\$	\$	\$

**Medical Cost Sharing:** Report total costs or percent of allowable charge amount. If there are differing rates for in/out of network care, report in-network rates.

- PCP Office visit for sick care
- PCP Office visit for preventive services
- Emergency room visit

Answer for each of your top three (3) medical plans:

Medical Cost Sharing	Medical Plan #1	Medical Plan #2	Medical Plan #3
PCP Office visit for sick care	\$ copay or % coinsurance	\$ copay or % coinsurance	\$ copay or % coinsurance
PCP office visit for preventive care	\$ copay or % coinsurance	\$ copay or % coinsurance	\$ copay or % coinsurance
Emergency room visit	\$ copay or % coinsurance	\$ copay or % coinsurance	\$ copay or % coinsurance

**Structure of Behavioral Health Benefits:** Select the type of behavioral health benefits offered by the employer. Select only one of the following for each of your top three (3) plans:

- Administered separately by a third party provider;
- Integrated into the medical plans offered; or
- No behavioral health benefit is offered.

Financial Structure	Medical Plan #1: Behavioral Health	Medical Plan #2: Behavioral Health	Medical Plan #3: Behavioral Health
Select one that applies	Administered separately by a third party provider	Administered separately by a third party provider	Administered separately by a third party provider
	Integrated into the medical plans offered	Integrated into the medical plans offered	Integrated into the medical plans offered
	No behavioral health benefit is offered	No behavioral health benefit is offered	No behavioral health benefit is offered

## PLAN DESIGN ELEMENTS: PHARMACY

Provide your company's responses to the following GH plan design elements, using the EMPAQ® Data Submission Tool. For your convenience, write your answer in the boxes provided below as you are gathering your data. Then log onto the EMPAQ® website ([www.empaq.org](http://www.empaq.org)) to provide your company's data.

**Tiered Pharmacy Program:** Tiered pharmacy programs are generally structured with the lower copay (or coinsurance) for generic drugs, and the higher copay(s) or coinsurance for brand-name drugs. (Consult the plan's Summary Plan Description or SPD for your pharmacy program's design.) Here are some examples:

- 1-tier: This design generally has one copay for all covered drugs (generic or brand-name).
- 2-tier: There are two copay tiers. The first tier has the lowest copayment and usually applies to generic drugs. The second copay tier would apply to brand-name drugs.
- 3-tier: There are three copay tiers. The first tier has the lowest copayment and usually applies to generic drugs. The second tier may apply to formulary brand-name drugs, while the third-tier copay is usually for non-formulary drugs.
- 4-tiers or more: This design tends to follow the structure of the 3-tier design. The fourth tier has the highest copay and may include "lifestyle drugs" or specialty pharmaceuticals (biologics).

Designate if Pharmacy Program contains tiers for each of your top three plans. If yes, answer how many tiers are in the Pharmacy Program:

Tiered Pharmacy Program	Medical Plan #1: Pharmacy Plan	Medical Plan #2: Pharmacy Plan	Medical Plan #3: Pharmacy Plan
Contains Tiers?	Yes or No	Yes or No	Yes or No
If Yes, how many tiers?	# of tiers	# of tiers	# of tiers

**Rx Cost-Sharing structure:** Indicate the copay (\$ amount) or coinsurance (% amount) for each tier of the employer's pharmacy program for the top three plans:

Tiered Pharmacy Program	Medical Plan #1: Pharmacy Plan	Medical Plan #2: Pharmacy Plan	Medical Plan #3: Pharmacy Plan
1 <sup>st</sup> Tier: Preferred Brand	Copay (\$) or Coinsurance (%)	Copay (\$) or Coinsurance (%)	Copay (\$) or Coinsurance (%)
1 <sup>st</sup> Tier: Generic	Copay (\$) or Coinsurance (%)	Copay (\$) or Coinsurance (%)	Copay (\$) or Coinsurance (%)
2 <sup>nd</sup> Tier: Preferred Brand	Copay (\$) or Coinsurance (%)	Copay (\$) or Coinsurance (%)	Copay (\$) or Coinsurance (%)
2 <sup>nd</sup> Tier: Generic	Copay (\$) or Coinsurance (%)	Copay (\$) or Coinsurance (%)	Copay (\$) or Coinsurance (%)
3 <sup>rd</sup> Tier: Preferred Brand	Copay (\$) or Coinsurance (%)	Copay (\$) or Coinsurance (%)	Copay (\$) or Coinsurance (%)
3 <sup>rd</sup> Tier: Generic	Copay (\$) or Coinsurance (%)	Copay (\$) or Coinsurance (%)	Copay (\$) or Coinsurance (%)
Note: EMPAQ® does not collect data for Non-Preferred Brands			

**PLAN DESIGN ELEMENTS: PHARMACY (continued)**

**Mail-Order Pharmacy:** Does the pharmacy program include a mail-order option? Mail-order benefits provide participants with an option to typically receive a greater supply of prescription drugs (such as a 90-day supply) through the mail-order pharmacy than at a retail pharmacy (such as a 30-day supply). Generally, mail-order pharmacy programs are designed for participants taking medication on an ongoing basis (i.e., maintenance drugs). Answer Yes or No for each of your top (3) plans.

**Mail-Order Copay:** If the employer’s pharmacy program includes a mail-order option, indicate if the copay (or coinsurance) for the mail-order pharmacy differs from the copay (or coinsurance) for the retail pharmacy. Answer Yes or No for each of your top three (3) plans.

<b>Mail-Order</b>	<b>Medical Plan #1: Pharmacy Plan</b>	<b>Medical Plan #2: Pharmacy Plan</b>	<b>Medical Plan #3: Pharmacy Plan</b>
Include a mail-order option?	Yes or No	Yes or No	Yes or No
If yes, differs from the retail pharmacy?	Yes or No	Yes or No	Yes or No

**Open Formulary:** An Open Formulary refers to a formulary in which all eligible prescriptions are covered, but at various levels of cost sharing. A closed or restricted formulary restricts coverage to a narrow list of drugs. Designate if the formulary for the pharmacy program is an Open or Closed (restricted) formulary for each of your top three (3) plans. Answer: Open or Closed

<b>Open Formulary</b>	<b>Medical Plan #1: Pharmacy Plan</b>	<b>Medical Plan #2: Pharmacy Plan</b>	<b>Medical Plan #3: Pharmacy Plan</b>
Is your formulary open or closed?	Open or Closed	Open or Closed	Open or Closed

# Incidental Absence (IA) and Total Absence (TA) Metrics and Data Elements

**Note:** If the employer cannot make the distinction between scheduled and unscheduled leave in their PTO bank, then do not submit data for these metrics.

## Absence Definitions:

The following definitions provide background for calculating the absence headcount and cost metrics:

**Incidental Absence:** Any unplanned time an employee misses from work. Generally, the absence is less than 5 days in duration and given the unplanned nature, is not predictable. It does not include an intermittent absence that is covered under a Family Medical Leave.

## Incidental Absence Category:

Provide your company's responses to the following IA cost metrics, using the EMPAQ® Data Submission Tool. For your convenience, write your answer in the boxes provided below as you are gathering your data. Then log onto the EMPAQ® website ([www.empaq.org](http://www.empaq.org)) to provide your company's data.

**Average Number of Active Employees Covered for Incidental Absence:** The average number of active U.S. employees who are covered for incidental sick day absence at the mid-month (or mid-quarter) during the reporting period, summed and then divided by the total number of months (or quarters) during the reporting period. Note: This is not the count of covered employees.

Example: 
$$\frac{10,000 (Q1) + 10,000 (Q2) + 10,000 (Q3) + 10,000 (Q4)}{4}$$

Your Company's Response:

---

**Unpaid Incidental Sick Days:** The number of unpaid sick days or PTO unplanned/unscheduled days that were taken during the reporting period. For employers that utilize a PTO bank, do not capture days in this element unless they are unpaid.

Your Company's Response:

---

**Paid Incidental Sick Days:** The number of paid sick days or PTO unplanned/unscheduled days that were taken during the reporting period. For employers that utilize a PTO bank, use unplanned or unscheduled days if leave is not discretely identified as a sick day. Exclude days approved for another type of benefit (STD, WC or FMLA).

Your Company's Response:

---

## **Total Absence Category:**

**Wage Replacement as a Percentage of Payroll:** The total cost of wage replacement benefits (i.e., indemnity payments) paid during the reporting period under STD, LTD and WC indemnity programs divided by the total gross W2 payroll.

**Note:** This Total Absence metric is calculated by integrating data collected from the STD, LTD and WC programs plus Total Payroll data from the Demographics section. Check to verify that data has been submitted from your disability programs in order to calculate this metric for benchmarking reports.

## **Employee Assistance Program (EAP) Metrics and Data**

**Elements** (Based on recommendations from the National Business Group on Health's An Employer's Guide to Employee Assistance Programs, December 2008).

### **EAP Definitions:**

**The following definitions provide background for calculating EAP cost metrics:**

The vast majority of Fortune 500 companies offer EAPs to deliver a variety of health and productivity services to improve organizational performance, as well as assist individual employees and their dependents. EAPs can help employers address a variety of employee problems and proactively deal with workplace issues that can lead to workplace violence, physical and mental health issues or declining morale among workers. These programs are staffed by practitioners who provide preventive services and short-term problem-resolution services to individual employees and families. EAP practitioners:

- Provide consulting services to managers and supervisors regarding employee performance;
- Serve as behavioral consultants to corporate leaders when unexpected events occur, such as natural disasters, plant accidents, mergers and bankruptcies; and
- Help with industry-specific emergencies such as providing support to bank employees who witness robberies while at work.

**New EAP Case:** A single New EAP Case is established when EAP staff performs each of the following tasks with a covered individual. These activities may be performed face-to-face, online or via telephone:

- Collects demographic data;
- Conducts an initial assessment that results in identifying and documenting a presenting problem;
- Creates a baseline measure detailing the impact of the presenting problem on job performance;
- Creates a plan of action;
- Makes recommendations;
- Identifies a referral type (if relevant);
- Provides a referral and/or short-term problem resolution; and
- Provides follow-up contact with appropriate parties.

**Active EAP Case:** Similar to a New EAP Case, a single Active EAP Case is determined when EAP staff performs each of the following tasks with a covered individual. These activities may be performed face-to-face, online or via telephone:

- Collects demographic data;
- Conducts an initial assessment that results in identifying and documenting a presenting problem;
- Creates a baseline measure detailing the impact of the presenting problem on job performance;
- Creates a plan of action;
- Makes recommendations;
- Identifies a referral type (if relevant);
- Makes a referral or provides short-term counseling; and
- Provides follow-up contact with appropriate parties.

## **EAP Headcount and Cost Category:**

Provide your company's responses to the following EAP headcount and cost metrics, using the EMPAQ® Data Submission Tool. For your convenience, write your answer in the boxes provided below as you are gathering your data. Then log onto the EMPAQ® website ([www.empaq.org](http://www.empaq.org)) to provide your company's data.

**Average Number of Employees Covered for EAP:** The total number of employees who are eligible for EAP services during the reporting period.

- Exclude retirees, spouses and dependents.
- Also, do not assume that "number of employees covered for EAP" is equivalent to "employees enrolled in the organization's health benefit plan(s)", since eligibility for EAP benefits may be different.
  - For example, part-time employees that may not be eligible for health benefits may be eligible for the EAP.

Your Company's  
Response:

---

**Total Number of New EAP Cases:** Number of new EAP cases in the reporting period. Include cases that may extend into the following time period.

Your Company's  
Response:

---

**Total Number of Active EAP Cases:** The number of open or active EAP cases in the reporting period, even if those cases were opened in a previous time period or extend into a subsequent time period.

Your Company's  
Response:

---

**EAP Program Costs:** Total direct cost of the EAP paid by the employer in the reporting period.

Your Company's  
Response:

---

## **More Information on EAP Cases:**

The following is provided as a supplement for EMPAQ® users seeking more information on the establishment of an EAP case. (Courtesy of the National Business Group on Health's An Employer's Guide to Employee Assistance Programs, December 2008).

**Problem Group Cases:** Problem groups resulting in the creation of a case will be consolidated and placed into standardized groupings for EMPAQ® reporting purposes to include:

- Work-related problems.
- Substance use and abuse (alcohol and drugs).
- Psychological/emotional problems.
- Family/marital/relationship problems.

A problem-group case may include multiple issues associated with a single problem, which may result in multiple referrals. This type of case scenario can be reflected in program statistics to recognize the intensity of EAP activity associated with each problem case and to assist in monitoring the staffing resources of an EAP's internal operations. However, multiple problems and multiple referrals must not be counted as multiple cases for the purpose of determining participation rates.

A presenting problem(s) is defined as the initial reason(s) a client gives to the EAP during the initial contact. In that initial contact, the EAP professional should consider identifying a primary presenting issue and note any additional issues raised, which would then be classified as secondary presenting issues. Upon completion of the assessment, the EAP professional will select an "assessed issue/ problem."

While the presenting and/or "assessed issue/problem" may be adopted, the EAP Metrics Subcommittee believes that the "assessed issue/problem" demonstrates a value-added activity on the part of the EAP. In other words, a professional assessment of an issue is performed and appropriate alignment of resources is established, which results in alleviating the impact of the issue on the employee's situation and related level of productivity.

**Opening and Closing Cases:** Existing EAP case files should be closed when the following occurs:

- An Active EAP Case has not had any activity within the past 90 days, and/or
- An Active EAP Case treatment plan timeframe has expired (e .g., in substance use and abuse cases being monitored over a long period of time).

Clients with an existing EAP case file who contact the EAP for additional services and have met the above conditions will be considered as a potential New EAP Case.

# Health Management Program (HM) Metrics and Data Elements

## HRA and Screening Category:

Provide your company's responses to the following HM metrics, using the EMPAQ® Data Submission Tool. For your convenience, write your answer in the boxes provided below as you are gathering your data. Then log onto the EMPAQ® website ([www.empaq.org](http://www.empaq.org)) to provide your company's data.

**Average Number of Employees Covered for HRAs:** The average number of active employees (excluding retirees, spouses, and dependents) eligible to take a Health Risk Appraisal (HRA) during the reporting period.

The average number of eligible employees is obtained by adding the number of eligible employees at the mid-point of each month (or each quarter) for 12 months (or four quarters) of the program year, then dividing the sum total by 12 (or 4 if reported by quarter).

Your Company's Response:

\_\_\_\_\_

**Total Number of Employees Participating in HRAs:** The total number of active, eligible employees (excluding retirees, spouses, and dependents) who take HRAs during the reporting period. If an employee takes an HRA more than once during the same reporting period, such an employee should be only counted once. An HRA is considered complete if questions on both age and gender have been answered.

Your Company's Response:

\_\_\_\_\_

**Average Number of Employees Covered for Screening:** The average number of active employees (excluding retirees, spouses, and dependents) eligible to participate in health management programs during the reporting period.

The average number of eligible employees is obtained by adding the number of eligible employees at the mid-point of each month (or each quarter) for 12 months (or four quarters) of the program year, then dividing the sum total by 12 (or 4 if reported by quarter). Only include active employees (no retirees, spouses, or dependents).

Your Company's Response:

\_\_\_\_\_

**Total Number of Employees Participating in Screening:** The total number of active, eligible employees (excluding retirees, spouses, and dependents) who participate in screening during the reporting period. Include only screening results performed by the employee's physician OR results obtained in an employer-sponsored event. Self-reported measures of health status (for example, as entered by the employee on his or her HRA) are NOT considered screening and should not be included when counting screened employees. If an employee participates in screening more than once during the same program year, such an employee should be only counted once.

Your Company's Response:

\_\_\_\_\_

## **HM Plan Design Category:**

**Programs Offered to Employees, Health Risk Appraisal (HRA):** The Health Risk Appraisal (HRA) questionnaire, sometimes called a Health Risk Assessment, is generally a tool that an employee uses to submit individual health and risk factor data. The HRA includes questions on lifestyle, health behaviors, and personal and family medical history. This information is analyzed and reported back to the individual as an individualized assessment of the employee's current health status/quality of life and often contains strategies for reducing risk. The assessment promotes individual health awareness through the review of one's lifestyle practices and the subsequent discovery of those behaviors that may impact current or future health status. Answer Yes or No.

**Programs Offered to Employees, Screening:** An employer-sponsored initiative during which laboratory tests or other physical measurements are conducted. In this metric, the assessment of any health indicator beyond the HRA will be classified as "screening." Examples of these health indicators can include measures of weight, height, body mass index (BMI), waist circumference, blood pressure, blood sugar, lipid panel (cholesterol, high density lipoprotein [HDL], triglycerides), body fat, vision, hearing, and mental health. Answer Yes or No.

<b>Program Screening</b>	<b>Offered to Employees?</b>
Screening, Body Weight	<b>Yes or No</b>
Screening, Height	<b>Yes or No</b>
Screening, Waist Circumference	<b>Yes or No</b>
Screening, Blood Pressure	<b>Yes or No</b>
Screening, Blood Sugar	<b>Yes or No</b>
Screening, Lipid Panel	<b>Yes or No</b>
Screening, Body Fat	<b>Yes or No</b>
Screening, Vision	<b>Yes or No</b>
Screening, Hearing	<b>Yes or No</b>

**Programs Offered to Employees, Health Education Programs:** Programs that provide health-related information to employees, intended to improve understanding of the factors that promote health and reduce risks. Information may be disseminated via newsletters, seminars, email and/or web page. Answer Yes or No.

**Programs Offered to Employees, Wellness Intervention Programs:** Programs that actively engage employees in behavior modification over time, intended to modify risk factors and promote health behavior. Examples of such programs include (but are not limited to) exercise class (walking/weight training/aerobics), nutrition/healthy eating classes, weight maintenance or weight loss programs, smoking cessation courses, and stress reduction programs. Answer Yes or No.

**Programs Offered to Employees, Coaching:** A process by which a health coach or counselor helps an individual address and manage health behavior change. Health coaching may be offered to all employees (regardless of risk status) or targeted to those with chronic conditions. Coaching may be telephonic, in-person, or web-based. Answer Yes or No.

## **HM Plan Design Category (continued):**

**Financial and Non-Financial Incentive:** In general, an incentive is anything, which encourages participation and includes (but is not limited to) cash, gifts, vouchers, premium differentials, raffles, and contributions to a healthcare spending account. Answer Yes or No.

**Financial and Non-Financial Disincentives:** A disincentive is a penalty for failing to take specified action(s) to improve health status or lifestyle behavior (e.g. to remain tobacco free and/or participate in a smoking cessation program). However, some employers offer access to the preferred plan design only for wellness program participants; ineligibility for these plans may be viewed as a penalty (thus disincentive) by non-participants. Answer Yes or No.

## Index

Elements	Page	Elements	Page
Active Claim (LTD)	24	Closed Claim (LTD)	24
Active Claim (STD)	6	Closed Claim (WC)	16
Active Claim (WC)	16	Company Size	3
Active EAP Case	48	Cost Sharing Percentage (LTD)	28
Approved Claim (LTD)	24	Cost Sharing Percentage (STD)	13
Approved Claim (STD)	6	Definition of Disability (LTD)	28
Age Breakdown – Over Age 55 (%)	5	Definition of Disability (STD)	13
Age Breakdown – Under Age 30 (%)	5	Dental Health Employee Contributions	39
Approved Claim (WC)	16	EAP Program Costs	49
Average Active Headcount (GH)	35	Elimination Period (LTD)	28
Average Employee Concentration by State (WC)	17	Elimination Period (STD)	13
Average Number of Active Employees Covered for Incidental Absence	44	Employees – Active	3
Average Number of Behavioral Health Covered Employees (if separate)	36	Employees – Covered	3
Average Number of Covered Lives for Group Health	36	Employees – Eligible	3
Average Number of Covered Subscribers for Dental Health	39	Employees – Full-Time Hourly	4
Average Number of Covered Subscribers for Group Health	36	Employees – Full-Time Salaried Exempt	4
Average Number of Employees Covered for EAP	49	Employees – Full-Time Salaried Non-Exempt	4
Average Number of Employees Covered for HRAs	51	Employees – Part-Time	4
Average Number of Employees Covered for Screening	51	Finance Structure of Company's Health Insurance Plan(s)	41
Average Number of Employees Covered Under LTD Plan	25	Financial and Non-Financial Disincentives	53
Average Number of Employees Covered Under STD Plan	7	Financial and Non-Financial Incentives	53
Average Number of Employees Eligible for FMLA	30	Full-Time Equivalent	3
Average Number of Group Health Covered Employees	35	Group Health Employee Contributions	37
Average Number of Medical Plan Covered Employees	35	Healthcare Reimbursement Account (HRA)	34,42
Average Number of Pharmacy Plan Covered Employees	36	Health Savings Account (HSA)	34,42
Average Size of Workforce (Demographics)	3	Incidental Absence	46
Behavioral Health Program Costs for Covered Employees (if separate)	38	Indemnity Claims (WC)	16
Behavioral Health Program Costs for Covered Lives (if separate)	38	Length of Employment – Less Than 1 Year (%)	5
Closed Claim (STD)	6	Length of Employment – More Than 10 Years (%)	5

## Index (continued)

Elements	Page	Elements	Page
Lost Calendar Days Associated with Closed STD Claims	9	Programs Offered to Employees, Screening	52
LTD Offset by Social Security Employee Benefits Only	29	Programs Offered to Employees, Wellness Intervention Programs	52
LTD Offset by Social Security Family Benefits	29	Return to Work (RTW)—WC	17
Mail-Order Copay	45	Return to Work (RTW)—STD	7
Mail-Order Pharmacy	45	Rx Cost Sharing structure	44
Major Diagnostic Category (MDC) Codes (GH)	39-40	Screening, Blood Pressure	52
Major Diagnostic Category (MDC) Codes (LTD)	26-27	Screening, Blood Sugar	52
Major Diagnostic Category (MDC) Codes (STD)	11-12	Screening, Body Fat	52
Maximum Benefit Period (LTD)	29	Screening, Body Weight	52
Maximum Benefit Period (STD)	14	Screening, Hearing	52
Maximum Duration for Mental/Nervous Disabilities (LTD)	29	Screening, Height	52
Medical Cost Sharing	43	Screening, Lipid Panel	52
Medical-Only Claims	16	Screening, Vision	52
Medical Plan Deductibles	43	Screening, Waist Circumference	52
Medical Program Costs Paid by Employer for Covered Employees Including Behavioral Health	37	SIC Code	4
Medical Program Costs Paid by Employer for Covered Lives Including Behavioral Health	37	STD Offset by Other Sources	14
NAICS Code (2-digit or 4-digit)	4	STD Offset by Statutory STD	14
New Claim (LTD)	25	STD Offset by WC	14
New Claim (STD)	7	Structure of Behavioral Health Benefits	43
New Claim (WC)	17	Surviving Spouse	34
New EAP Case	48	Temporary Total Disability (TTD)	17
Non-Concurrent (FMLA)	30	Tiered Pharmacy Program	44
Open Formulary	45	Total Active Claim Costs (WC)	19
Paid Incidental Sick Days	46	Total Benefits Paid (STD)	8
Pharmacy Program Costs Paid by Employer for Covered Employees	38	Total Benefits Paid for Closed STD Claims	10
Pharmacy Program Costs Paid by Employer for Covered Lives	38	Total Costs of Closed Claims	20
Plan Administrative Type (GH)	41-42	Total Dental Health Program Costs for Covered Employees	38
Population Female (%)	5	Total Dental Health Program Costs for Covered Lives	39
Population Unionized (%)	5	Total Indemnity Costs of Closed Indemnity Claims	20
Programs Offered to Employees, Coaching	52	Total Indemnity Costs for Indemnity Claims	18
Programs Offered to Employees, Health Education Programs	52	Total Group Health Subscribers' Contributions	37
Programs Offered to Employees, Health Risk Appraisal (HRA)	52	Total LTD Benefits Paid	25

## Index (continued)

Elements	Page	Elements	Page
Total Medical Costs for Indemnity Claims	18	Total Number of FTEs Covered for WC	17
Total Medical Costs for Medical-Only Claims	18	Total Number of Lost Workdays (STD)	9
Total Medical Costs of Closed Indemnity Claims	21	Total Number of Lost Workdays from Date of Injury for Closed TTD Claims	22
Total Medical Costs of Closed Medical-Only Claims	21	Total Number of Lost Workdays for TTD Claims	22
Total Number of Active EAP Cases	49	Total Number of Non-Concurrent FMLA Claims	31
Total Number of Active STD Claims	8	Total Number of Non-Concurrent FMLA Lost Workdays	32
Total Number of Active TTD Claims	20	Total Number of New EAP Cases	49
Total Number of Active WC Claims	20	Total Number of New LTD Claims	25
Total Number of Active WC Indemnity Claims	19	Total Number of New STD Claims	7
Total Number of Active WC Medical-Only Claims	19	Total Number of New STD Maternity Claims	10
Total Number of Claims RTW Transitional Duty	23	Total Number of New WC Indemnity Claims	18
Total Number of Claims on RTW Transitional Duty (STD)	11	Total Number of New WC Medical-Only Claims	118
Total Number of Closed Claims (WC)	20	Total Number of Open LTD Claims	26
Total Number of Closed Indemnity Claims	21	Total Number of Transitional Duty Workdays (WC)	23
Total Number of Closed Medical-Only Claims	21	Total Number of Workdays with Employees on RTW Transitional Duty (STD)	11
Total Number of Closed STD Claims	10	Total Payroll	5
Total Number of Closed TTD Claims	22	Unpaid Incidental Sick Days	46
Total Number of Employees Participating in HRAs	51	Wage Replacement as a Percentage of Payroll	47
Total Number of Employees Participating in Screening	51	Wage Replacement Structure (LTD)	29
Total Number of FMLA Claims	30	Wage Replacement Structure (STD)	14
Total Number of FMLA Lost Workdays	31	WC Settlement Costs	21

## **About the National Business Group on Health**

Founded in 1974, the National Business Group on Health is the nation's only non-profit organization devoted exclusively to representing large employers' perspective on national health policy issues and providing practical, forward-thinking solutions to its members' most important health care and health benefits challenges. Members of the Business Group drive today's health agenda while exchanging ideas for controlling health care costs, improving patient safety and quality of care, increasing productivity, supporting healthy lifestyles, and sharing best practices in evidence-based health benefits design. Recognized as the leading voice of large employers, the Business Group represents almost 300 members, primarily Fortune 500 companies and large public sector employers, who provide health care for 55 million U.S. workers, retirees, and their families. For more information, contact [membership@businessgrouphealth.org](mailto:membership@businessgrouphealth.org).

## **About the Institute on Health, Productivity, and Human Capital**

The Institute on Health, Productivity, and Human Capital was established by the National Business Group on Health to develop and share solutions aimed at improving employee health and productivity. The work of the Institute examines and supports the business relationship between population health, engagement and organizational performance.

EMPAQ® is an initiative of the Board of the Institute on Health, Productivity, and Human Capital, part of the National Business Group on Health. Information developed and shared about EMPAQ® is considered proprietary and confidential unless otherwise determined by the National Business Group on Health. For more information, visit [www.empaq.org](http://www.empaq.org).