

2010 Employer Health Care Benefits Report

A Comprehensive Trend Report for Benefit Managers

This report explores the benefit and inflation trends dominating health benefits right now.

This analysis from our Actuarial and Compliance Divisions is the most authoritative source of regional inflation rates and cost trends specific to the regional market place. Pulling together data from surveys, large employers, reinsurance programs, insurance company actuaries and underwriters, we are able to identify inflation rates and trends long before others. Simply put, no one else has the vantage point and data access Benecon has.

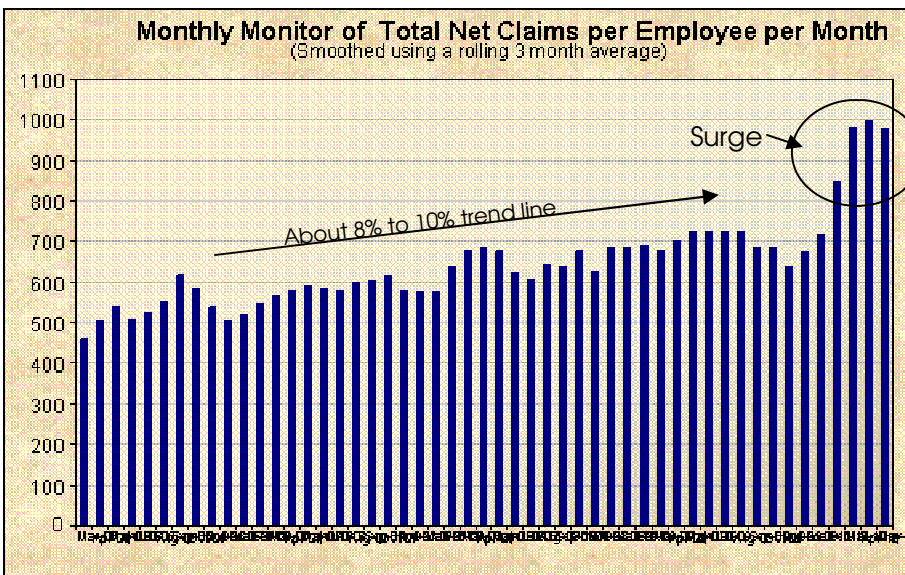
Medical Inflation Shows Strong Surge in 2010

Rx trend is still a moderating impact overall with Rx inflation rate below medical.

Benecon's research data base shows a sudden surge of inflation coincident with the passage of health care reform. The graph below, tracking claims cost per employee per month for the prior 4½ years, illustrates a dramatic upturn.

We believe this represents a bump in trend from the 8% to 10% range to

the 10% to 12% range. Further information and commentary about the history, drivers, and consequences of medical trend is contained throughout this report. You will find information on Rx trends, specialty drugs, unique historical perspectives, and our prediction for the next three years.



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2010 Employer Report

This report summarizes national and regional surveys including data from our proprietary Benecon data base and consolidates the information into one report for easy benchmarking.

For further information or explanations, or to arrange speakers for the information in this report, please contact Danielle Omans at the Benecon office in Lititz, PA.

www.benecon.com or
call Benecon at
888-400-4647.

About the Benecon Report and Survey

From our Editor, Danielle Omans



Benchmarks with Perspective

This 2010 report explores inflation trends dominating employer and carrier activity right now, and also provides a look back at recent trends and cycles. Inflation trends have been historically cyclical for the past 50 years. We believe it's important to track the historic trend and understand where we are in the cycle.

Similarly, many of the benchmarks in this report show the past few years, again, to gain better perspective on how rapidly, or slowly, things are changing.

We believe the sweeping perspectives provided in this report, since 2003, add value and insight generally not available in other survey reports.

National Surveys and Reports

This report includes findings on employer health plans including coverage, costs, enrollment patterns, health plan choice and employee costs. It summarizes national and local surveys, including data from our proprietary Benecon data base, and consolidates the information into one report for easy benchmarking. The following national and local sources were reviewed:

Express Scripts
Kaiser Family Foundation
BenefitNews.com
Wall Street Journal

The Council of Insurance Agents and Brokers
Lancaster Chamber Survey
The Segal Company
Interviews with Central Pennsylvania actuaries and underwriters

The Benecon Data Base

The Benecon Group produces this annual survey based on data in part obtained from the Benecon research data base representing over \$300 million of health care financing, as well as information obtained from processing thousands of quotes and renewals from the major insurance carriers we represent as a general agent. Our data base encompassed a wide range of industries purchasing health care through collective buying arrangements managed by the various divisions of Benecon.

Data obtained for the special municipal section shown on pages 10 and 11 covers over 300 Municipal and County governments in Pennsylvania, ranging in size from less than 5 to almost 2,000, covering all four of the regional markets (West, Central, Northeast, and Philadelphia). This report represents the largest municipal survey of its kind published in Pennsylvania.



Benecon Model Featured in National Publication

Excerpts from the March issue of **The Self-Insurer**, the official publication of the Self-Insurance Institute of America, Inc. (SIIA).

Authored by Rick Burd, Executive Vice President of Actuarial Services

STOP LOSS START OVER

Group purchasing presents an opportunity for mid-size employers to aggregate together, design a new model that eliminates the perils of self funding, and welcome stop loss carriers as a partner, not an adversary.



An important observation to make is that underwriters generally do not avoid claims, but rather re-direct who pays the claims. They shove the claim back to the employer through denials or lasers. Employers sometimes try to shove the claim to their administrator if it was their disclosure mistake that led to the denial, or, even worse, to the participant with the least amount of resources, who failed to follow the managed care protocols.

All this underwriting and claim audit activity generates a lot of cost but doesn't really take any money out of the system – it's just a game of hot potato to see who gets stuck with the claim.

A successful group purchase program has the opportunity to re-write the rules. Employers who come together in a consortium can mutually agree to share the risk of shock claims that are covered by their plan documents. The financing mechanism should be stop loss insurance without the coverage gaps. There is no need for disclosure, lasers, and coverage gaps since these mechanisms simply re-direct which employer gets stuck with the claim and don't really save money from the system. The underwriting function is reduced to preventing anti-selection by any employer wanting to join the consortium.

Employers have a choice of traditional stop loss with all the inherent instability and uncertainty, or else they can agree, with their consortium partners, to jointly finance the shock claims across the consortium with fairness, spread of risk, and year to year stability.

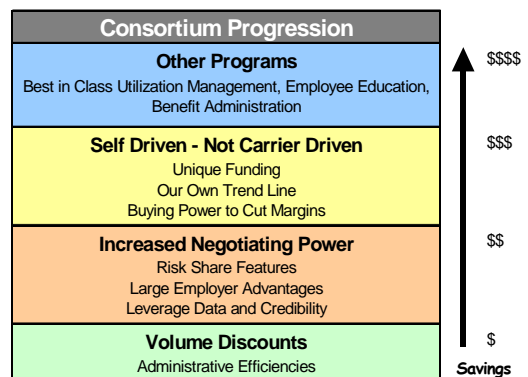
Similarly, on the aggregate side, a cluster of employers can aggregate for the purpose of sharing aggregate risk and place attachment points at a level that actually has some meaning. That is to say, place attachment points that will cap the self-funded aggregate claims each year for some members of the pool that experience the occasional high claim year.

This system is actually cheaper since it eliminates the overhead and administrative complexity of underwriting, disclosure, claim denials, law suits, constant

shopping, and flights in and out of fully-insured programs. This system is more efficient because it enables employers to create a stable platform that unlocks the savings of self-funding but eliminates the array of hazards that cause failure of this financing method for many.

Consortiums for Private Employers

Building on our 18 years of experience in developing and managing municipal consortiums, Benecon has successfully extended our proprietary consortium principles to the commercial market including colleges and universities, public school districts, banks, nursing homes, social service agencies, and clusters of employers who participate in Workers' Compensation group purchases. The consortium strategy goes beyond simple volume discounts and involves risk management strategies, custom funding formulas, and increased actuarial credibility.



Specialty Drugs—A Game Changer for Rx Risk

Commentary from our Actuary

By Brad Kopcha, FSA, MAAA

Specialty drugs are expensive medications that are used to treat complex diseases such as hemophilia, rheumatoid arthritis, multiple sclerosis, and cancer. Costs for these medications run from \$15,000 to upwards of \$200,000 per person per year. Treatment for more rare diseases, such as Gaucher’s Disease, can cost over \$250,000.

Specialty drugs are usually injectable, and often “biological”. This means they are proteins produced by living organisms and are designed to address chronic conditions and disease. They are not easily reproduced into generics because the cell-based synthesis of the biologic drug is much more difficult to control. The manufacturing process has to be approved to assure the right end product.

Simple drugs, such as Prozac for example, are easily replicated into generics by simply following a defined sequence of chemical reactions.

Costs and usage of these drugs are rising rapidly and dramatically change the dynamics of Rx risk management.

Specialty drug spending now represents 17% of the pharmaceutical market. Increasingly, specialty medications are being prescribed for more common illnesses.

Finally, many specialty medications (about half) are currently paid through the medical benefit program. As a result of their complexity, they are administered in the doctors office, out-patient hospital facility, or home infusion. These costs do not yet appear as drug costs. As new therapies are developed, some drugs will be shifted from the medical benefit to the prescription drug benefit, thereby increasing cost seen under the Rx benefit.

Express Scripts reports 2009 Rx trend at 6.4% in total, but wildly different between traditional drugs and specialty drugs.

Express Scripts, publisher of the leading detailed annual report on drug trends, now reports traditional drugs and specialty drugs as separate entities due to their divergent trends and characteristics. They report 2009 Rx trend at 6.4% in total, but wildly different between traditional drugs and specialty drugs.

Traditional vs. Specialty Drugs		
	Traditional Drugs	Specialty Drugs
2009 Trend	4.8%	19.5%
Cost per Prescription	\$54.53	\$1,867
Percentage of Rx Spend	88%	12%

4 times as much
34 times as much

Top Diseases for Specialty Drugs	
Percent of Specialty Drug Spending	
Autoimmune condition	27%
Multiple Sclerosis	20%
Cancer	17%
Possible Yearly Cost Per Patient	
Multiple Sclerosis	\$30,000
Hemophilia	\$150,000
Gaucher’s Disease	\$300,000
Immune Disorders	\$125,000

Unexpected Side Effect of Specialty Drugs — The New Shock Claims

Specialty Drugs May Be Hazardous to Your Measurements of Performance

In a phenomenon only an actuary might notice, the emergence of specialty drugs has disrupted a traditional and consistent benchmark used by health plans for the past decade to measure success — the comparison of average costs and utilization and average claim size to industry norms. Specialty drugs now have the same disruption on average costs that shock claims have in medical care data bases rendering Rx measurements much less useful.

Carriers need to react to this new reality by instituting shock claim pooling for specialty drugs in their renewal processes as they do for shock medical claims, but we are dismayed they have shown no inclination to do so.



The History (and Future) of Inflation

Ancient History

Underwriting cycles were pretty regular during the 1960s, 70s, and 80s with three up years and three down years. A sine wave.

HMO Era

The historical three-year pattern was broken during the HMO era when the pause in inflationary pressure extended for 4 or 5 years during the early 90s. We all thought HMOs would save us and the six year cycle was dead.

Paybacks are Brutal

However, the inflation swing following the HMO era came with a vengeance, producing 5 years of very stiff inflation, from 1997 into 2003.

The Great Pause of 2003, 2004

By 2004, it became apparent (to us) that inflation suddenly paused (lowered) sometime in late 2003 into 2004 in the Central PA market. This was likely a by-product of both a national trend and the breakup of BCBS.

The Carriers Didn't Get the Memo

The carriers, slow to react to the lower trend 2004, continued to batter their customers after inflation suddenly paused.

Windfall Profits

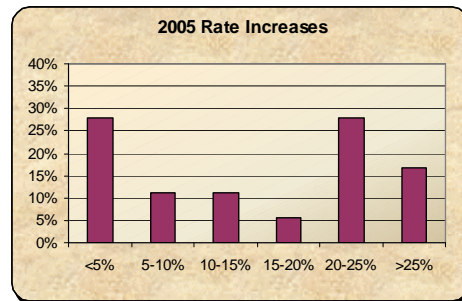
Thus, with large increases in 2005 and 2006, and little inflation, carriers basked in all the money and belatedly began to hand out minimal increases, and some decreases in 2007.

Historic Rx Flip Flop

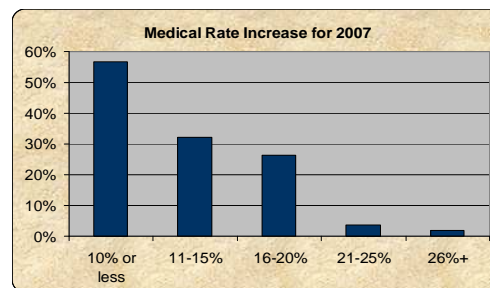
During 2005, in the midst of large rate increases, slow inflation, and massive insurance company profits, the long-term trend line for Rx, driven by increased generic usage, dropped below medical trend for the first time since drug coverage was carved out of the old major medical policies during the 1980s.

Up Again 2006 Through 2010

In 2006, the pause ended just as the carriers were lowering new business rates, and turned more sharply in 2007. Inflation during 2007, 2008, and into 2009 held steady in the 8% to 10% range. However, the Benecon research data base now detects trend ratcheting up to the 10% to 12% range during the previous 12 months. The renewal patterns in 2010 look like 2005—see the chart on page 8.



Carriers were slow to react to the inflation pause of 2004, and continued to pound their customers with significant increases in 2005.



In 2007, most renewals were single digits, with many decreases resulting from the windfall profits of 2005 and 2006. There were major cuts in new business rates.

Future Prospects—The Benecon Prediction

We believe the increased intensity in trend, from 8% up to 10% to 12%, is driven by some of the usual suspects including continued increases in advanced treatments, specialty drugs, and cost shift. In addition, there is much uncertainty about health care reform, and insurers and providers are trying to capture as much revenue as possible before the full impact of reform kicks in.

We expect a continuation of fairly intense inflation for 2011; 10% to 12%. After 4 years of significant price increases (2008 through 2011), the sector will be ready for the inevitable pause, probably during 2012. At that time, price positions will be well-padded, the consequence of reform will be more assimilated, and things will cool off. Trend will drop suddenly.

The pause of 2012 will not be detected until well into 2013 as claim data and results for 2012 and early 2013 are examined. In the normal course of events, carriers would not give rate relief until 2014, but by then, full reform will kick in, and the dynamics of the new market will control events.



Patient Advocacy

Study by Johns Hopkins Shows Savings

Benecon launches ConnectCare3 — Now serving 20,000 members



The Benecon Group, a market leader in innovative concepts, now offers the most cost-effective and comprehensive program of risk management and claims control in the market.

By focusing on major catastrophic claims, the ConnectCare3 program completes the care management strategy by complementing other wellness and disease management initiatives. The program targets high-cost claims, manages end-of-life situations, and brings patient and family-centric advocacy and coaching services to distressed plan members. CC3 organizes the medical providers, patient services, and family members into a cohesive team to coordinate care, reduce costs, and provide appropriate care for patients.

Employers can conveniently think about their risk management and care management strategies along three dimensions:

- Managing Health
- Managing Care
- Managing Costs

Wellness programs and initiatives attempt to manage the health of about 2/3 of the population. Disease management programs, if properly designed, can effectively address the chronic diseases

that effect about 1/3 of the population. This is managing care. Finally, catastrophic illnesses and end-of-life situations for 1% or less of the population can account for 25% or more of costs. Traditional tools used to manage these costs are discharge planning, large-case management, and centers of excellence.

A 2008 study stemming from an joint research project between Benecon and Johns Hopkins Bloomberg School of Public Health and School of Medicine demonstrates savings.

It's this third leg of risk management, managing costs, that we believe has failed to address the significant costs involved, as well as providing appropriate needs for the patient. Our program, ConnectCare3, re-invents the approach to catastrophic cost management and patient services.

Stemming from a joint research project between Benecon and

Johns Hopkins Bloomberg School of Public Health and School of Medicine, the program integrates patient advocacy, care coordination, second opinion peer review by leading specialists, and family-based decision coaching and support, to produce outstanding cost control for the employer, and appropriate treatment and outcomes for the patient.

This program achieves a respectable ROI for the employer while providing an essential and well-received employee benefit for the most distressed members of the population.

The Johns Hopkins Study - Excerpts

- *“Those enrolled in the program had 86% less odds of having one or more hospital admissions versus those in the comparison group.”*
- *“This type of program may improve outcomes for patients.”*
- *“Few of these programs are currently available, particularly since they may not fit well in many care or insurance structures.”*
- *“A program where patients with advanced illness met with a health professional in a series of structured sessions to facilitate communication, coordinate care, help with advance directive completion, and provide psychosocial support, showed that patients in the intervention arm were more satisfied with care.”*

How Can Patient Advocacy Save Money and Result in Better Care at the Same Time?

Variation in Delivery of Health Care

It is one of the paradoxes of the American Health Care System that wide variation is measured in the cost of care by region, by provider network, and by diagnosis. One of the most plausible reasons for this variation lies in what is called "supply sensitive care." That is, the amount of care, and type of care, is influenced by the capacity of the system. More beds, more specialists per capita, more high-tech equipment, results in more use.

Excess and inappropriate care driven by supply sensitive factors is a key target of CC3. For supply-sensitive care, more is worse. In several well-constructed cohort studies, patients exposed to health care systems that deliver more supply-sensitive care use significantly more resources and do not live longer than those exposed to more efficient care. In fact, the evidence suggests that those who receive more supply-sensitive care are more likely to die.

"Preference Sensitive" Care

Another category of care includes conditions where there are options in treatment, where the options have different risk-benefit ratios and where only the patient can evaluate the risks and benefits. This can be called Preference-sensitive care. In general, patients participating in shared decision making, where their preferences are revealed and honored, are more likely to choose the conservation treatment. This presents another opportunity to both reduce costs and meet patient needs. Interventions from our trained staff are aimed toward exposing patients true preferences and values for the risks and benefits of high-end treatment, and supporting them in efforts to choose treatment in accordance to these preferences and values.

Benecon Wellness Programs

A Benecon wellness program will reduce an employer's health care costs in the short term and long term by keeping healthier, more productive employees on the job. They enhance the professional productivity and personal quality of life of your workforce.

The first objective of our wellness programs is to improve the health and wellness of employees to reduce the risk of chronic illness among the workforce. Seventy percent of chronic illness can be directly linked to lifestyle and behavior. Our programs target employees who are leading high-risk lifestyles. We educate and encourage these employees to make changes in their lifestyles to improve their health and prevent expensive medical conditions.

Benecon's long-term objective is to create a culture of wellness and accountability within a company. We know that wellness programs work best in an environment where wellbeing is understood, accepted, and encouraged by employees at all levels. Our wellness programs empower employees by giving them the necessary tools to support them in taking responsibility for their own health.



Benecon and CC3 Wellness Director Mark Krug is certified by the American Council on Exercise as a personal trainer, and by the American Fitness Professionals & Associates as a Post Rehabilitative Exercise Specialist, Functional Training Specialist, and Nutrition & Wellness Consultant.

Meet our Actuarial and Compliance Professionals

Benecon offers its clients the talents of a team of actuarial and compliance professionals. This report, prepared by Benecon's Actuarial and Legal Staff, is one product of Benecon's ongoing research program, helping employers design and evaluate their benefit programs from a scientific basis.

Richard H. Burd, FSA, MAAA, is Executive Vice President of Benecon's Actuarial Division. Rick has over 35 years of actuarial experience working with group medical plans and other employee benefit programs. Prior to joining The Benecon Group in 2001, he was Vice President and Corporate Actuary for Educators Mutual Life Insurance Company in Lancaster, Pennsylvania.



Brad Kopcha, FSA, MAAA, joined Benecon in 2008 and is Vice President of Actuarial Services. Prior to Benecon, Brad spent over ten years in the actuarial department of Capital BlueCross in Harrisburg, PA. Before his time at Capital BlueCross, he worked in the Actuarial and Benefits Consulting division of Deloitte in New York City.



Judy Griffith, Esq. is an insurance professional and managed care attorney with diversified experience in group insurance management, legal compliance, employee benefit contract development, and managed care contracting. She is an expert on HIPAA compliance, employer regulatory issues, and employee benefit contracts. Prior to joining Benecon, Judy operated her own firm, Health Compliance Associates, LLC. She was also employed by Stevens & Lee, Educators Mutual Insurance Company, and Educators Health Partners.



Trend Up To 10% - 12%, Renewals Up To 19%

With health care reform now the law, renewal rates are increasing significantly and employers are looking for ways to cut the cost of group medical benefits.

On page 5, we discuss our measurement of the Benecon research data base showing an increase in trend from 8% to 10% or higher over the past 12 months, also dramatized in the graphs at the bottom of this page.

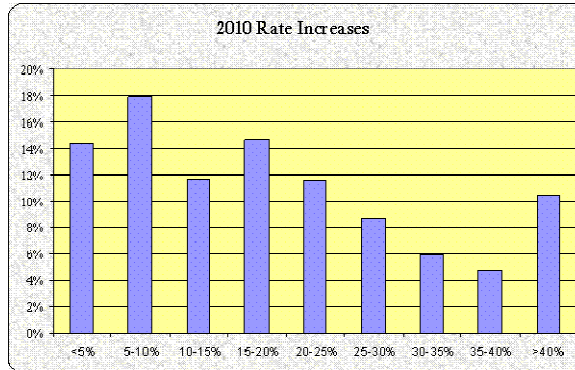
Even though we measure a sudden spurt in inflationary trends, the carriers continue to use trend factors even higher. A review of over 1,000 recent renewals delivered within the last six months showed an average of 19% in-

crease prior to plan design change. More than half are 15% or higher. One quarter are over 30%!

So, why do carriers continue to use trend factors consistently exaggerated from all the credible empiric measurements? Well, in their business model, everything has to have a margin of error. They don't shoot for the average. They want renewal increases that cover most of the trend on most of the groups most of the time; kind of worse case assumption. In other words, they don't want to be right half the time, they want to be right 90% of the time.

Over 1,000 renewals delivered in 2010 averaging 19%

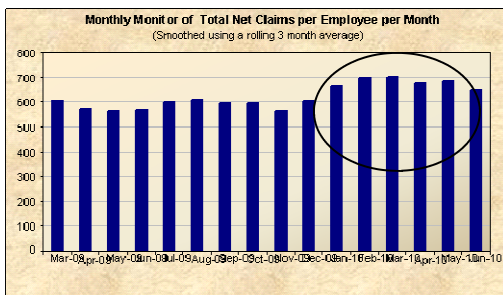
<5%	166
5-10%	207
10-15%	134
15-20%	169
20-25%	133
25-30%	100
30-35%	69
35-40%	55
>40%	121
Total	1154



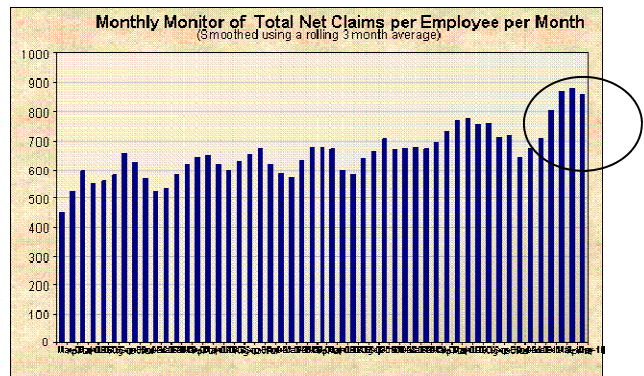
	Medical	Rx
Highmark	13%	11%
CBC	11.75%	10.8%
HA	13%	10.5%

Dramatic Evidence of Recent Trend Change

The graphs below track monthly claims costs per employee over an 18-month period for our college research data base on the left and 4-year period for our municipal research data base on the right. Each graph shows a noticeable bump in trend in the last six months indicated in the circled area.



College research data base



Municipal research data base



The Most Important Benchmark Employers Never See

Employers typically only pay 55% to 60% of the cost of the plan; employees pay over 40%.

Employer-financed medical insurance has eroded so much over the years that it is close to becoming *employee financed - employer subsidized* health insurance. For years, it has been said medical care inflation just can't keep going up two or three times the pace of general inflation without hitting some kind of wall. Have we hit the wall?

In the past two years, employers have shifted most inflation to employees. To a large extent, they have stopped absorbing increases in cost. The growth in insurance premiums for carriers has slowed considerably due to "benefit buy-down" as deductibles and co-pays are raised. Insurance companies, accustomed to fat growth in premium as a normal operating model, are not happy about slow growth and reacting with ever larger increases in premium that exacerbate the cost shift to employees.

The recent survey by the Lancaster Chamber of Commerce reports employees pay 44% of the cost of insurance, 22% through payroll contributions, and 22% through deductibles and copays. In a similar study, Milliman, the nation's most prestigious actuarial firm, reports that employees pay 41% of total costs, 24% in contributions and 17% in deductible and copay out-of-pocket costs. Similar local results are reported by Navigator Benefit Solutions in Berwyn.

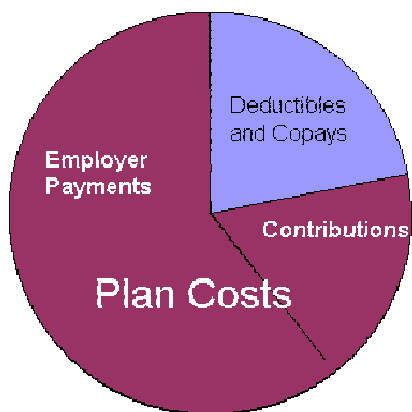
Typically, the true burden being placed the employee population is not displayed to employers as

part of traditional brokerage services or benefit planning. The figures are not captured by insurance companies who don't know the employee contribution, nor calculated by brokers who don't know the mathematics. Thus, employers have not deliberately planned for the 58/42 split, but rather simply wound up there through a sequence of haphazard plan adjustments over the years.

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%.

Typical Benefit Plan & Contributions



The insurance premium (and MERP costs) represents about 80% of the costs. Out-of-pocket deductibles and copays represent about 20%.

The employee payroll contributions, at 27% of insurance premiums, represent about 22% of total costs.

Thus, the actual employer cost is only about 58% of total costs. Employees pick up 42% of costs.

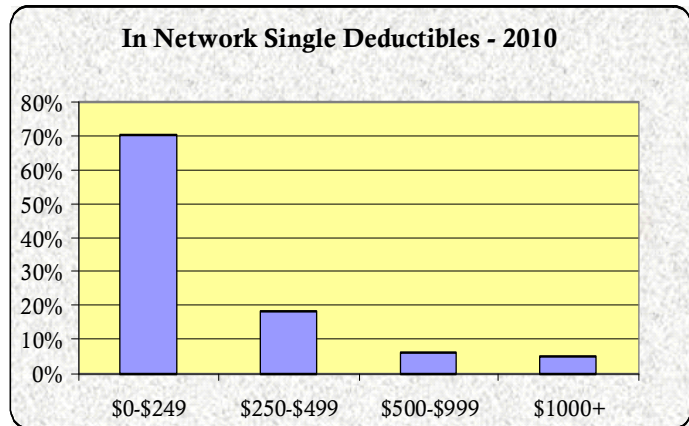
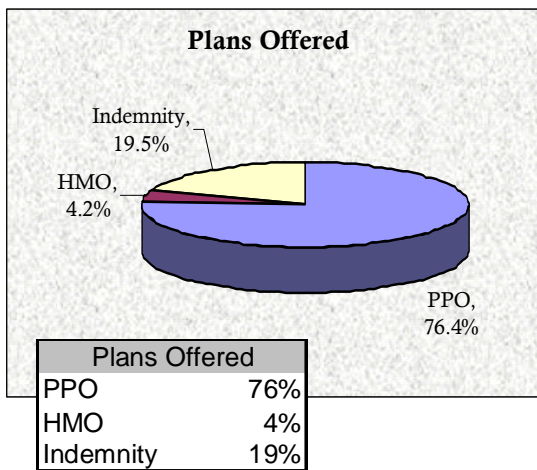


Municipal Measures Show Large Contrast With Commercial Market

The graphs and charts below illustrate plan design parameters from the Benecon survey data base.

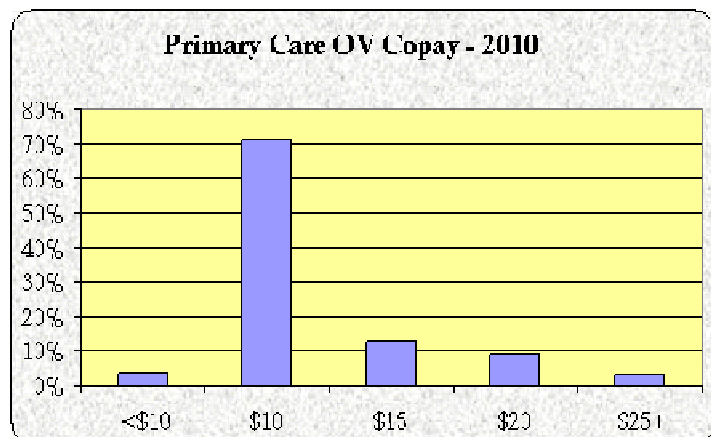
Plans Offered

In the commercial (non-public) market, indemnity plans have all but disappeared, but still represent 20% of municipal plans



Individual In Network Deductibles

A majority of plans in the commercial market have deductibles of \$500 or higher.



Rich Plans

Rich plans are characterized not just by size of deductible, but by first dollar coverage that waives deductible and pays 100% benefit for such things as Hospital Inpatient, Surgery, and Diagnostics & X-ray.

In the commercial market, we find about 15% of the plans maintain these features.

Benefits Covered at 100% with No Deductible	
Benefit	% of Plans
Hospital Inpatient	93%
Outpatient Diag and Xray	91%
Outpatient Surgery	81%
Inpatient Surgery	92%

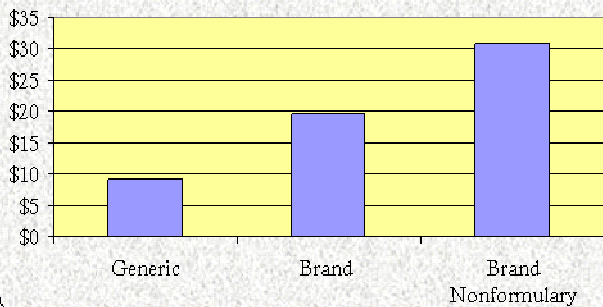
Specialist Office Visit Copays

The commercial market shows 84% of plans have higher co-pays for specialist visits compared to primary care physicians. The municipal data base shows just 2% of plans use this cost containment feature.

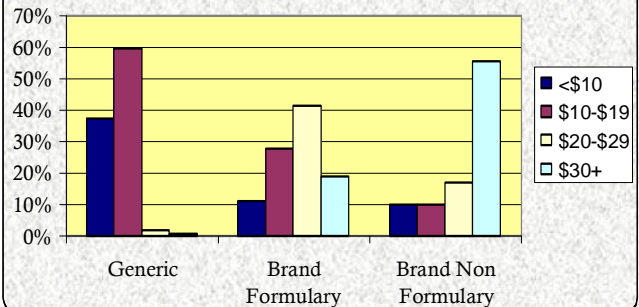
Medical Plan Coinsurance	
Level	% of Plans with Level In Network
Paid in Full	79%
90/10	0%
80/20	21%
70/30	0%



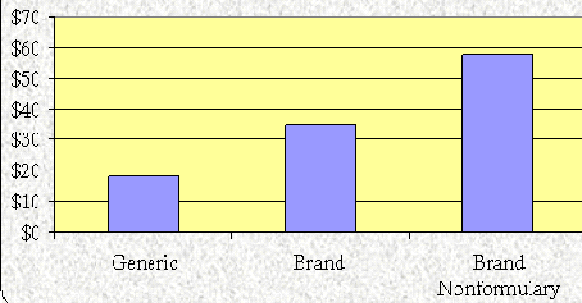
Average Retail Drug Copays - 2010



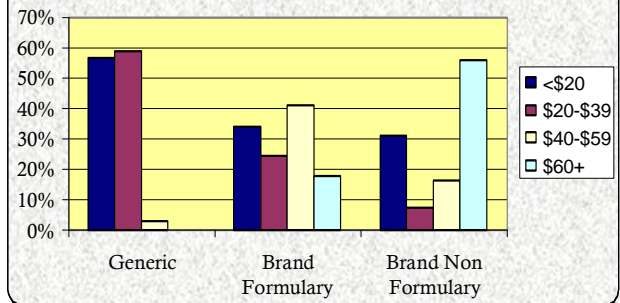
Retail Drug Copays - 2010



Average MO Drug Copays - 2010



Mail Order Drug Copays - 2010



Six Years of Inflation

The table below shows the average premium equivalent for municipal health plans. For a longer term comparison, we have showed 2004 and see rates are up about 68% over six years. This represents an annual trend of about 9%, consistent with the general long-term trend of medical cost increases.

Coverage Type	2010		2004		Increase
	Average Premium	Average Premium	Average Premium	Average Premium	
Single	\$570.03	\$339.34			68%
EE/Spouse	\$1,104.58	\$706.22			56%
EE/Child	\$827.42	\$606.47			36%
EE/Children	\$1,126.45	\$692.72			63%
Family	\$1,489.25	\$888.27			68%

	Generic	Brand Formulary	Brand Non Formulary
<\$10	37.4%	11.4%	10.0%
\$10-\$19	59.7%	28.0%	10.0%
\$20-\$29	1.9%	41.2%	17.1%
\$30+	0.9%	19.0%	55.5%

Copay versus Coinsurance

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.



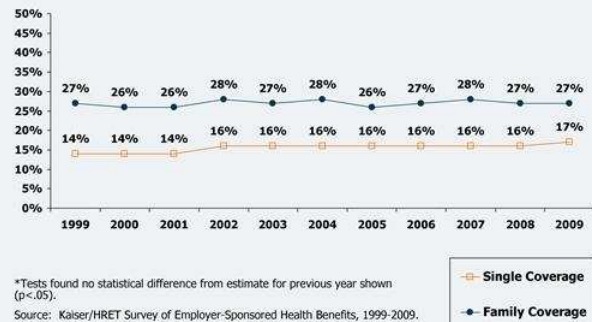
Trends in Employer-Sponsored Health Benefits

Average Annual Premiums for Single and Family Coverage, 1999-2009



* Estimate is statistically different from estimate for the previous year shown (p < .05).
Source: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2009.

Average Percentage of Premium Paid by Covered Workers for Single and Family Coverage, 1999-2009*



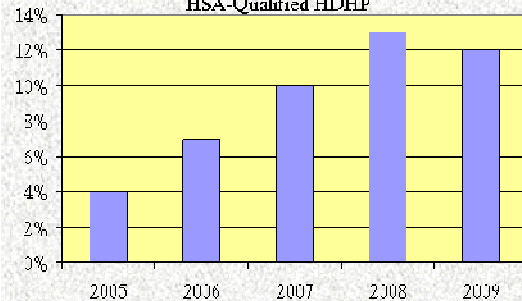
*Tests found no statistical difference from estimate for previous year shown (p < .05).
Source: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2009.

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%

Source: Lancaster Chamber of Commerce and Industry 2010 Policies and Benefits Survey

Percentage of Firms that offer either an HRA or an HSA-Qualified HDHP



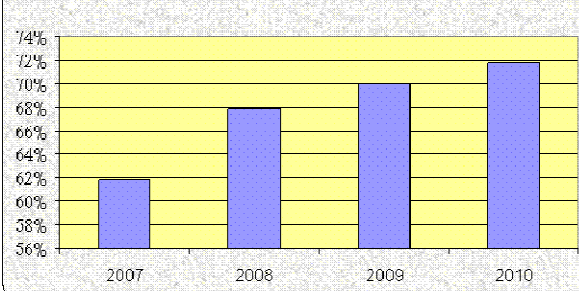
Source: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2005-2009

Average Contributions as a Percent of Premium

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

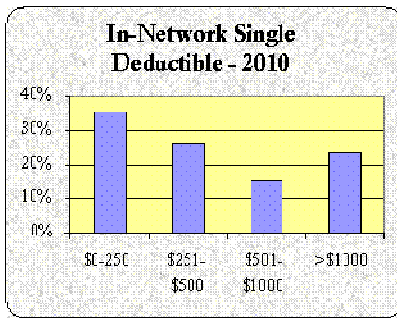
Source: Lancaster Chamber of Commerce and Industry 2010 Policies and Benefits Survey

Generic Fill Rate



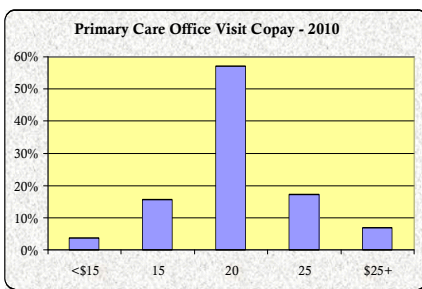
The generic fill rate, that was at 40% in 2000, has now passed 70%.



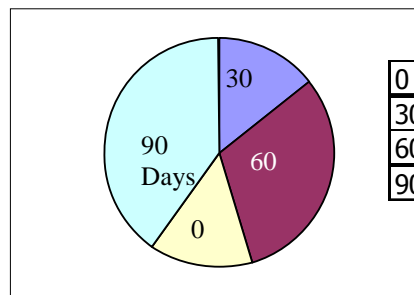


In Network Deductible	
Single Deductible	Percent
\$0-\$250	35%
\$251-\$500	26%
\$501-\$1000	15%
>\$1000	24%

Office Visit Copay	
Copay	Percent
<\$15	4%
\$15	17%
\$20	50%
\$25	21%
\$25+	9%



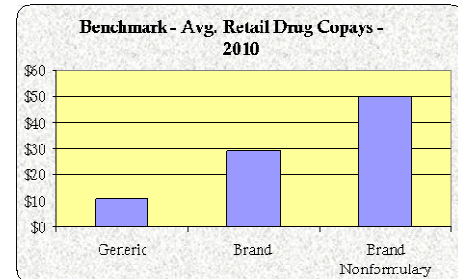
Waiting periods



Rx Benchmarks

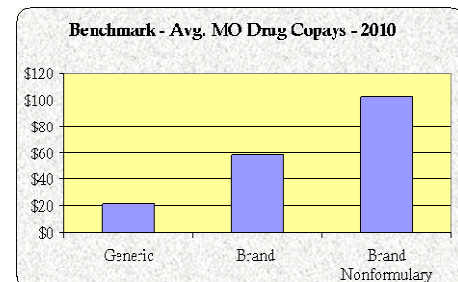
Generic Benchmark now at 70%

Data from the Benecon data base shows generic usage topping 70%. The average generic cost (after converting mail order to 30-day equivalents) is \$16.98.



Benchmark for Rx Costs per Script

Type of Drug	2010			2009	
	Percent of Scripts	Cost per Script	Total Cost	Percent of Scripts	Cost per Script
RETAIL	Brand	14.81%	\$108.05	15.26%	\$99.76
	Generic	43.57%	\$15.72	40.70%	\$15.42
	ALL RETAIL	58.38%	\$39.14	55.95%	\$38.42
MAIL ORDER	Brand	5.54%	\$402.18	5.96%	\$365.77
	Generic	8.33%	\$57.51	8.72%	\$54.26
	ALL MAIL ORDER	13.87%	\$195.18	14.68%	\$180.72
SUB-TOTALS	All Brand	31.43%	\$121.80	33.14%	\$111.72
	All Generic	68.57%	\$16.98	66.86%	\$16.47
GRAND TOTAL	100.00%	\$49.93	\$10,381,987	100.00%	\$48.03



To merge the retail and mail order costs in the Sub Total and Total section, we converted mail order to a 30-day script to retain "apples to apples".



Grandfather Status – What’s the Big Deal?

At first, it seemed the grandfather provision would protect employers from costly new mandates of the health care reform law, such as providing preventive care without co-pays. Employers thought grandfathering would preserve their ability to contain costs, while requiring less administrative burden than that impose on new or non-grandfathered plans.

But now that the regulations have been published, employers are beginning to realize that they can do very little in terms of changing the cost sharing arrangements of their current plans if they want to maintain grandfather status. The expense of maintaining a grandfathered plan is now a more prominent issue. The entire approach has flipped from, “how do I maintain grandfather status?” to, “what will it cost to lose that status and do I care?”

We believe most employers won’t care and may even find it less expensive to change the cost sharing requirements of their plan and comply with the rules for non-grandfathered

plans. Further, the choice may be taken away by the carrier or administrator when they decide it’s too administratively complex to maintain two sets of customers on their claims and administration systems and to train employees in two separate benefit structures – as

HealthAmerica has done for all groups under 99 lives.

The items affected by grandfathering, along with a description of the estimated impact, are listed on page 15.

All of the above has to be balanced against the burden of remaining in a grandfather status: To maintain its grandfathered status a health plan must:

- include a statement in plan materials that the plan believes it is a grandfathered health plan and must provide contact information for questions and complaints.
- maintain records documenting the terms of the plan as in effect on March 23, 2010 and any other documents that will be required to verify, explain or clarify its status, manage, understand, and obey the complex rules that regulate and restrict plan changes for grandfathered plans.

On balance, we believe there will be few employers for whom maintaining grandfather status will make sense over the next few years. The government even estimates 50% to 80% of employers will lose grandfather status by 2013. We think this estimate is too light.

Employers are making pretty radical changes to their plans to control their budgets. The LCBGH 2010 survey found 38% of employers changed carriers, 48% increased contributions, and 18% reduced benefits in the past year. Most of these changes would cause loss of grandfather status. For most employers, the freedom to continue to adjust plan design, contributions, and carriers will outweigh the added burdens of complying with the law’s new provisions.

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Items to Consider Regarding Grandfathering

Topic	Summary – as it affects non-grandfathered plans	Impact
Dependent to Age 26 Coverage	Children must be eligible for coverage to age 26, regardless of whether or not they are full-time students or dependent on the parent-employee.	Cost impact of <1% compared to grandfathered plans. (Total cost impact of age 26 provision may be 2%, but even grandfathered plans have to comply with most of it.)
Benefit Changes	No referral for OB/GYN. Can designate primary care provider for pediatrics. Out-of-network emergency services covered as in network.	Mostly done now. Little impact.
First dollar coverage for preventive services	Extensive and complex list of services that will not allow co-pay or deductible.	Varied range of impact depending on plan design. But, preventive care services in total is only a small fraction of total costs (less than 5%), and the vast majority of plans provide fairly rich preventive benefits now and will experience 1% increase in costs or less.
Appeals process	Provides for external appeal process, notice to employees.	Not normally a big deal.
Non-discrimination rules	Insured plans, currently exempt, become subject to non-discrimination.	No impact except for discriminatory plans.
Annual Reporting requirements	Annual report to participants open enrollment	No rules issued until late 2012.

Our Attorney Comments on the Increasing Importance of Compliance in Employer-Sponsored Healthcare—*Judy Griffith, Esq.*

Health Care Reform law will radically change the nature of employer-sponsored health benefits and the service mix of the vendors who serve the plans. For 40 years, there has been one major problem—cost inflation higher than CPI. The increasing complexity of building regulatory requirements has been in the background on a slow burn, but now has exploded with PPACA. The new landscape not only challenges employers, but also their consultants. The core skill of brokers and consultants over the years has been to find the best price. With the government dictating all the rules of

underwriting and pricing in the future, costs will become increasingly homogenized and commoditized, and the value from “shopping the market” will shrink because all the carriers must follow the same rules. Consultants after full implementation of PPACA will need to bring a better mix of administrative and compliance expertise to their customers to address their new biggest headache: understanding and complying with the law.



The Benecon Employer Health Care Benefits Report Shows Excellent Track Record in Anticipating Trends



Readers of this report should not have been surprised by any of the changes occurring in medical care trends.

In the **2003 Report**, Benecon was first to measure and predict easing of trends at a time when most, if not all, national publications and consultants in the market were calling for continuing strong inflation:

"The health care market is at a turning point in the underwriting and claim cycle, and things could look a lot different one year from now." "Our observation is that the rate of claim cost inflation eased by about 3-5% during 2003, for both medical and drug."

By the end of 2005 and into 2006, carriers were reducing rates.

In the **2004 Report**, Benecon was a leader in predicting an improving picture for Rx inflation long before others.

"After years of runaway inflation, prescription drug coverage trends may soon prove to be the bright spot in the broad picture of employee health plans."

In the **2005 Report**, we boldly predicted Rx trend moving below medical.

"On the prescription drug side, we believe 2005 will be marked as the year Rx trends dropped below medical trends for the first time in over a decade and are likely to stay there for years." and

"The market is flooded right now (in 2006) with single digit increases, and even a few decreases in insurance premiums. This does not mean zero or small increases are sustainable or to be expected next year. Rather, it's a temporary breather that reflects over-pricing in prior periods."

Within two years, all the carriers dropped Rx trend below medical.

In the **2007 Report**, Benecon predicted modest inflation for 2007 and 2008 with an upward turn in mid-2009.

"We expect the single-digit trend to continue in the 4-8% range until mid-2009, with a definitive turn upward by the end of 2009."

Got this one right, too. See pages 5 and 8 of this report to read about the "turn" that happened just as predicted.

How do we consistently get it right? This analysis from our Actuarial Division is the most authoritative source of regional inflation rates and cost trends specific to the regional market place. Pulling together data from surveys, large employers, reinsurance programs, insurance company actuaries and underwriters, we are able to identify inflation rates and trends long before others. Simply put, no one else has the vantage point and data access Benecon has.

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About The Benecon Group

The Benecon Group specializes in developing innovative and effective employee benefit solutions. Our company goal is to help employers effectively control benefit plan expenditures and design programs that meet the strategic needs of the employer and the personal needs of the employees.

Headquartered in Central Pennsylvania, the professional consulting staff of the **Consulting Division** and the **Actuarial Division** serve the needs of larger employers on a fee-for-service basis. The **Public Sector Services Division** manages group purchasing cooperatives for municipalities, authorities, and school districts. In addition, the **Producer Services Division** serves as a marketing distribution point for major insurance companies. The **Compliance Services Division** provides guidance relating to regulatory and legal issues for our entire array of customers.

The combined divisions of The Benecon Group distribute products or consulting services to employers that cover over 100,000 employees and family members.