LANCASTER COUNTY
BUSINESS GROUP ON HEALTH

2008 Benefit Survey

The Lancaster County Business Group on Health (LCBGH) and the Lancaster Chamber of Commerce and 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.

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Survey Highlights

- Survey results represent 109 employers insuring over 32,000 members, or roughly 15% of the commercially insured population in Lancaster County.
- This survey presents comparisons with prior years so trends in plan design can be observed.
- The plan design platform (PPO versus HMO versus Indemnity) is no longer an interesting question. PPO with a single carrier is the predominate model.
- The figures indicate fewer employers are "reducing benefits" as a cost control strategy. This is consistent with the view that there's a limit to the ability to reduce benefits beyond which employer's have to seek other methods to control costs.
- Primary care office visit copays have steadily increased along with plan deductibles, but drug copays have leveled off.
- There is more activity changing carriers than in past years.
- Average employee contributions continue to rise.
- This report matches plan design to employee contributions, and finds employees are paying 38% of total costs through either contributions or deductibles and copays. Employers are financing about 62% of total medical costs.
- A majority of employers expect 10% or less medical increase in 2009.
- The survey shows virtually no change in dental plan design over the years except for gradually higher maximum in ortho coverage for those who offer it.

Employers Surveyed

The survey was made available to all employers who are members of the LCCI or LCBGH. The employers who responded ranged in size from four employee companies to companies with over 1,700 employees.

Respondent's Group Size	
Employees	Percentage
2-50	49%
51-100	13%
101-500	29%
501-1000	9%
>1000	1%

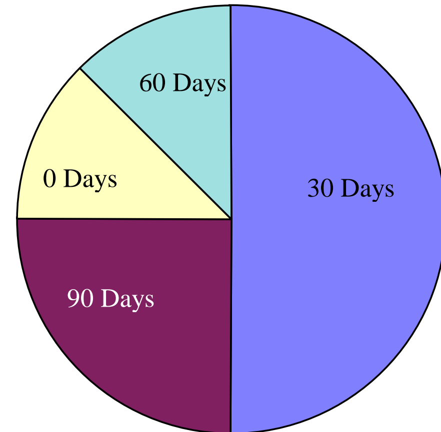
About 70% of those employers surveyed insure their benefit plans, while the remaining 30% has self-funded plans. This represents a slight shift from the prior survey toward self insurance, but probably not significant. The prior survey showed about 25% self insured.

About 15% of fully insured employers reported accepting self funding of all or a portion of the plan deductible.

Waiting Periods

The distribution of waiting periods for healthcare benefits eligibility shows the same general pattern as previous years.

Roughly, about half the employers use a 30 day waiting period. The second most common is 90 days representing about a quarter of the employers. The remainder is split between zero and 60 days.



Plans Offered

The movement over the years towards PPO plans can be seen in the table below. PPO now represents the predominant plan with over 88% of the respondents saying PPO was the primary health plan.

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

The question of PPO versus HMO versus Indemnity is no longer a question of interest. PPO with a single carrier is the predominate model.

Cost Control Strategies

2008 shows greater movement between carriers than in prior years. Also, the figures indicate declining rates of "reduced benefits". This is consistent with the view that there's a limit to the ability to reduce benefits beyond which employer's have to seek other methods to control costs.

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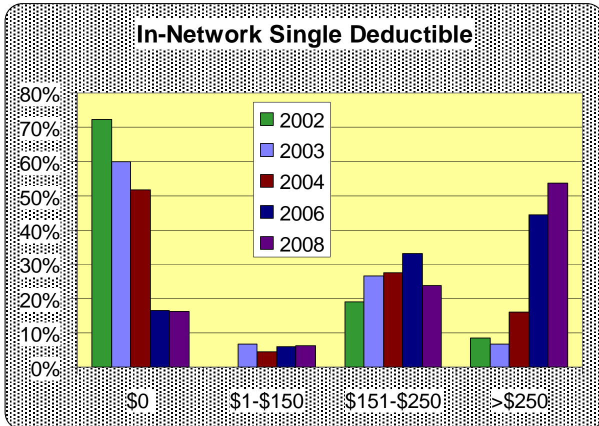
Change Made	2004	2006	2008
Changed Carrier	21%	18%	26%
Increased Single Contribution	37%	37%	31%
Increase Family Contribution	42%	34%	40%
Reduced Benefits	22%	17%	15%

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.

Medical Plan Designs

The chart below shows the continuing shift toward higher deductibles. Surprisingly, about 15% of plans still maintain zero deductible, about the same as 2006. However, the percentage of plans with deductibles over $250 has surpassed 50%.



$500 is now the predominate benchmark (statistical mode) for in-network deductibles. If your plan is at $500, it is at the current market benchmark. Plans with deductibles at $1,000 or higher generally are using consumer directed plans of some sort.

"Rich" Plans Shrinking, but not Disappearing

In 2004, the survey indicated that almost half of all employers have plan designs that provide very "rich" plans that pay most of the claims costs for employees. The predominant plan had modest individual or family deductible and office visit copays of either $10 or $15 per visit. These plans typically covered surgery (both inpatient and outpatient), diagnostic x-rays, laboratory and hospital expenses at 100%. These major cost items represent over 60% of the health care dollar.

Today, these "rich" plans represent between 15% and 30% of the respondents.

Office Visit Copays

Primary care office visit copays have steadily increased along with plan deductibles. In 2002 the most common copay was $10, in 2003 and 2004 it was $15. The 2008 survey shows over half the plans with copays of $20 or more.

2008 Primary Care Office Visit Copay	
<$10	13%
10	10%
15	23%
20	43%
$25+	13%

Specialists Visits

Just over half our respondents indicated they use a higher doctor visit co-pay in situations where the services of a specialist are used. In these cases, the most typical differential is $10. That is, if the office visit co-pay is $20, then the specialist co-pay is $30. This $10 differential is the same as reported in 2006.

While co-pay amounts have gone up from prior surveys, the most common differential has remained the same.

Individual and Family Deductibles

As Individual deductibles have risen, we detect a migration toward Family deductibles of two times the individual deductible.

In the past, this survey reported plans with low individual deductibles often had family deductibles that were three times the individual deductible. This design is fading in popularity.

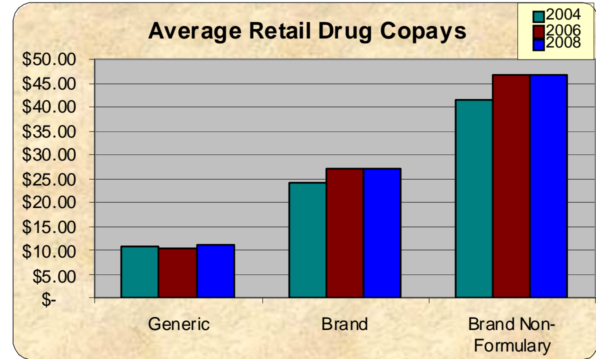
Today's benchmark is a substantial individual deductible with two times family deductible. This concept is reflected in the legislated definitions of the "High Deductible Health Plan" (HDHP) used for HSA's.

Drug Plan Designs

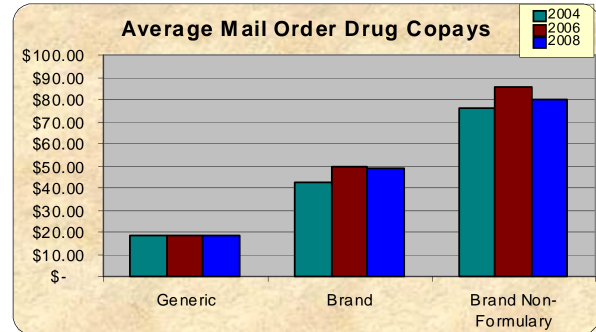
Most drug plans, about 90%, continue to use *co-pays* versus *coinsurance percentage*. A coinsurance percentage is favored in theory because it automatically keeps pace with inflation (as drug prices go up, so does the employee share), whereas a co-pay needs to be adjusted periodically to keep pace with inflation. Nonetheless, the co-pay structure is usually used because it is more popular and easier to understand than coinsurance.

The proportions of plans with mandatory generic provisions have stabilized at around 60%.

The increase in drug co-pays has leveled off, consistent with the declining ability to reduce benefits discussed on page 2 and 3. The average retail copays for a 3-tier Rx program are shown in the following table.



The average mail order copays (see below) show the same leveling trends as the retail drug copays.



Premiums and Contributions

The survey showed average employee contributions are about $57 per month for single and $287 for family. Both are slightly higher than the 2006 survey which showed averages of $54 and $277 respectively.

Over that same time period the average premium rate reported actually dropped. Thus, the percentage of employee and family contributions went up.

Single – 16%, up from 15%
Family – 32%, up from 26%.

Average Premium Rates and Conbributions

Tier	Rate	2004	2006	2008
Single	Premium	$273	$365	$359
	Contribution	$38	$54	$57
Family	Premium	$758	$1,075	$ 902
	Contribution	$192	$277	$287

The drop in premium is not an indicator of inflation. Rather, it possibly reflects what the carriers call "benefit buy down". That is to say, reduction in benefits or conversion to high deductible consumer driven plans.

To confirm the drop in premium, we checked with the local major insurance companies. Perhaps HSA's Health Savings Accounts, HRA's (Health Reimbursement Accounts) and other consumer driven vehicles have indeed produced lower premium. The carriers reported that consumer driven vehicles and other plan design changes have indeed slowed the growth in actual premium flowing to the carriers, but it was still a positive increase. Thus, our results probably arise from simply a different market basket of responding employers than last survey.

Employer – Employee Co-Share

Employees share the cost of health insurance through two vehicles:

- Employee contributions
- Plan design deductibles and copays

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.

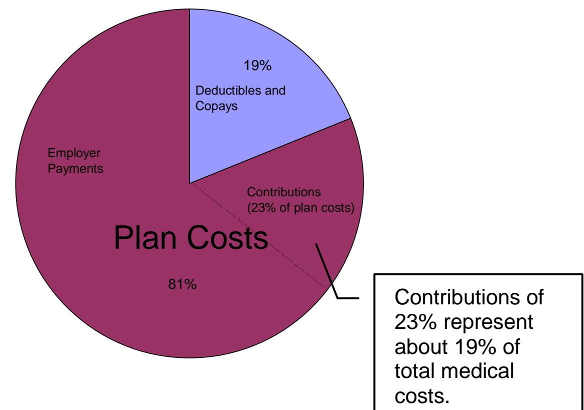
This section addresses these questions:

1. When employee contributions are matched with employee out-of-pocket expenses arising from plan deductibles and co-pays, what percent of global medical care costs do employees really pay?
2. Alternatively, what percentage of global costs do employers really pay after shifting costs to employees using both contributions and plan design co-share?
3. Is there any correlation between the size of employee contributions, and the richness of plan design?

Key results are:

- Employers pay about 62% of medical costs. Employees pay about 38%.
- On average, employees pay about 19% of costs through contributions, and about 19% through plan deductibles and copays.
- The results showed no correlation or coordination between contributions and plan design. That is, some employers have low contributions for a rich plan, and some have high contributions for a thin plan, and everything in between.

Think of it this way. A typical employer plan passes about 19% of medical costs to the employees through deductible and copays. Thus, the insurance premium (or self funded plan) covers about 81% of costs. Then, employees are asked to pay about 23%% of the employer costs through contributions. 23% contribution of the 81% the plan covers represents the other 19%.



The chart on the following page plots employee contributions versus the expected proportion of out-of-pocket.

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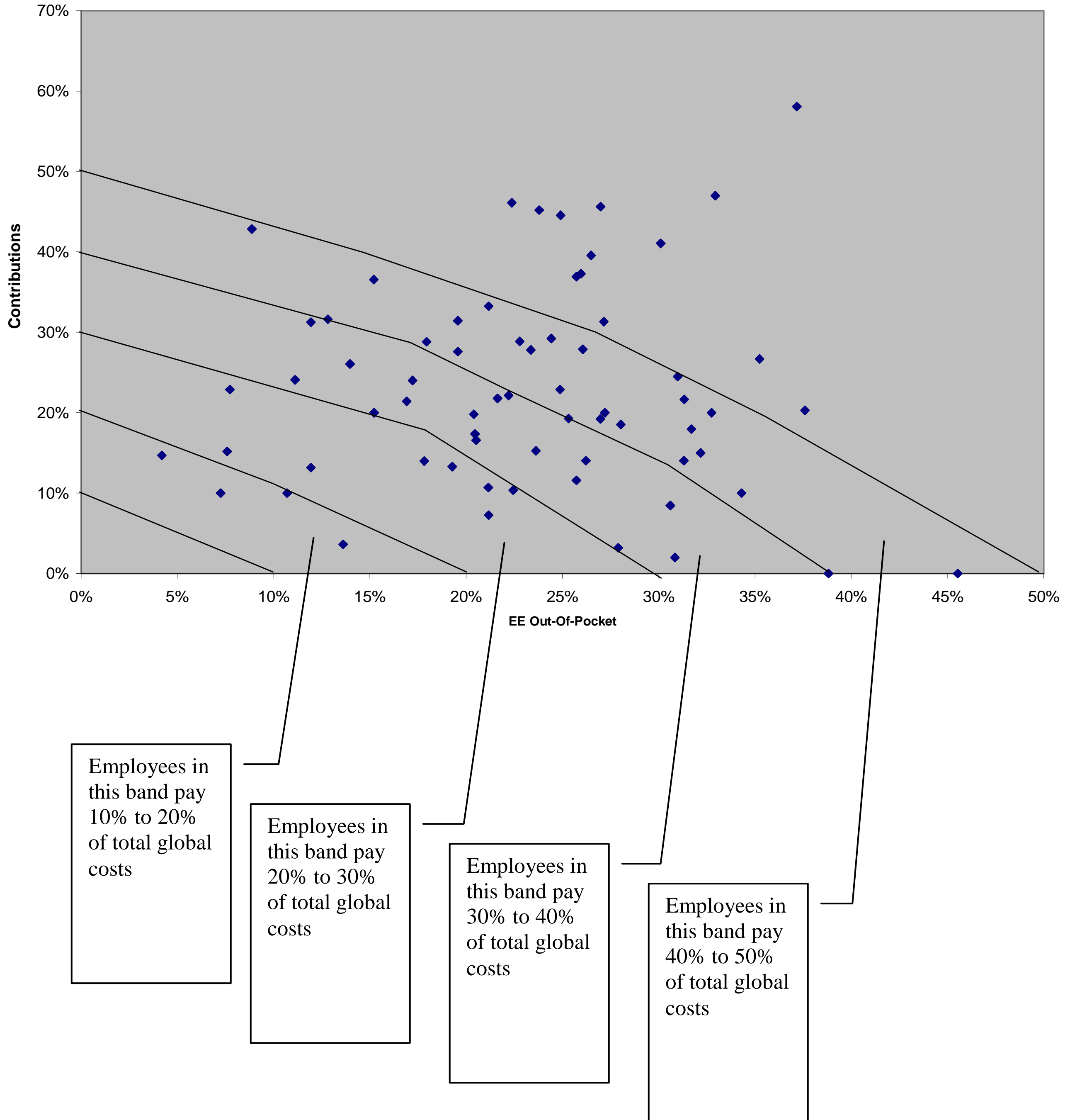
The plot graph shows quite of bit of randomness in the connection between contributions and the richness of benefits. Further, bands are drawn in the graph to show what global percentage of costs are paid by employees through both contributions and benefit design.



We see from this plot graph that there is very little coordination between richness of plan and employee contribution across employers.

This analysis doesn't take into account employer financing of high deductibles, often through consumer driven high deductible plans. So the results understate the amount of employer financing. Perhaps the adjusted result would be 65% employer, 35% employee.

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 suspect these are not significant and represent a different market basket of participating employers in each survey.

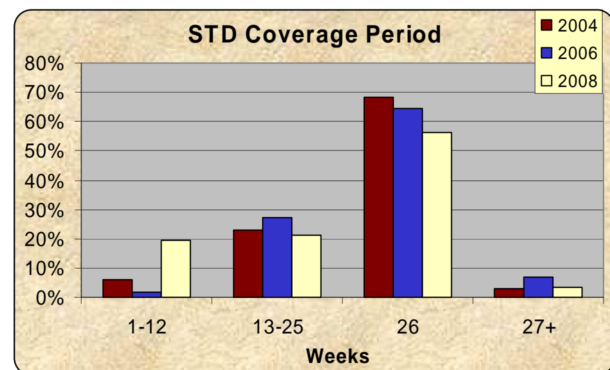
Percent of Employers Offering Other Coverages			
	2004	2006	2008
STD	**71%**	**68%**	**80%**
LTD	**64%**	**67%**	**67%**
Dental	**71%**	**73%**	**67%**
Vision	**58%**	**64%**	**46%**

Disability

Most employers (90%) offer some disability coverage. Approximately four in five employers surveyed offer short term disability and about two thirds of all employers offer long term disability coverage. A little more than half (56%) offer both short term and long term disability coverage.

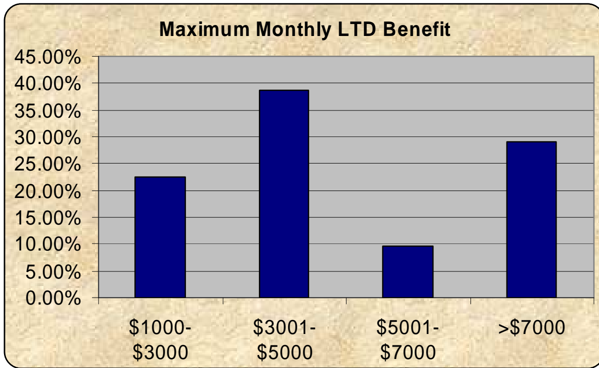
The plan design mix for short-term disability coverage remains roughly 1/3, 2/3 split between plans with is a 26-week benefit period and 13-week benefit period respectively. Less than 5% of plans vary from these two core plans.

The majority of benefits are a percent of salary in the range of 60% to 67%. A small portion of employers have plans that vary the benefit depending on job class or length of service.



Sixty-seven percent of employers offer a long term disability benefit and of those that do offer LTD, 88% 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 in accord.

Maximum monthly benefits range from $1,000 to $10,000, with $5,254 being the average monthly maximum. A few employers indicated that they provide a different benefit maximum depending on the employee's job classification.



Dental

Of the companies surveyed that offer dental benefits, 40% indicated that they self-fund their dental plan. This compare with 53% in the last survey.

About 10% 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 half the respondents indicated the plan covers orthodontia expenses. Most plans that do provide orthodontia coverage pay 50% of the expenses. Lifetime ortho maximums range from $750 to $3,000. This is the first time a $3,000 max has shown up in the data.

The survey shows virtually no change in dental plan design over the years. Employers do not address plan design in dental the way they do in medical. The only material change compared to prior surveys is gradually higher maximum in ortho coverage for those who offer it.

Miscellaneous Benefit Issues

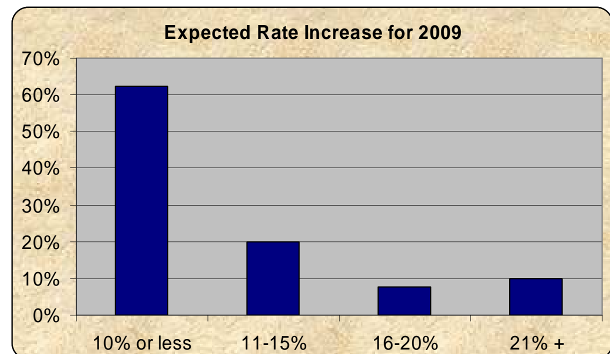
Respondents indicated that they provide a variety of other benefits as shown in the table below.

Benefit	2004	2006	2008
Retiree Medical Coverage	16%	11%	10%
Pre-tax Premium Contributions	64%	58%	56%
Flexible Spending Account (FSA)	52%	49%	41%
Dependent Care FSA	43%	41%	35%
Defined Benefit	36%	26%	33%
Defined Contribution	75%	79%	79%
Pre-Tax (401K)	70%	67%	78%
After-Tax (savings & thrift)	6%	8%	6%
Deferred profit sharing	12%	10%	6%
Stock ownership plan	9%	3%	5%

Consistent with the marketplace, we see less retiree medical being offered.

Inflation and Trends

Finally, the respondents were asked their expected rate increase for 2009 and 63% of the respondents expect an increase of 10% or less. The breakdown of expectations is shown below.



This executive summary and accompanying analytic research was prepared by **The Benecon Group** on behalf of the Lancaster County Business Group on Health (LCBGH) and the Lancaster Chamber of Commerce and Industry, and with review from members of the Strategic Planning Committee of LCBGH.

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

For information on LCBGH membership please:
- call the LCBGH office at (717) 239-6954
- select the "How to Become a Member" tab on the website at **www.lcbgh.org**; or
- write to LCBGH, PO Box 1558, Lancaster, PA 17608-1558.

To join the Lancaster Chamber or for more information on membership:
- visit **www.lancasterchamber.com** and complete the online membership application under “Join the Chamber”
- call the Lancaster Chamber at 397-3531; or
- write to The Lancaster Chamber of Commerce and Industry, 100 South Queen Street, PO Box 1558, Lancaster, PA 17608-1558

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