

## 2006 Survey of Employer-Provided Health Benefits

HEALTHCARE CONTINUES TO BE THE MAJOR COST DRIVER IN EMPLOYEE BENEFIT PLANS. EMPLOYERS ARE CONTINUING TO STRUGGLE TO FIND WAYS TO CONTROL THESE COSTS WHILE BALANCING THE NEEDS OF THEIR EMPLOYEE POPULATION AND ORGANIZATION. THE INFORMATION IN THIS REPORT IS DESIGNED TO PROVIDE EMPLOYERS WITH INSIGHT INTO THE REGIONAL (PENNSYLVANIA, NEW JERSEY AND DELAWARE) HEALTHCARE MARKET. IT CAN BE USED TO BENCHMARK BENEFIT PLANS, AS WELL AS SERVE AS A BASIS FOR EMPLOYEE COMMUNICATIONS TO HELP THEM BETTER UNDERSTAND PREMIUM COSTS AND SUPPORT THE ORGANIZATION IN CONTROLLING INCREASES.

Savitz has been working with regional employers to help them benchmark their healthcare programs and develop cost saving alternatives to their current arrangements. One challenge to this process has been the ability to access timely and credible local data.

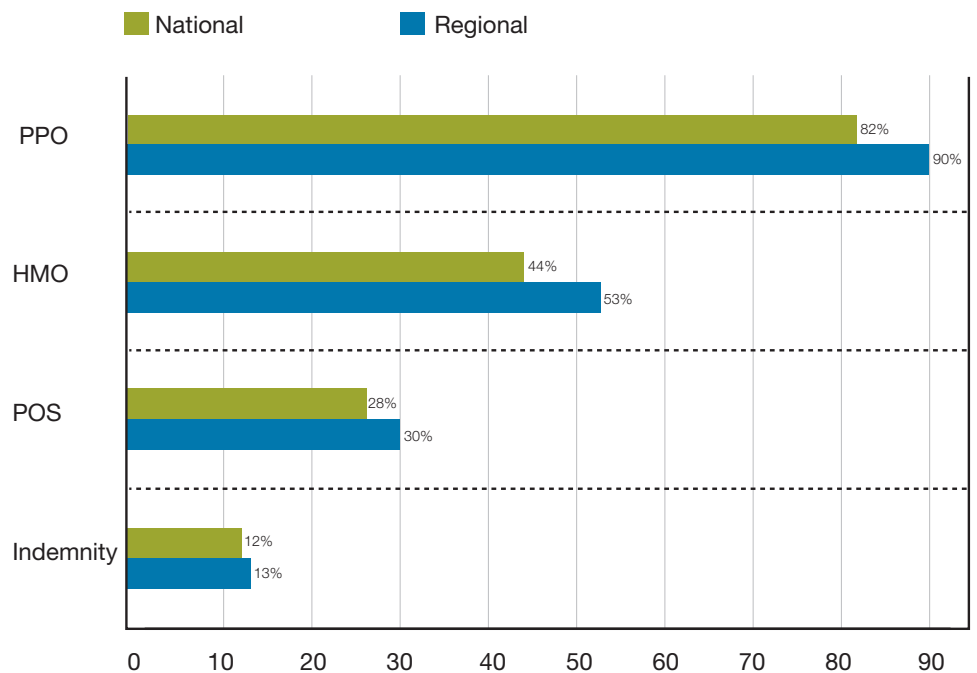
Consequently, we have received numerous requests from our clients for credible sources of information to compare their medical plan designs and costs to those offered by other employers in their geographic area. To respond to this growing demand for healthcare data, we have undertaken our first annual *Savitz Survey of Employer-Provided Health Benefits*.

Most healthcare surveys are backward looking and focus on prior year information rather than current year cost. This creates additional work for plan sponsors since they need to take prior year information, predict what the market increases have been for the current year and then apply those increases to historical data to develop current year costs.

This survey allows plan sponsors to skip this step on the regional level and use Savitz data for the current 2006 calendar year.

In 2007 and future years, the survey will be conducted at the beginning of the calendar year to offer current year cost and plan design data.

**EXHIBIT A: TYPES OF PLANS OFFERED**  
(percent of survey respondents offering various plans)



**SUMMARY OF KEY FINDINGS: THE DATA AND ANALYSIS OF THE 2006 SAVITZ SURVEY OF EMPLOYER-PROVIDED HEALTH BENEFITS PRODUCED THE FOLLOWING KEY OBSERVATIONS:**

Most employers offer their employees a choice of health plan options. More than half of the survey respondents offer more than one type of plan. The most common combination offered to employees is a choice between a preferred provider organization (PPO) and a health maintenance organization (HMO).

Among the different types of health plans offered, the most common is the PPO. Ninety percent of survey participants offer at least one PPO. The second most prevalent plan is the HMO, offered by slightly more than half of the participants. Point of service (POS) plans rank a distant third choice (30% of plans), and indemnity plans are the least popular offering (13%).

Among local employers responding to the survey, the consumer driven health plan model has not yet taken hold. None of the survey participants offer a qualified high deductible health plan with or without a health savings account (HSA). Only one survey participant provides a health reimbursement account (HRA).

Employers continue to pay the majority of the premium cost toward healthcare which is between 72% and 85% of premium on average for single coverage and 72% to 77% for family coverage. However, the survey participants also reported passing more of the premium cost increases on to employees in 2006.

Employees on average pay 20% of the premium cost for single coverage and 27% for family coverage.

In network benefit plan provisions are fairly generous. Two-thirds of the PPO plans in the survey do not require up-front deductibles or coinsurance. None of the HMO or POS plans require in network deductibles or coinsurance.

Doctors' office visit co-pays and ER co-pays in network are still low. The most common co-pay for a non-specialist doctor's office visit is \$10 or \$15 while the most common emergency room co-pay remains \$50.

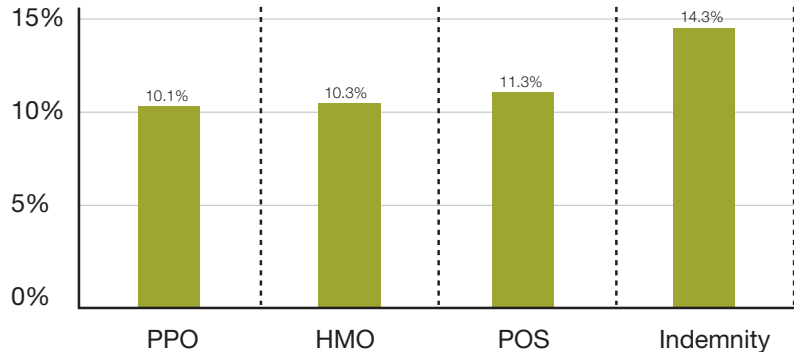
The majority of prescription drug plans are still bundled with the medical plan. Carved-out stand alone drug plans are reported by just over one-third (37%) of the employers in this survey.

Nearly all of the drug plans have a three tier co-pay design. The most common co-pays are \$10 for generics, \$20 for formulary brand name drugs and \$35-\$40 for non-formulary brand drugs. Interestingly, almost half of the employers who have carved prescription drugs out of the medical plan base the co-pay design on a coinsurance percentage.

**SURVEY FINDINGS AND ANALYSIS: THE FOLLOWING SECTIONS OUTLINE THE KEY FINDINGS OF THE 2006 SAVITZ SURVEY.**

<p><b>COST:</b></p>	<p><b>EXPECTED RATE/PREMIUM INCREASE:</b> (Exhibit B)</p>
<p>Plan cost is controlled by two major factors in most companies: employee premium contributions and plan design cost sharing. Each company has a philosophy about which approach to use or a balance between the two approaches. In most companies today, employers maintain a delicate balance between the required premium contribution employees must pay and the level of plan co-pays and deductibles they must also pay if they or their dependents actually use the plan benefits.</p>	<p>Each year at renewal time, employers hope for little to no increase over current year cost just to get some relief from the pressures of cost control and plan design changes.</p> <p>As a group, the employers responding to the Savitz survey reported 2006 increases that were slightly higher than national trends. Local employers' premiums increased on average 10% to 11% from 2005 to 2006 compared to the reported national average increases of 8% to 9%.</p> <p>Local premium increases varied by plan type with HMO (7%) and POS (8%) plans experiencing the lowest increases and PPO (11%) and indemnity (17%) plans the highest increases. This indicates that local employers are seeing larger increases annually than reported nationally. Contrary to some nationally reported survey information, local employers anticipate that they will still see plan increases in the double digits for 2007.</p>

**EXHIBIT B: EXPECTED RATE OF INCREASE FOR 2007**



**KEY TERMS:**

**Preferred Provider Organization (PPO) plan** – A medical plan offering in and out of network benefits. In network benefits are delivered through a preferred provider network with a higher level of benefits provided when services are rendered by a provider in the network. Out of network benefits require the employee to pay higher coinsurance and deductibles when accessing services. The employee is not required to select a primary care physician and the employee self refers either in or out of network.

**Point Of Service (POS) plan** – A medical plan offering in and out of network benefits. In network benefits and referrals are coordinated in many cases through a primary care physician selected by the employee, and services are delivered through a preferred provider network with a higher level of benefits provided when services are rendered by a preferred provider in the network. Out of network benefits require the employee to pay higher coinsurance and deductibles when accessing services. For out of network benefits, the employee is not required to select a primary care physician, and the employee self refers for out of network services.

**Health Maintenance Organization (HMO) plan**– A medical plan that only offers in network benefits through a preferred provider network with essentially no benefits provided when services are rendered outside of the network. A primary care physician is required to manage all care and referrals.

**TOTAL ANNUAL PREMIUM COST:** (Exhibits C and D)

In addition to the pure percent increase year after year, employers monitor the premium cost for single and family coverage as well. Local employers report that the 2006 average annual total premium cost for all plan types is \$4,433 for single coverage and \$12,505 for family coverage. Most of the survey participants reporting also include the cost of prescription drugs in these medical plan costs. (Note: The total premium cost for all plan types is a blend of the cost for all plan designs reported at the single rate and the family rate tier.)

For 2005, local average annual total premium cost for all plan types was \$4,021 for single coverage and \$11,308 for family coverage. Nationally, comparable 2005 data for all plan types showed average annual total premium cost for single coverage at \$4,024, which was almost identical to the premium costs reported by local employers. However, the 2005 average annual premium cost for family coverage nationally was \$10,880, about 4% lower than regional rates.

On average for both 2005 and 2006, local employers report that HMO plans have the lowest premium cost and indemnity plans the highest. Surprisingly, the 2005 national data shows indemnity plans having the lowest cost in 2005 while PPO plans report the highest cost. Nationally, indemnity plans may have higher deductibles or feature more employee cost sharing than regional indemnity plans and PPOs.

**EXHIBIT C: 2005 REGIONAL AVERAGE ANNUAL COST PER EMPLOYEE FOR SINGLE AND FAMILY COVERAGE**

	Single Coverage	Family Coverage
PPO	\$4,196	\$11,857
HMO	\$3,552	\$9,926
POS	\$3,607	\$10,735
Indemnity	\$5,027	\$13,574
All Plans	\$4,021	\$11,308

**EXHIBIT D: 2006 REGIONAL AVERAGE ANNUAL COST PER EMPLOYEE FOR SINGLE AND FAMILY COVERAGE**

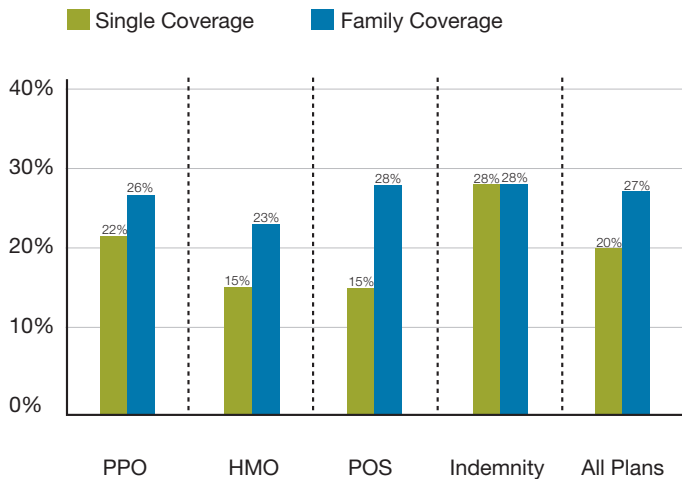
	Single Coverage	Family Coverage
PPO	\$4,660	\$13,141
HMO	\$3,791	\$10,635
POS	\$3,886	\$11,134
Indemnity	\$5,891	\$15,836
All Plans	\$4,433	\$12,505

**PREMIUM COST SHARING:** (Exhibits E and F)

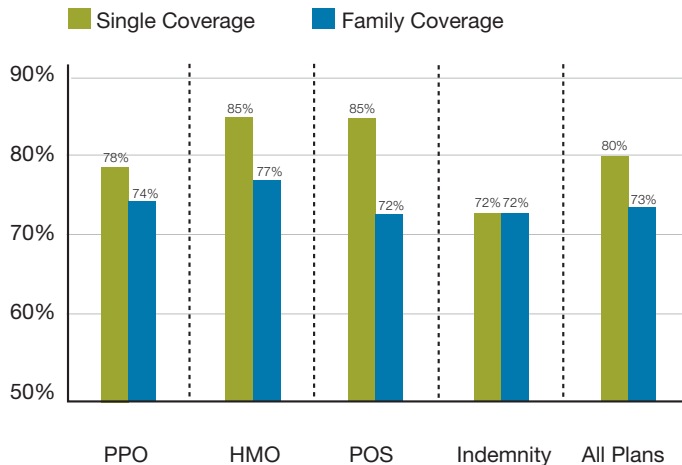
Local employers report paying the bulk of the premium cost of healthcare coverage for their employees. Employers pay a greater portion of the total premium for single coverage (80%) than for family coverage (73%), and a greater portion of the cost for lower cost plans (HMO, POS) than higher cost plans (PPO, indemnity). Nationally, the majority of employers pay 84% of the cost of single coverage and 74% of the cost of family coverage.

This type of cost sharing profile is consistent with most employers' philosophy of offering fair and affordable coverage to their employees and supporting the employees in their need to provide health coverage for their families. In addition, many employers "support" the most cost effective plan by paying the highest percentage toward that plan's premium cost. Employees may choose from other, more expensive plan offerings, but are then responsible for the difference in premium cost for these plans.

While employees still pay less in premium cost than their employers for their health coverage, local employers report that they passed along more of the total premium increases for 2006 to their employees. This indicates that the local market is still engaging in cost shifting as a way to curb the impact of healthcare spending on the bottom line.



**EXHIBIT E: PERCENT OF PREMIUM COST PAID BY EMPLOYEE**



**EXHIBIT F: PERCENT OF PREMIUM COST PAID BY EMPLOYER**

**PLAN DESIGN:** (Exhibits G and H)

Employers can share the cost of health benefits with employees in multiple ways. The most common is through premium cost sharing. Nationally, almost 80% of covered workers with single coverage and 90% of covered workers with family coverage made a contribution toward their health plan premiums in 2005.

Another method of cost sharing is through plan design elements incorporated into the plan. The employee or their dependent must pay a deductible, co-pay or coinsurance when they access services through the health plan. Most plans now encourage the use of in network services through lower co-pays, deductibles and coinsurance than would be paid for out of network services.

Employers responding to the local survey report generous in network benefits in the plans they offer. None of the

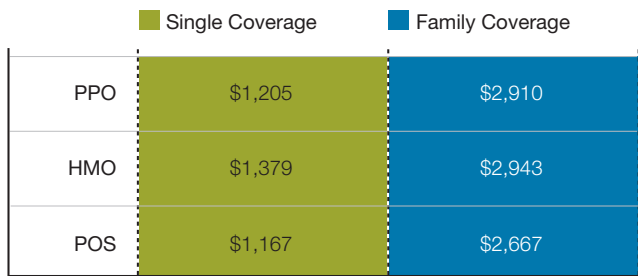
surveyed HMO or POS plans require up-front deductibles or coinsurance from plan participants before they access services. Two-thirds of the PPO plans also do not require deductibles. Of the one-third that do, the average deductible for in network services for a single person is \$256 and \$606 for family coverage. Three quarters of the PPO plans do not require coinsurance from the participant to receive in network benefits. Because of the favorable local plan provisions, only about half of the plans include a limit on out-of-pocket costs incurred by plan participants.

Nationally, fifty-six percent of workers must meet a deductible before plan benefits are provided. In PPOs, the most common type of plan offered nationally, the average deductible for in network services for a single person is \$323 and \$679 for family coverage. These deductibles are higher than those

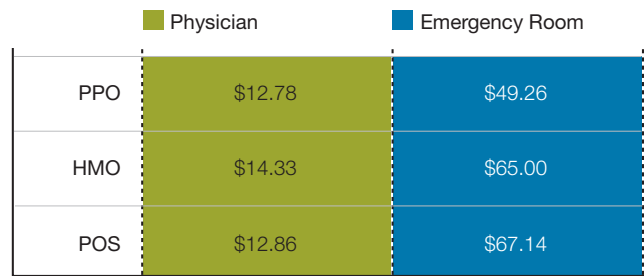
reported by plans that require them locally. It should also be noted that these deductible amounts are substantially higher nationally for smaller employer plans (those with less than 200 workers) than for larger employer plans.

Local employers also report more generous plan design co-pay features than are reported nationally. For example, the most common co-pays for non-specialist doctor visits are \$10 or \$15 for all types of plans among local employers. Nationally, co-pays for doctor's office visits are higher. Forty-four percent of covered workers were in a plan in 2005 that required a \$20 to \$25 co-pay for doctor's office visits. The same situation applies to emergency room co-pays. Locally, emergency room co-pays vary more according to plan type, with \$50 being the most common co-pay amount for PPO plans and \$50-\$100 the most common co-pays for HMO and POS plans.

**EXHIBIT G: AVERAGE OUT-OF-POCKET MAXIMUMS (of plans with maximums)**



**EXHIBIT H: AVERAGE PHYSICIAN AND EMERGENCY ROOM CO-PAYS**



**PRESCRIPTION DRUG BENEFITS:**

Slightly more than one third (37%) of the local survey participants have carved their prescription drug benefit out of their medical plans and offer prescription drug plans on a stand alone basis. The majority of plans still provide prescription drug benefits bundled with their medical plans and nearly all of these bundled plans have a three-tier co-pay plan design. (The most common bundled drug plan co-pays are \$10 for generics, \$20 for formulary brand name drugs and \$35-\$40 for non-formulary brand drugs.)

For the survey participants who have carved prescription drug benefits out of their medical plans, the majority also have a three tier co-pay design. Interestingly, this group is almost evenly divided between those plans that base the co-pay on flat dollar amounts and those that base it on coinsurance. For those that have a flat dollar co-pay, the most common design is \$10 for generic, \$20 for brand name and \$40 for non-formulary brand name drugs. Of the plans that base the co-pay on coinsurance, most increase either the coinsurance level according to the type of drug or the minimum co-pay associated with the coinsurance. The minimum coinsurance that the employee is required to pay is 20%.

Nationally, the majority of workers must pay a co-pay or deductible when they get a prescription filled. For workers covered by drug plans with a three-tier co-pay structure, the average co-pays are \$10 for generic, \$22 for preferred drugs and \$35 for nonpreferred drugs. Some plans even have a fourth tier with an average co-pay of \$74. Compared to national trends, local employers with three tier plans parallel national practices. Those local employers implementing coinsurance in combination with or instead of a co-pay structure for drugs are to be commended, since they have implemented plan designs that are more progressive than national practice. Linking drug cost sharing to the cost of the drug through coinsurance saves the employer from continuously updating the co-pay structure, as well as educating the employees on the true cost of drugs. Each time the cost of the drug goes up, the employee will have a corresponding increase in cost sharing. This type of design can be very effective in encouraging employees to utilize lower cost brand drugs or generic equivalents.

#### KEY TERMS:

**Indemnity plan** – Otherwise known as a traditional insurance plan, this is a medical plan that does not have a preferred provider network. Benefits are payable usually after meeting a deductible. The service must be a covered service and the provider must be a participating licensed provider.

**“Carve-out” prescription drug plan** – A prescription drug plan that covers all employees regardless of which medical plan they select. These plans are often self-funded, even among smaller employers, and are frequently managed by a Pharmacy Benefit Manager (PBM) or a PBM/TPA (Third Party Administrator) combination.

**High Deductible Health Plan (HDHP)** – A medical plan that falls into the newer consumer driven health plan category. A qualified HDHP is a health plan that has a deductible of at least \$1,050 for single coverage and \$2,100 for family coverage (2006 figures). These plans also may have an HSA (health savings account) feature which is an account that can be funded with both employer and employee dollars. However, HSAs can only be offered with qualified high deductible health plans. Some plans may include an HRA (health reimbursement arrangement) feature instead. An HRA is an account funded by employer dollars only.

**Health Reimbursement Arrangement (HRA)**– An employee account funded by pre-tax employer dollars used to pay expenses not covered by a benefit plan.

**Health Savings Account (HSA)** – An employee account funded by pre-tax dollars that can be funded through employer and/ or employee contributions used to pay expenses not covered by a benefit plan. HSAs must be offered with qualified high deductible health plan.

**METHODOLOGY:**

**PARTICIPANT INFORMATION:**

Savitz invited prospective participants to participate in an online survey accessed through our website. Prospects were chosen across all industries and were headquartered in either New Jersey, Delaware or Southeastern Pennsylvania with employee populations ranging in size from 100 to 10,000.

Thirty employers responded to the survey and provided data about their 2006 medical and prescription drug benefit plans for our survey. A total of fifty-six plans are provided by these employers. The average number of benefit eligible employees for the survey group is 1,237. The median benefit eligible employee size is 854.

**SURVEY INFORMATION:**

The survey, conducted between March 3, 2006 and April 24, 2006, focused on key cost, enrollment, and plan design trends by plan type (POS, PPO, HMO and indemnity plans) and included specific questions about the prevalence of carve-out prescription drug plans and High Deductible Health Plans/Consumer Driven Health Plans. Savitz professionals reviewed the data submitted for accuracy and consistency and either contacted participants to confirm data or excluded data that appeared to be invalid.

**ABOUT SAVITZ:**

Savitz is an employee benefits consulting firm dedicated to developing long-term partnerships with our clients to help them maximize their employee benefits program and meet their strategic, HR and financial goals.

Our firm focuses on three core practice areas: retirement consulting for both defined benefit and defined contribution plans, group benefits consulting and brokerage services, and administrative outsourcing for defined benefit and health and welfare plans.

We work with a broad range of plan sponsors, including public and private corporations, tax-exempt entities, and union-management groups.

For more information, please visit [www.savitz.com](http://www.savitz.com)

**RESOURCES:**

2005 KAISER/HRET SURVEY OF EMPLOYER-SPONSORED HEALTH BENEFITS [WWW.KFF.ORG](http://WWW.KFF.ORG)

U.S. DEPARTMENT OF LABOR, BUREAU OF LABOR STATISTICS BENEFITS SURVEY [WWW.BLS.GOV](http://WWW.BLS.GOV)

METLIFE— EMPLOYEE BENEFIT TRENDS [WWW.METLIFE.COM](http://WWW.METLIFE.COM)

CENTERS FOR DISEASE CONTROL AND PREVENTION – HEALTHCARE TRENDS IN AMERICA - [WWW.CDC.GOV/NCHS](http://WWW.CDC.GOV/NCHS)

ANY SPECIFIC NATIONAL TREND DATA IN THIS REPORT REFERS TO THE 2005 KAISER/HRET SURVEY OF EMPLOYER-SPONSORED HEALTH BENEFITS

