



THE LANCASTER
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Lancaster County
Business Group on Health
Affiliate of The Lancaster Chamber

2010 Executive Summary of Medical Insurance Policies and Benefits

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Survey Highlights

- There is significant movement toward self-funding deductibles on fully-insured plans. Employers are finding value in buying high deductible plans from carriers, and then taking the risk of financing part or all of those deductibles.
- Most medical trend increases are being passed through to employees with changes in plan design and changes to contributions. Employer costs show only small changes.
- There is a substantial shift toward longer waiting periods, with 90-day wait the prominent design in our survey.
- Activity in changing carrier and increasing employee and dependent contributions are higher than any time in the past.
- Deductibles have increased rapidly, with \$500 or more representing almost 75% of plans.
- This report matches plan design to employee contributions, and finds employees are paying 44% of total costs through either contributions or deductibles and co-pays. Thus, employers are financing only about 56% of total medical costs.
- Over 90% of employers expect a medical increase at their next renewal of 10% or more.

The Lancaster Chamber of Commerce & Industry (LCCI) recently surveyed many of the County's employers about the employee benefits that they offer, including employee contributions, strategies to contain costs, and their views on health care issues. The results provide a benchmark for County employers to assist them in evaluating the competitiveness and appropriateness of their current benefit package.

Introduction

Survey results represent 72 employers insuring about 40,000 members, or roughly 15% of the commercially insured population in Lancaster County.

The presentation and approach of this survey is unique and distinctive from the many surveys available from other sources. First, it's locally based. Second, it covers a wide range of employee benefits. The major statistic used is the average benchmark as opposed to the array of raw answers. Comparisons with prior years' surveys are presented so trends in plan design can be observed. An analysis of employee medical cost share, both in premium contributions and deductible out-of-pocket costs, provides an interesting perspective on financing of health care.

Finally, this survey report from your Chamber of Commerce makes commentary and observations and interpretations of the results in a way that brings more meaning to the figures. Some benchmarks are shifting rapidly; some are not. Some benchmarks are being influenced by marketplace events that are not part of the survey or easily measured. This report attempts to identify those influences and provide context to the numbers.

Some measures introduced in this report two years ago are now central to the structure of health care reform. This report identifies and provides commentary on those benchmarks in light of the new reform law.

Employers Surveyed

The survey was made available to all County employers. The employers who responded ranged in size from less than 5 to almost 2,000 employees. One large employer covering over 6,000 employees participated, but their Lancaster employee base is much smaller.

Respondent's Group Size	
Employees	Percentage
1-50	29%
51-100	27%
101-500	34%
501-1000	4%
>1000	7%

Percentage of employers in each size range

Profile and Strategies

About 70% of those employers surveyed insure their benefit plans, while the remaining 30% have self-funded plans. This represents no change from 2008, but a slight shift from prior years that showed about 25% self-insured.

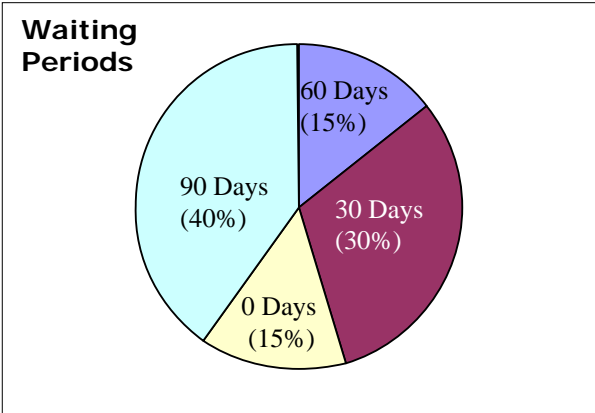
However, about 35% of fully-insured employers reported accepting self funding of all or a portion of the plan deductible. This is more than double from past surveys.

Waiting Periods

The survey measured a prominent shift toward longer waiting periods with 90 days being the most commonly used length of time before benefits begin.

More than half (55%) of the employers have waiting period of 60 or 90 days, up from about 40% two years ago. The increase in

longer waiting comes at the expense of 30-day waits that decreased in usage. The number with "no wait" remains the same (15%) as two years ago.



Cost Control Strategies

2010 shows a dramatic increase over prior years in shopping carriers and raising contribution rates. Almost half of employers have raised contributions in the past year.

Change Made	2004	2006	2008	2010
Changed Carrier	21%	18%	26%	38%
Increased Single Contribution	37%	37%	31%	48%
Increased Family Contribution	42%	34%	40%	47%
Reduced Benefits	22%	17%	15%	18%

About 18% of employers reported HSAs and twice that many, 36%, with HRAs.

The last several surveys have shown between 5% and 10% per year also are switching to or offering some sort of consumer directed health care.

Carriers

Of the three major insurance carriers, Health America covered 33% of the respondents, with Capital Blue Cross and Highmark each at about 20%. This is either for insurance coverage or administration.

Pharmacy Benefit Managers (PBM)

There is probably confusion regarding PBM's and their identity and role in health plans. About 30% of respondents simply reported their carrier as the PBM or left this blank.

Plans Offered

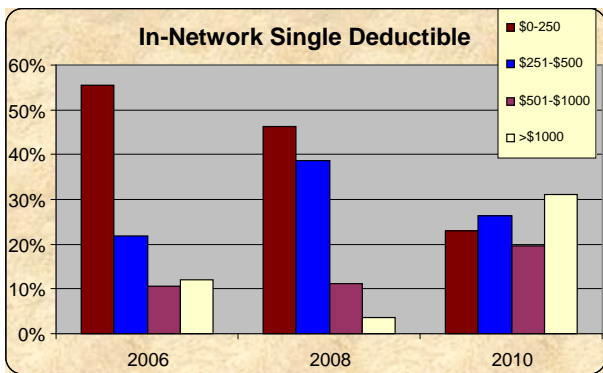
The movement over the years toward PPO plans can be seen in the table below. PPO now represents the predominant plan with 98% of the respondents saying PPO was the primary health plan.

Year	2003	2004	2006	2008	2010
PPO	43%	60%	68%	88%	98%

HMO, when available, now serves as the second plan option for about 15% of the employers in the survey. Indemnity plans are pretty much non-existent except in the public sector.

Medical Plan Designs

The chart below shows the continuing shift toward higher deductibles. The percentage of plans with deductibles at or over \$500 is almost 75%.



Plans with deductibles at \$1,000 or higher generally are using consumer directed plans of some sort. Therefore, the deductible benchmark has become more difficult to interpret since so many employers are self-funding a portion of the risk on the higher deductibles.

Office Visit Co-pays

Primary care office visit co-pays have steadily increased along with plan deductibles. In 2002, the most common co-pay was \$10. In 2003 and 2004, it was \$15. The 2008 survey showed over half the plans with co-pays of \$20 or more. Now, 80% of plans are \$20 or more.

<\$15	3%
\$15	16%
\$20	57%
\$25	17%
\$25+	7%

Specialist Visits

Most plans now require a higher doctor visit co-pay in situations where the services of a specialist are used. In past years, this was typically a differential of \$10. That is, if the office visit co-pay is \$20, then the specialist co-pay is \$30. The differential is now predominately \$15 or \$20.

Individual and Family Deductibles

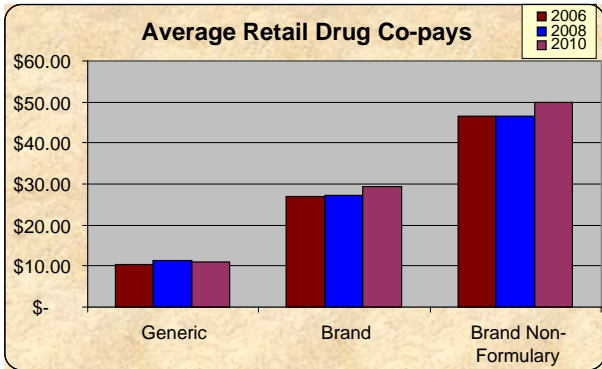
As individual deductibles have risen, and with the advent of federally mandated standard plan designs for High Deductible Health Plans (HDHPs), we have seen the virtual disappearance of three times family deductibles.

Drug Plan Designs

Most drug plans (about 85%) continue to use *co-pays* versus *co-insurance percentage*. A co-insurance percentage is favored in theory because it automatically keeps pace with inflation (as drug prices go up, so does the employee share), whereas a co-pay needs to be adjusted periodically to keep pace with inflation. Nonetheless, the co-pay structure is usually used because it is more popular and easier to understand than co-insurance.

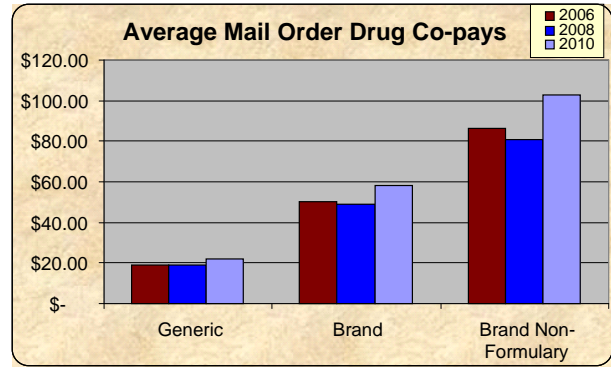
The proportion of plans reported with mandatory generic provisions has decreased to 20%.

Average co-pays showed some increase in 2010 compared to the prior two surveys.



	2006	2008	2010
Generic	\$ 10.40	\$ 11.30	\$ 10.88
Brand	\$ 26.86	\$ 27.22	\$ 29.28
Brand Non	\$ 46.61	\$ 46.59	\$ 49.78

The average mail order co-pays (see below) show a bit more increase over the prior two surveys.



	2006	2008	2010
Generic	\$ 18.83	\$ 18.78	\$21.89
Brand	\$ 50.39	\$ 49.18	\$58.30
Brand Non	\$ 86.31	\$ 80.58	\$102.55

It is now widely suggested that mail order co-pays ought to be 2½ times retail to be cost-effective, but our survey continues to reflect a ratio of about 2.

Premiums and Contributions

The survey showed average employee contributions are about \$76 per month for single and \$307 for family. The employee figure is about 25% higher than the 2008 survey, which showed averages of \$57 and \$287 respectively.

Average Premium Rates and Contributions				
Tier	Rate	2006	2008	2010
Single	Premium	\$365	\$359	\$389
	Contribution	\$54	\$57	\$76
Family	Premium	\$1,075	\$902	\$976
	Contribution	\$277	\$287	\$307

The relatively low growth in premium from the table above is not an indicator of low inflation. Rather, it possibly reflects what the carriers call "benefit buy down." That is to say, reduction in benefits or conversion to high deductible plans.

Tier	2006	2008	2010
Single	15%	16%	20%
Family	26%	32%	31%

Employer – Employee Co-Share

Employees share the cost of health insurance through two vehicles:

- Employee contributions
- Plan design deductibles and co-pays

This survey provides a rare view of the interaction of these two parameters of employee cost sharing.

It is interesting to note that this perspective of the financial burden of employee deductibles and co-pays will soon be more familiar with the advent of health care reform. The reform bill does several things with these parameters:

- The law defines an affordable plan in terms of the percentage of costs expected to be paid by deductibles and co-pays. (It can't be more than 40% of costs attributed to employee out-of-pocket obligations for deductibles and co-pays.)
- The law examines contributions as a percent of personal income to help determine affordability. (It can't be more than 9.5% of family income).
- The law will establish an array of plan options for the exchanges based on employee deductibles and co-pays equivalent to 10%, 20%, 30%, and 40%.

These concepts were introduced to readers of this report two years ago. We found at that time, with similar results this survey, that there is no correlation or coordination between contributions and plan design. That is, some employers have low contributions for a thin plan, and some have high

contributions for a rich plan, and everything in between.

Historically, employers have never strategically coordinated the two items nor had a view of just how much the employees share in the cost in total. Such a coordinated view has never been part of traditional brokerage services and requires data not generally available. Employers really have no tools to understand just how much they are asking employees to support the program.

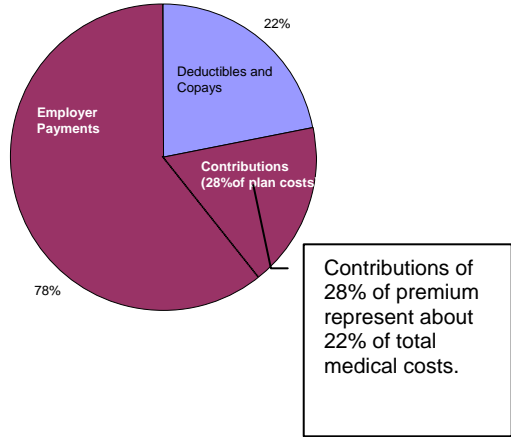
Using plan design parameters, the estimated employee out-of-pocket expenses (co-share) was estimated using actuarial models. This was then matched to the reported employee contributions.

Key results are:

- Employers pay about 56% (62% last survey) of medical costs. Employees pay about 44% (38% last survey).
- On average, employees pay about 22% of costs through contributions, and about 22% through plan deductibles and co-pays.
- The range of employee support for medical benefits among participating employers in the survey was from 22% of total costs to over 60%.

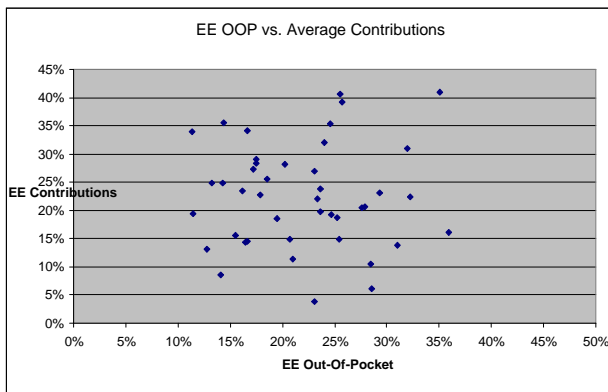
Think of it this way: A typical employer plan passes about 22% of medical costs to the employees through deductible and co-pays. Thus, the insurance premium (or self-funded plan) covers about 78% of costs. Then, employees are asked to pay about 28% of the insurance premium through contributions. 28% contribution of the 78% the plan covers represents the other 22% of total costs.

Plan Costs



These measurements miss the amount that employers are now contributing to self-fund high deductibles, so actual employer costs overall are probably about 60%.

The scatter graph below indicates the lack of coordination between plan design and employee contributions.



In this survey, all the employers passed the first test from health care reform for affordability. That is, no plan expected employees to pay more than 40% in deductibles and co-pays.

If we applied the contribution test for affordability under the reform law, the average family contributions would breach the affordability test at family incomes of about \$39,000.

Disability, Dental and Vision

A large portion of employers offer ancillary coverage to their employees. The table below shows some changes from prior surveys. We see significant growth in dental and vision coverage. However, there is some statistical fluctuations depending on the mix of employers that respond each year.

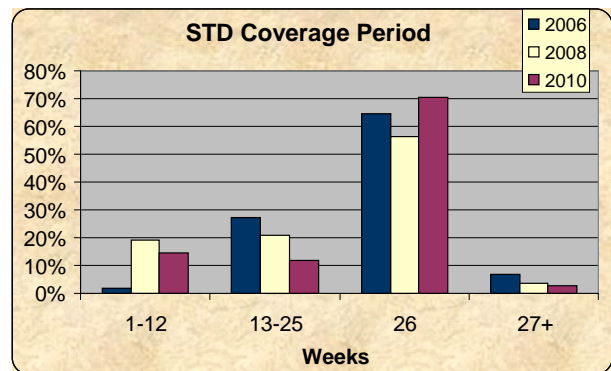
	2006	2008	2010
STD	68%	80%	76%
LTD	67%	67%	67%
Dental	73%	67%	82%
Vision	64%	46%	65%

Disability

Most employers (86%) offer some disability coverage, either short-term or long-term. A little more than half (57%) offer both short-term and long-term disability coverage.

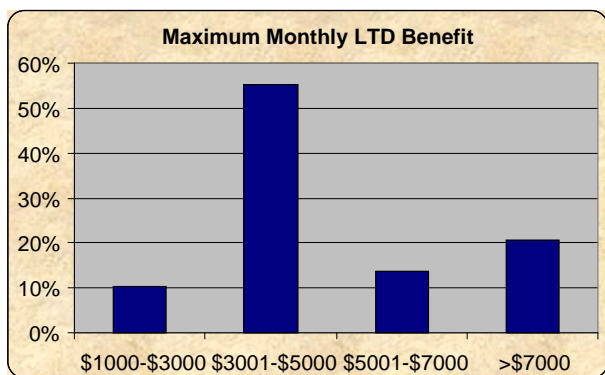
The most dominant benefit period is 26 weeks at about 70% of the plans. This is up from prior years.

The majority of benefits are a percent of salary in the range of 60% to 67%.



Sixty-seven percent of employers offer a long-term disability benefit, and of those that do offer LTD, about 90% offer a percentage of salary rather than a flat amount. Almost all respondents with a percentage of salary benefit provide 60% to 66 2/3% salary replacement.

Maximum monthly benefits range from \$1,300 to \$15,000, with \$5,900 being the average monthly maximum.



Dental

Of the companies surveyed that offer dental benefits, 33% indicated that they self-fund their dental plan. This compares with 40% and 53% in prior surveys.

About 35% of employers offer voluntary dental.

The predominate dental deductible is \$50 waived for Type A services. Survey data indicates very little deviation from this standard. The most common plan design is 100% coverage for Type A (preventive) expenses, 80% coverage for Type B (basic) expenses, and 50% coverage for Type C (major restorative) expenses.

About 40% respondents indicated the plan covers orthodontia expenses. Lifetime ortho maximums range from \$1,000 to \$3,000.

Tier		2008	2010
Single	Premium	\$22	\$27
Family	Premium	\$57	\$69

Miscellaneous Benefit Issues

Respondents indicated that they provide a variety of other benefits as shown in the table below.

Benefit	2006	2008	2010
Retiree Medical Coverage	11%	10%	9%
Pre-tax Premium Contributions	58%	56%	68%
Flexible Spending Account (FSA)	49%	41%	57%
Dependent Care FSA	41%	35%	28%
Defined Benefit	26%	33%	32%
Defined Contribution	79%	79%	71%
Pre-Tax (401K)	67%	78%	68%
After-Tax (savings & thrift)	8%	6%	7%
Deferred profit sharing	10%	6%	10%
Stock ownership plan	3%	5%	1%
Money purchase pension	2%	0%	1%

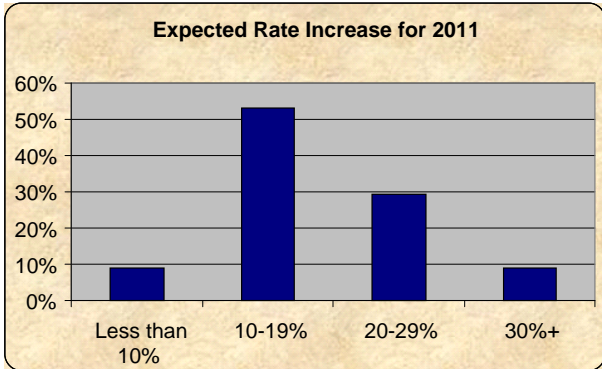
Consistent with the marketplace, we see less retiree medical being offered. This year's survey registered a significant increase in use of FSAs and pre-tax contributions.

The chart below shows the prevalence of communication methods:

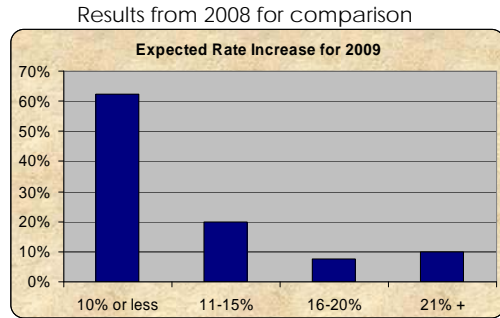
All employee meetings	87%
Benefits fair	13%
Individual annual reports (Benefit Statements)	23%
Lobby kiosk/VCR	2%
Website postings	22%
Regular benefit communication publications	35%
Paycheck stuffers	52%
Retirement seminars	23%
Employee surveys	23%
Other	10%

Inflation and Trends

Finally, the respondents were asked their expected medical rate increase for 2011 and almost 90% expected 10% or more. Almost 40% expect 20% or more.



From two years ago, the results are dramatically different when 63% of the respondents expected an increase of 10% or less.



This executive summary was prepared by the **Strategic Planning Committee** of the Lancaster County Business Group on Health on behalf of The Lancaster Chamber of Commerce & Industry.

The commentary, opinions, and interpretation of results are purely those of the committee members.

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