

Benefit Insights

Summary of Survey Results

We recently completed our 19th annual **Lambert & Carney Benefits Group Employee Benefit Survey**. This survey encompasses healthcare benefits (medical, dental, vision, and prescription drug), life, disability and other ancillary benefits and represents the responses of over 530 companies.

Our 2005 survey results reflect how employers are dealing with escalating healthcare cost. Further, over the last four years, an increasing number of employers are offering dental and vision coverage. Some of this growth can be attributed to the increased popularity of voluntary plans since most employers are reluctant to take on any additional cost. Since the inception of our survey, there has been a significant shift in cost to employees. This shift has accelerated in recent years. Employees are paying a larger share of the cost of medical coverage both in the form of contributions and the out of pocket costs they are expected to pay. As employers grapple with controlling dramatically rising healthcare costs, the trend toward shifting the burden to employees is evident in a number of ways:

- In 2005, over 94% of companies require employee contributions for medical benefits vs. 58% in 1987. 86% include employee contributions for dental (vs. 56% in 1987).
- The size of employee contributions continues to rise as well with 41% (vs. 37% last year) of respondents requiring contributions of 25% or more for the employee and 54% for the dependent coverage.
- Out of network deductibles have grown significantly with nearly 24% of plans having a deductible over \$1,000. This increase is designed to reduce premiums and drive participants to use in network providers.
- 42% of the plans offered by surveyed employers include in-network deductibles.

- Out of pocket employee expenses are also on the rise with 42% of plans requiring copays of \$20 or more compared to 37% last year.
- So called “consumer driven” models of coverage (HRA and HSA plans) are offered by 30% of companies. Many of these plans are offered as an option to employees and not as the sole alternative.

Life insurance and disability coverage continue to be the core elements of most benefit plans with over 96% of respondents offering life insurance and over 80% offering short and long term disability. As compared to health insurance, the percentage of employers that pay the entire cost of basic life insurance has increased since 1987 to 92% (up from 22%) while the percentage of employers paying the entire cost of short term disability coverage has remained fairly constant at 80% over the same time period. Long term disability contribution requirements have decreased gradually since 1987.

Employers need to continue to seek ways to offer competitive plans that are financially sound. Current strategies focus on employers offering a broader array of benefits (e.g., voluntary benefits, etc.) while requiring employees to shoulder a larger portion of escalating health insurance costs. We anticipate that these trends will continue as employers work to keep benefits attractive for employees while controlling costs.



We are pleased to present to you Lambert & Carney's Employee Benefits newsletter. This newsletter is designed to give you timely and important information regarding employee benefits, government regulations, new products, and other areas of interest to employers and their employees. We value you, your employees, and your business and continue to strive to provide you with the very best products and service available.

Please contact Paul Lambert or Sean Carney at (800) 357-1840 if you have any questions.

Lambert & Carney Benefits Group, LLC
1700 Post Road
Fairfield, CT 06824
Phone: 800-357-1840

Paul Lambert
plambert@lcbenefits.com
Sean Carney
scarney@lcbenefits.com

Prescription Drug Plan Design Evolves in Effort to Contain Costs

Although medical plan cost increases have moderated over the past couple of years, by most reports, prescription drug costs continue to rise at rates that exceed those of other health care costs. Prescription drug usage is unlikely to decrease, given an aging population, the influence of direct-to-consumer advertising, and the ongoing development of new drug therapies. In fact, according to a recent WebMD Medical News article, most of last year's increase in drug spending was due to a 5.4% jump in utilization. Consequently, employers that offer prescription drug benefits are examining cost management strategies—both old and new—in an effort to bring these costs under control.

A popular prescription drug cost management strategy is tiering, with different medication types being assigned to different “tiers,” and the co-payment or coinsurance that the patient pays for a particular medication based on its tier. Most plans today typically use three tiers, composed of generic drugs, preferred (formulary) drugs, and nonpreferred (nonformulary) drugs. Some plans are adding a fourth tier, typically for lifestyle drugs. According to the Kaiser Family Foundation's (KFF) 2004 Survey of Employer Health Benefits, nationally, 65 percent of workers covered for prescription drug benefits were in plans using three tiers, and an additional 3 percent were in plans using four tiers. Average co-payments were \$10 for Tier 1, \$21 for Tier 2, \$33 for Tier 3, and \$48 for Tier 4.

In the Northeast, over 90% of the companies with benefits offer a plan with a three tier strategy, according to a recent Lambert & Carney Benefits Group survey. The tier copayment levels were similar to those reflected in the KFF survey.

While co-payments are the most common type of employee cost sharing in a prescription drug plan, some plans use coinsurance instead. One advantage of coinsurance is that a portion of any cost increases in prescribed medications automatically are passed on to the patient, simply through how coinsurance works, without the need for any plan changes to adjust for such increases. Consequently, a patient may be motivated to ask his or her doctor about alternatives to a medication that has gone up in cost. When used in conjunc-

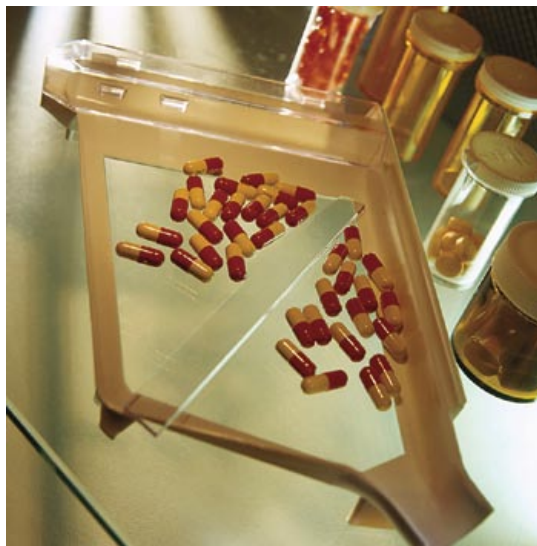
tion with tiering, the average coinsurance percentages are 20% for Tier 1, 26% for Tier 2, and 31% for Tier 3 or Tier 4, according to the KFF survey.

Another, more infrequently used type of cost sharing in prescription drug programs is “reference pricing.” The plan selects benchmark, or “reference” drugs in therapeutic clusters (these benchmark drugs are considered to be effective substitutes for higher-price alternatives), and then bases its coverage on the reference drug. For example, the plan may pay 80 percent of the cost of the benchmark drug, and if the doctor prescribes a more expensive alternative in the same therapeutic class, the patient will be responsible for the difference between the prescribed drug's cost and 80 percent of the benchmark drug's cost.

“Allowance plans” are a relatively new approach in prescription drug cost sharing between plan and patient. Instead of the patient paying a set amount, or co-payment, when filling a prescription, the plan fixes the amount it will pay toward the prescription cost, and the patient pays the remainder of the cost. If the cost of the drug is less than the allowance, the patient will be able to fill the prescription for free. The allowance may vary, based on the tier of the prescribed drug, and is set to drive the patient toward generics or drugs with proven medical cost-effectiveness.

Use of generic medications as a way to manage prescription drug costs has long been standard fare. Most plans use incentives to drive patient choice in favor of generics—such as the tiered co-payment or coinsurance mechanisms discussed above—but some plans take it a step further. According to the KFF survey, 19 percent of workers covered for prescription drugs faced mandatory use of generics in their plans, with slightly larger percentages of HMO-covered individuals subject to this plan feature.

Though the results from use of these strategies will vary, it's clear that there are cost savings to be realized. For example, pharmacy benefit manager (PBM) Walgreens Health Initiatives reported a 7.2 percent increase for clients included in its 2004 drug trend report using generic drug promotion programs, and PBM Express Scripts reported no increase for drug benefit plan sponsors that used two or more cost-management programs as part of their plans.



Employers Discovering Wellness Programs Help Rein in Health Care Costs

While employers continue to use cost shifting to control their health care plan expenses, many also are making wellness programs part of their health care cost control strategy and are seeing these programs as a long-term investment in a healthier workforce.

A survey of 365 companies by the ERISA Industry Committee (ERIC) and the Deloitte Center for Health Solutions found that 62 percent have implemented wellness programs to improve employees' health. Of these companies, 64 percent cited rising health care costs as a "major factor" in the decision to sponsor a wellness program, and 34 percent said that health care costs played "some role" in the decision. In a separate survey by PricewaterhouseCoopers, 80 percent of surveyed business executives said that the best option for reducing health care costs was to provide financial incentives for employees to lead healthier lifestyles.

Health risk assessments lead the list of wellness initiatives used by the ERIC/Deloitte-surveyed employers, followed by smoking cessation programs. Specifically, the surveyed companies offered the following wellness initiatives—

- Health risk assessments—61 percent
- Smoking cessation programs—56 percent
- On-site workout facilities—50 percent
- Employee diet groups—48 percent
- Adding healthier foods to the cafeteria menu—48 percent
- Subsidized gym programs—43 percent
- Allowing employees to use time during the workday to exercise—27 percent
- Diet counseling—27 percent
- Other initiatives, such as free flu shots, healthier vending machine choices, wellness Web sites, and on-site massages—32 percent

Almost half (47 percent) of the companies with wellness programs offered employees incentives to participate, includ-

ing cash payments, reduced medical co-payment costs, rebates on wellness program costs, gift certificates and prizes.

While the surveys cited above focused on large companies, small and midsize businesses are also offering wellness initiatives. Data from the Small Business Administration cited by the National Federation of Independent Business indicates that more than 80 percent of businesses with 50 or more employees have implemented some type of wellness program.

Most companies with wellness programs understand that it will take some time to see the payoff from these programs. When companies in the ERIC/Deloitte survey were asked the question—"Do you believe that helping employees lead healthier lifestyles will make a noticeable difference to the company's health care costs?"—80 percent said "Yes, but it will take a while to see results." Only four percent expected immediate improvement. Another 14 percent thought an impact on health care costs was only a possibility, and that "there are other reasons we wanted to do this."

The actual financial payoff any company reaps from a wellness initiative is impossible to predict, and will depend on the type of program and extent of employee participation, the latter of which can vary, driven by such factors as the availability of participation incentives, employee awareness, and the extent to which the employer stands behind the program. However, wellness programs can do more for a company than help contain its health care costs. Healthier employees are likely to be more productive, have fewer absences, and have a better overall attitude toward the business. Sponsorship of wellness programs also can enhance a company's recruitment efforts, and improve its image in the community.



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tribute substantial amounts—persist as employee's age. Competing financial responsibilities may still be present (such as a mortgage) or may have shifted to a different form (maybe the mortgage is paid off, but the kids are approaching college age). To encourage eligible employees to utilize a catch-up contribution provision, plan sponsors might revisit strategies used to encourage 401(k) participation in general.

For example, the availability of a matching contribution usually is considered the most effective way to increase 401(k) plan participation rates. Yet, according to the PSCA,

only about a quarter of the plans permitting catch-up contributions offered a match on these contributions. Also, some research indicates that financial education can be just as effective as matching contributions in encouraging participation. This suggests that employers with plans that permit catch-up contributions might consider targeted communications about their availability, along with general financial and retirement savings education.

To promote a catch-up contribution provision the message that it's "never too late" to save for retirement can take on added meaning for those who are eligible.

Catch-Up Contributions Can Help Build Retirement Nest Egg

Catch-up contributions enable older 401(k) plan participants to make up some of the ground they may have lost in saving for retirement during their younger years. Beginning in the year a 401(k) participant turns age 50, he or she may make additional pretax contributions in excess of the statutory limit. In 2005, for example, when the statutory limit on pretax contributions to a 401(k) plan is \$14,000, participants' age 50 and older may contribute up to an additional \$4,000 in catch-up contributions (both amounts are indexed). In addition to not counting toward the statutory limit, catch-up contributions do not count toward any employer-imposed contribution limit, and they are not considered in nondiscrimination testing.

Plans are not required to permit participants to make catch-up contributions, but most plans do. According to an annual survey by the Profit Sharing/401(k) Council of America (PSCA), 95 percent of plans include a provision for catch-up contributions. A survey by the Vanguard Center for Retirement Research of 2,000 Vanguard plans put this figure at 86 percent.

Oddly enough, very few participants who are eligible to make catch-up contributions actually take advantage of this opportunity. The PSCA reported that 24 percent of those eligible to make catch-up contributions did so, while the Vanguard survey put this figure at only 13 percent. Household

income related strongly with making catch-up contributions: 32 percent of eligible participants with a household income of \$150,000 or more made catch-up contributions, compared with five percent of eligible participants with a household income under \$50,000.

Household Income	Eligible Participants Making Catch-Up Contributions
Less than \$50,000	5 %
\$50,000-\$74,999	7 %
\$75,000-\$99,999	12 %
\$100,000-\$124,999	18 %
\$125,000-\$149,999	22 %
\$150,000 +	32 %

According to Vanguard, participants making catch-up contributions also had higher 401(k) account balances (\$253,000 versus \$89,000) and were more likely to be registered to use the Internet to manage their 401(k) account, compared with those who were eligible to make catch-up contributions but did not. Also, 60 percent of those making catch-up contributions were, by Internal Revenue Service definition, highly compensated employees.

Apparently, the reasons many employees fail to participate in their 401(k) plans—or, if participating, fail to con-

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Lambert & Carney Benefits Group, LLC
1700 Post Road, Suite B-1
Fairfield, CT 06824

Paul Lambert
plambert@lcbenefits.com
Sean Carney
scarney@lcbenefits.com