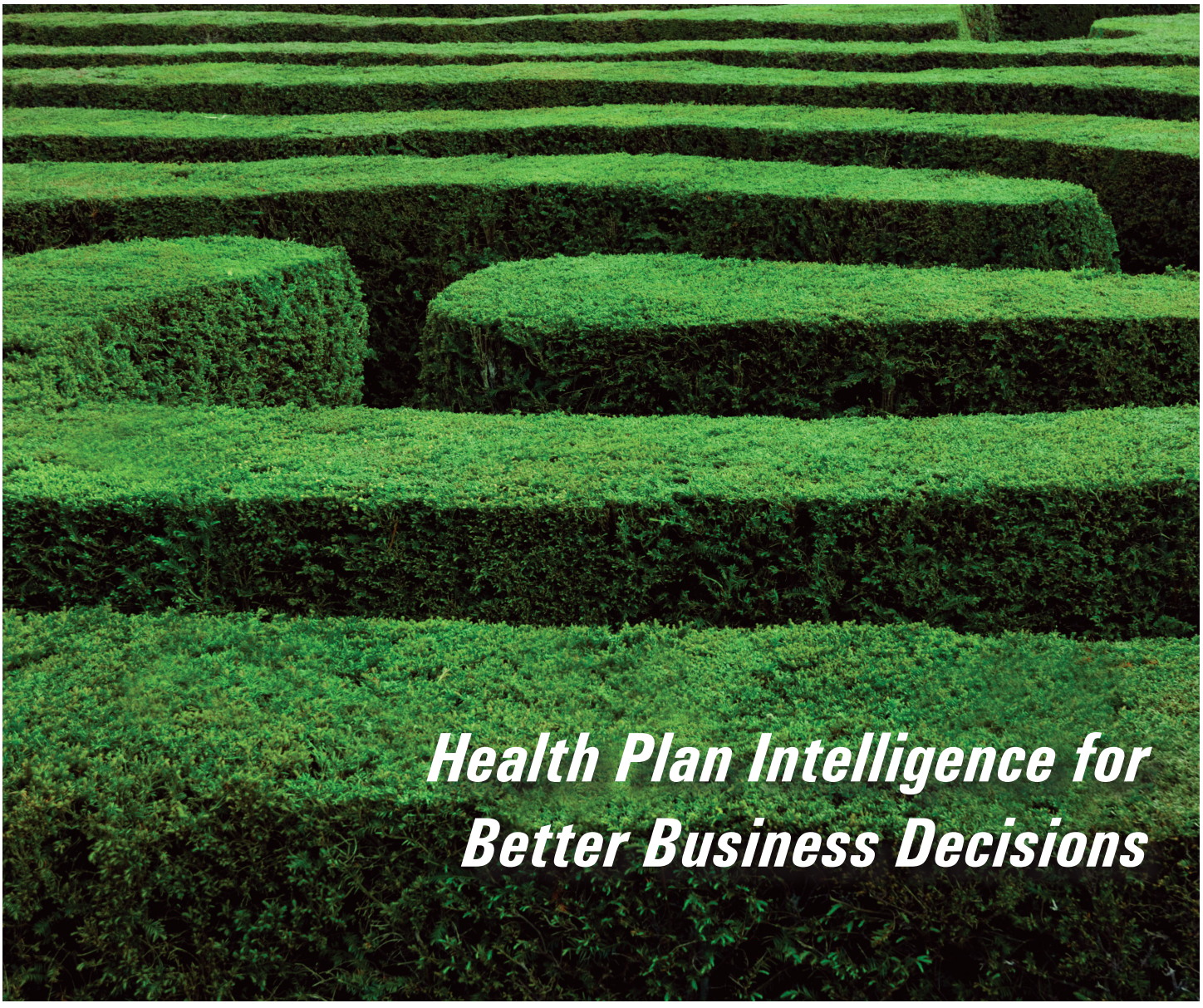
UBA HealthPlanSurvey



Health Plan Intelligence for Better Business Decisions

2015 EXECUTIVE SUMMARY

Benefit Plan Design and Cost Benchmarking Key Results

UBA United Benefit Advisors

Shared Wisdom. Powerful Results.®

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INTRODUCTION

Since 2005, United Benefit Advisors® (UBA) has surveyed thousands of employers across the nation regarding their health plan offerings, their ongoing plan decisions in the face of significant legislative and marketplace changes, and the impact of these changes on their employees and businesses. The annual UBA survey represents the nation's largest health plan benchmarking survey and the most comprehensive source of reliable benchmarking data.

For more information on how the 2015 survey was conducted, its scope and who participated, see page 23, "About This Survey."

TREND CHECKLIST

Here's a brief list of the top trends resulting from the complex legislative changes employers face and their ongoing efforts to manage health care costs.

✓ Rates are up modestly, but increases are on the horizon.

- Factors driving rates higher: Small groups forced into community-rated, high-cost plans that are compliant with the Patient Protection and Affordable Care Act (ACA), and lack of negotiating power among small groups.
- Factors temporarily holding costs steady: Large group negotiating power, grandmothered employers avoided ACA-compliant plans, UBA Partners leveraged their bargaining power.
- Rate outlook: Overall, rates are expected to rise and employers will continue to reduce benefits and pass costs to employees.

✓ Overall costs vary significantly by industry and geography.

- Retail, construction and hospitality employees cost the least to cover; government employees (the historical cost leader) and finance employees (the new leader) cost the most.
- Plans in the Northeast cost the most; plans in the Central U.S. cost the least.
- Retail and construction employees pay the most toward their coverage; government employees pay the least (bad news for taxpayers).

✓ The upcoming Cadillac tax isn't restricted to "rich" plans alone. In fact, a surprising number of employers are expected to exceed the Cadillac tax threshold.

✓ Employees feel the squeeze financially, but have more shopping options.

- Employee contributions are up modestly; copays held steady.
- Deductibles and out-of-pocket maximums are rising rapidly.
- Health savings account (HSA) plan contributions decreased.
- Employers are offering more plan options at different price points.

✓ PPOs, CDHPs and 4-tier prescription plans have the biggest impact.

- Preferred provider organization (PPO) plans cost more than average but still dominate the market.
- Consumer-directed health plans (CDHPs) cost less than average and enrollment is increasing.
- Prescription plans are rapidly moving to four tiers with blended copay/coinsurance models, making it the fastest growing pharmaceutical cost-containment strategy.

✓ Overall, wellness program adoption is up, but program design is changing.

- Health risk assessments are down while biometric screenings and physical exams are on the rise.

✓ Statistics to watch in 2016:

- Increase in self-funding for all group sizes.
- Decrease in dependent coverage.
- Rate stabilization in groups with 51 to 100 employees as an ACA amendment helps them avoid community rating.
- Mail order pharmaceutical programs more for convenience than cost savings.

✓ Metal levels are now tracked in the UBA Health Plan Survey.

- Most plans are gold metal level or higher.

SURVEY HIGHLIGHTS & KEY FINDINGS

The following are selected highlights and key findings from this year's survey.

1. Health Plan Options—More than half (53.7%) of all employers offer one health plan to employees, while 28.7% offer two plan options, and 17.6% offer three or more options. The percentage of employers now offering three or more plans is of particular interest since it represents nearly a 28% increase over the past five years. More and more, employers are offering expanded choices to employees either through private exchange solutions or by simply adding high-, medium-, and low-cost options; a trend UBA Partners believe will continue to increase. Not only do employees get more options, but employers can introduce lower-cost plans that ultimately may attract enrollment and lower their costs.

2. Health Plan Costs—The average annual health plan cost per employee for all plan types is $9,736 (employers pay $6,403 of this cost, while employees pay $3,333). Compared to 2014, overall costs, based on all plans surveyed, are up 2.4% and employers passed slightly less than half (45%) of this increase on to employees. This increase was modest because of employees enrolling in plans that weren't as rich, combined with large group negotiating power and small group grandmothering, as discussed later in this report.

Plan Type	Total Cost	Employee Cost	Employer Cost
PPO	$10,040	$3,422	$6,618
HMO	$9,446	$3,124	$6,322
POS	$9,905	$4,028	$5,877
CDHP	$9,210	$3,008	$6,202
EPO	$10,793	$4,004	$6,789
All Plans (Average)	$9,736	$3,333	$6,403

As you can see from the table above, health maintenance organizations (HMOs) have lower annual costs per employee than the average plan—3% lower, to be specific. On the other hand, point of service (POS) plans, exclusive provider organizations (EPOs), and PPOs all have higher annual costs per employee than the average plan: PPO costs are 3.1% higher, POS costs are 1.7% higher, and EPO costs are 10.3% higher. Despite this, PPOs continue to dominate the market in terms of plan distribution and employee enrollment.

3. Costs and Contributions by Industry—Total costs per employee for the retail, construction, and hospitality sectors are 8.6% to 21.2% lower than the average, making employees in these industries among the least expensive to cover. Employees in the retail and construction sectors pay 9.2% and 7.3% above the average employee contribution, respectively, so employers bear even less of the already low costs in these industries; hospitality employees pay approximately the average employee contribution. Surprisingly, the finance industry eclipsed the government sector—the perennial leader in the highest costs per employee—and now pays on average $11,842 per employee, a 16% increase from 2014. But government plans still have the third highest average cost per employee ($11,817), and employee contributions are 45.2% ($2,105) less than the average employee contribution of $3,333. Even the finance sector makes employees pay more for their pricey plans: $3,493, or nearly 5% more than average.

TOP 5 INDUSTRIES BY AVERAGE TOTAL COST

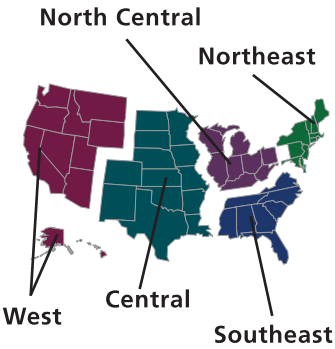
1. *Management of Companies and Enterprises - $12,871*
2. *Finance and Insurance - $11,842*
3. *Public Administration - $11,817*
4. *Utilities - $11,115*
5. *Educational Services - $10,557*

4. Out-of-Pocket Costs—Median in-network deductibles for singles jumped from $1,500 in 2014 to $2,000 in 2015, while families stayed at $4,000. When out of network, families got hit hardest: their median deductible rose from $6,000 in 2014 to $7,000 in 2015, while singles stayed at $3,000. Both singles and families are seeing large increases in median in-network out-of-pocket maximums (up $500 and $700, respectively, to $4,000 and $8,700). Families bear the brunt of the increase in median out-of-network out-of-pocket maximums, going from $16,000 in 2014 to $18,000 in 2015, while singles increased from $8,000 to $9,000.

5. Delay Tactics—Premium renewal rates (the comparison of similar plan rates year over year) increased an average of 6.2% for all plans—up from last year's 5.6% increase. Last year, employers overwhelmingly utilized early renewal strategies to delay moving to higher-cost ACA-compliant plans and keep increases in check. These delay tactics ran out this year and, as a result, many of these same small groups moved to the higher-cost, community-rated ACA plans. As small groups lack negotiating power, they largely drove premiums up from last year (a trend perhaps not revealed by cost surveys that only look at large groups).

6. Prevalence of Plan Type by Region—PPO plans are most prevalent in the Central U.S., though they generally dominate nationwide, except in the Northeast where CDHPs are most prevalent.

Plan Type	Northeast	Southeast	North Central	Central	West
PPO	23.2%	39.0%	53.5%	63.2%	48.7%
HMO	22.5%	14.7%	12.6%	6.8%	32.5%
POS	10.7%	20.6%	3.8%	8.3%	2.5%
CDHP	32.8%	24.9%	29.7%	19.8%	15.3%
EPO	10.7%	0.6%	0.3%	1.6%	0.9%

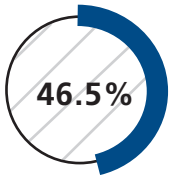


7. Enrollment by Plan Type by Region—PPO plans have the greatest enrollment in the Central U.S. The Southeast and Northeast saw the biggest increase in PPO enrollment (7% and 8% respectively) this year. HMO enrollment is down across most of the country, but is on the rise in the Central and Western U.S. POS enrollment has stayed virtually flat from last year. CDHP enrollment is highest in the Northeast U.S. at 29.2%, an increase of 11.5% over 2014. But the Southeast saw nearly a 23% increase in CDHP enrollment from 2014. Conversely, the North Central U.S. saw a 23.5% decrease in CDHP enrollment.

Plan Type	Northeast	Southeast	North Central	Central	West
PPO	39.5%	47.5%	54.7%	66.6%	60.9%
HMO	15.4%	13.4%	8.5%	6.9%	22.4%
POS	7.9%	11.0%	2.2%	4.4%	1.2%
CDHP	29.2%	22.7%	22.5%	20.6%	12.7%
EPO	7.9%	4.9%	12.0%	1.1%	2.8%

8. Eligibility for Coverage—Consistent with the last few years, when employers aren't required to offer coverage, they don't. Less than 10% of employers provide coverage to employees working fewer than 30 hours per week. Interestingly, a significant number of employers still do not provide coverage to those who must receive it under the ACA. Nearly 18% of plans require employees to work more than 30 hours per week to be eligible for medical coverage. This means that these plans have yet to be amended to cover all employees working 30 hours or more—an amendment that will need to take place for these plans to be in compliance with the ACA. In other words, these employers have yet to face the full costs of coming into compliance with the ACA. It is important to note that state laws do vary regarding the number of hours required for coverage.

9. Dependent Coverage—46.5% of all covered employees also elect dependent coverage, a 2.7% decrease from last year. Since dependent coverage percentages have remained essentially the same for the past three years, UBA believes this modest decrease is a trend to watch since many experts believe higher costs will lead to a rush to drop family coverage.



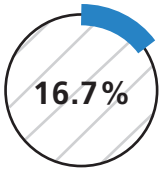
10. Spouse/Partner Coverage—61.3% of all employers provide no domestic partner benefits, a trend that has remained unchanged for the past three years; 30% provide coverage for both same-sex and opposite-sex domestic partners; 4.6% provide same-sex coverage only; and 4% provide opposite-sex domestic partner benefits only. The Supreme Court's decision in *Obergefell v. Hodges* may lead to an increase in plans that cover same-sex spouses.

11. Infertility Services—In 2015, 34.2% of all plans provided no benefits for infertility services. 36.7% of plans provided benefits for evaluation only, and 29% provided benefits for evaluation and treatment. These numbers have remained essentially the same for the past three years.

12. Comprehensive Wellness Programs—18.9% of all employers offered comprehensive wellness programs, which is a 2.7% increase from last year. Of these employers, 75.3% included health risk assessments, 67.6% offered employee incentives for participation, 67.5% offered biometric screenings or physical exams, 50.8% included on-site or telephone coaching for high-risk employees, and 42.4% included seminars or workshops. Compared to 2014, the use of health risk assessments is down 6.2%, while use of biometric screening and physical exams are up 6.5% and seminars are up 5.2%.

13. Bonuses to Waive Coverage—Fewer employers are offering bonuses to waive coverage, but for those that do, the bonus amount is on the rise. Only 2.9% of employers offered a bonus to employees to waive medical coverage in 2015, an 17.1% decrease from 3.5% two years ago. The average annual single bonus in 2015 was $1,680, which is a 10% increase from 2013.

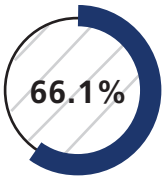

14. Grandfathering—The percentage of respondents' grandfathered plans has fallen. Only 7.8% of plans are considered grandfathered plans compared to 8.2% in 2014. Grandfathering allowed an employer group to maintain a health plan that was in place prior to March 23, 2010, and be exempt from many changes required under the ACA. Typically, plans lose their grandfathered status by making changes that reduce benefits or increase the employee's cost for benefits.



15. Grandmothering—Only 16.7% of respondents' plans are considered "grandmothered." Grandmothering provides small employers the option to maintain a pre-ACA health plan until 2016. To add an additional twist, not every state allowed grandmothering of policies and not all insurance carriers offered the option in those states endorsing it. The 29 states that allowed grandmothering permitted employers to continue to be composite rated, with rates based on the health status of the group. As a result, healthier groups maintained their pre-ACA status while groups with health conditions and poor claims experience migrated to the community-rated ACA-compliant plans, essentially providing the best of both situations to those employers. These states experienced lower average increases than states that did not allow this delay. Ultimately, they're merely delaying the record increases associated with the transition to ACA-compliant plans. However, some small groups (with 51 to 100 employees) may avoid community rating and its associated rate increases, due to the Protecting Affordable Coverage for Employees (PACE) Act, which amends the ACA to keep the small employer definition of 50 or fewer employees and allows states to move to 100 if they wish. But the timing of rate refiling processes and state legislature decisions could nevertheless cause disruptions to when this protection will be realized for this group.

16. Self-Funding—Overall, 12.2% of all plans are self-funded, nearly an 11% increase from 2014. UBA Partners believe that self-funding will be increasingly desirable to employers of all sizes in the coming years as a way to avoid various cost and compliance aspects of health care reform.

17. Prescription Drug Plans—66.1% of prescription drug plans utilize copays. Plans with four or more tiers grew 34%, with the intention of defraying the cost of more expensive drugs. Over the last two years, the number of 4+ tier plans grew 58.1%, making this a rapidly growing cost-control strategy. Median retail copays are: $10/$30 for two-tier plans; $10/$35/$55 for three-tier plans; and $10/$35/$60/$100 for four-tier plans.



18. Cadillac Tax Ramifications—Many employers are under the false assumption that the Cadillac tax will apply only to the richest plans. However, the UBA survey shows that's not the case. By compounding the current premium increases over time, we can see that 30% of employers will be subject to the Cadillac tax in 2018. And by 2022, nearly three quarters of employers will be subject to the tax.

MAIN SURVEY FINDINGS

1. IMPACT OF THE ACA

This section delves deeper into the major findings of the 2015 survey and explores some of their implications for the future of health care plans and the possible consequences for employers and employees.

As the fifth year of ACA implementation and regulation draws to an end, employers are continuing to change their plan designs in order to offer benefits that meet federal regulations while also appealing to their employees.

Plan Type	Renewal Rate Increase
CDHP	6.2%
PPO	6.5%
HMO	5.1%
POS	7.9%
EPO	5.3%
Overall Average	6.2%

Premium Rate Trends

Premium rate increases edged up from 5.6% in 2014 to 6.2%, on average, in 2015. A number of factors contributed to this increase while others kept it in check. Last year, there was an astonishing 322% increase in the number of plans utilizing an early renewal strategy on December 1, 2013, delaying many effects of the ACA until December 1, 2014. This delay tactic was the most popular cost avoidance strategy among 94% of small businesses that employ fewer than 50 employees. But this strategy has largely run its course, forcing many businesses to move to community-rated, higher-cost ACA-compliant plans. Nearly a third of small employers with 50 or fewer employees saw rate increases of more than 10%, while only a quarter of businesses with more than 50 employees also experienced double-digit increases. With no negotiating power, small groups were hit hardest. In the 20% to 30% increase category, fewer than 17% of larger employers saw that level of rate hikes versus 23% among smaller employers. Just over 5% of larger employers saw a rate increase of more than 30%, whereas 9.5% of small employers experienced such astronomical increases.

The new community rating system under the ACA played a big role in driving up costs among small groups. Prior to the ACA, many states had 7:1 premium ratios, meaning the oldest age rate band could be no more than seven times higher than the youngest. For example, if the youngest rate band was $100, the oldest could not be more than $700. Under the ACA, the rate bands compressed to 3:1, so the rates had to slide up drastically on the younger bands for the new compression to work. For example, if the oldest age rate came down to $600, the youngest would double to $200. The ACA also eliminated rates based on gender and health status, greatly affecting the rates as well.

There were several key strategies that kept overall premiums from rising even higher:

- Chief among them was the leveraged negotiating power of nearly three quarters of large employers, which kept their rate increases under 10%. Nearly 18% of these groups were able to keep their rates flat.

- Small businesses in states that allowed "grandmothering" (such as Nebraska, Michigan, North Carolina and Florida) also were immune from large rate hikes. Grandmothering refers to existing plans that do not meet the 2014 ACA requirements, but which have been allowed by the federal government and state insurance department to be renewed through October 1, 2016. Even though grandmothering was permitted at the federal level, each state had the ultimate power to determine whether or not to allow the extension. Adding yet another layer of complexity, carriers were not required to allow this extension. In other words, even though the states may have permitted grandmothering, some carriers required employers to transition to ACA-compliant plans. But for those employers who could leverage it, the grandmothering extension is permitted for policy years beginning on or before October 1, 2016. Non-grandmothered small businesses who couldn't negotiate their way to lower rates had no choice except to contain costs by raising deductibles, copays, or out-of-pocket maximums, and passing more costs on to employees.

- UBA Partners were able to bring their bargaining power to bear for nearly 11,000 employers with more than 18,000 plans nationwide. Comparing proposed rates from carriers to final rates, UBA Partners offered approximately 20% savings, aiding employers of all sizes at the bargaining table, not just the largest ones where savings are more likely. Looking at UBA savings by industry, UBA Partners were able to offer above-average savings in the utilities and mining/oil/gas industries. And when negotiating CDHP rates, UBA Partners garnered nearly a 47% savings off initial rates.

What Does the Future Hold for Rate Trends?

Although the ACA implementation is well underway, continued regulatory guidance will shape plan design and costs going forward. In 2015, regulatory agencies confirmed that, regardless of how the plan is structured, it is impermissible for an employer to reimburse or pay for an employee's individual premium. As employers stop that practice and offer group health plans to affected employees, the influx in participants will shape the way employers design plans.

The industry is still awaiting federal guidance on non-discrimination for fully insured group health plans, as well as finalization of proposed non-discrimination regulations in relation to Section 1557 of the ACA, which prohibits discrimination on the basis of race, color, national origin, sex, age or disability. It is certain that these rules, once finalized, will greatly affect plan design. Similarly, Cadillac tax implementation remains on the horizon for 2018. It is anticipated that many employers will trim down their group health plans or consumer-based accounts once it is understood how plan value is calculated.

Federal agencies also have confirmed that, beginning in 2016, self only cost-sharing limitations will apply to each individual on a health plan, regardless of whether the individual is enrolled in a self-only plan. The annual self-only out-of-pocket limit for 2016 will be $6,850. This requirement will apply to both high-deductible health plans (HDHPs) and non-high-deductible plans, and is in response to consumer complaints about high deductibles and out-of-pocket limits. In 2016, the HDHP maximum out of pocket amounts are $6,550 for an individual and $13,100 for a family.

Going forward, the family's cost sharing to the deductible limit can continue to be offered under the HDHP policy, as long as the self-only annual out-of-pocket limitation is applied to each individual on the plan. This change will have a significant impact on how employers select their cost-sharing limits. The new self-only cost sharing limitations will practically impact plans with a family out-of-pocket maximum that is over the self-only limit of $6,850.

The newly passed PACE Act, signed into law, may help employers with 51 to 99 employees avoid community rating and its associated rate increases. Community rating, which affects the small group and individual markets, is a policy by which personal factors used by an insurer to determine premium rates are very limited in scope. Instead, insurers follow instructions from the federal government on age curves, geographical rating, and state reporting to determine premiums. Prior to the ACA, all states defined small employers as those with 1 to 50 or 2 to 50 employees, but prior to the PACE Act being signed into law, many employers had already defined the group size up to 100 employees beginning in 2016 (which was the rule under the ACA prior to this latest amendment). While the PACE Act will enable states to roll back to the previous definition of a small group, the timing of rate refiling processes and state legislature decisions could, nevertheless, cause disruptions.

Out-of-Pocket Cost Increases for Employees

While the rate impact of the regulatory environment plays out, one thing is certain: employers continue to shift a greater share of expenses to employees through out-of-pocket cost increases and reductions in family benefits.

The average annual employee contribution was $3,333 in 2015, compared to $3,228 in 2014. Median in-network deductibles for singles jumped from $1,500 in 2014 to $2,000 in 2015, while families stayed at $4,000. Out of network, families got hit hardest, seeing their median deductible go from $6,000 in 2014 to $7,000 in 2015; singles stayed at $3,000. Both singles and families are seeing large increases in median in-network out-of-pocket maximums (up $500 and $700, respectively, to $4,000 and $8,700). Families bear the brunt of the increase in median out-of-network out-of-pocket maximums, going from $16,000 in 2014 to $18,000 in 2015; singles increased from $8,000 to $9,000.

Looking back over the last five years, the median in-network single deductible has doubled from $1,000 to $2,000 and employees' median out-of-network deductible went from $2,000 to $3,000, significantly increasing their overall out-of-pocket costs. Families haven't fared any better, seeing their median in-network deductible go from $3,000 to $4,000 and their median out-of-network deductible go from $4,000 to $7,000 in just five years.

Out-of-pocket maximums also have skyrocketed. Five years ago, a single employee faced an out-of-pocket maximum of $3,000 in-network and $6,000 out-of-network; these maximums are now $4,000 in-network and $9,000 out-of-network. Maximums for families went from $6,000 five years ago to $8,700 in-network today, and from $12,000 five years ago to $18,000 out-of-network today. Out-of-network expenses are not subject to ACA limitations, which means they'll likely continue to skyrocket.

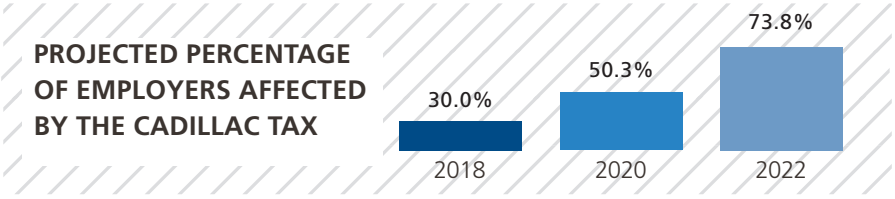
Looming Cadillac Tax Ramifications

Many employers are under the false assumption that the Cadillac tax will apply only to the richest plans. The UBA survey shows this is not the case. The Cadillac tax, set to start in 2018, is based solely on annual premium amounts—not on benefit levels. The thresholds for this 40% excise tax are $10,200 single coverage and $27,500 for anything other than single coverage. The excise tax is to be levied on annual premium amounts



Under the ACA, plans that cost more than $10,200 for individuals, and more than $27,500 for families, will face a 40% tax on the amount over the threshold.

in excess of the thresholds. It is anticipated that when plan value is calculated, the total will include employer contributions to health reimbursement arrangements (HRAs), health savings accounts (HSAs), and flexible spending accounts (FSAs); they also include employee contributions to HSAs and FSAs. Setting these amounts aside, by compounding a 6% rate increase, we see that the following percentages of employers will be subject to the Cadillac tax:



The average actuarial value (AV) of the benefits of the plans that will be subject to the excise tax in 2022 are (assuming no changes occur):

- Employers with plans with greater than 90% AV: 7.5%
- Employers with plans with AV between 80% and 89.9%: 58.7%
- Employers with plans with AV between 70% and 79.9%: 33.8%

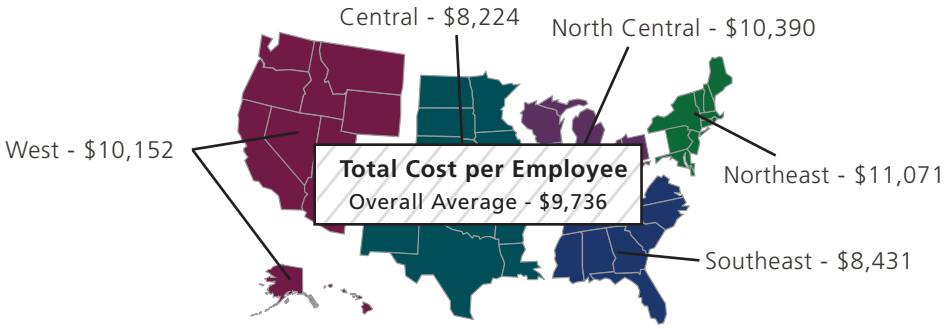
Even if they reduce benefits and premiums, many of these employers will not be able to lower their annual costs under the Cadillac tax thresholds. Employers should be strategizing now to mitigate the liabilities they could be facing in a few short years.

2. COSTS BY REGION, INDUSTRY, AND SIZE

Given the fluid nature of implementing the ACA, it's essential that businesses benchmark their medical plan costs using more than national or carrier data. Therefore, the benchmark data below are broken out by region, industry, and organization size.

Costs by Region

Overall cost increases were 2.4%, relatively flat from last year's 2.2% increase. This figure is typically kept low as employees move to lower cost plans. However, regional cost averages vary, making it essential to benchmark both nationally and regionally. Even with modest increases, a significant difference exists between the cost to insure an employee in the Northeast versus the Central U.S. Plans in the Northeast continue to cost the most since they typically have low or no deductibles, contain more state-mandated benefits, and feature higher in-network coinsurance, among other factors.



Costs by Industry

Costs by industry also vary, making it important for employers to benchmark by industry. The following are industry average costs in descending order:

Industry	Average Cost per Employee
Financial, Insurance, Real Estate	$11,426
Government, Education, Utilities	$11,087
Professional, Scientific, Technology Services	$9,912
Manufacturing	$9,706
Health Care, Social Assistance	$9,298
Construction, Agriculture, Transportation	$9,124
Wholesale, Retail	$9,102
Information, Arts, Accommodations & Food	$8,836
All Plans	$9,736

Total costs per employee for the retail, construction, and hospitality sectors are 8.6% to 21.2% lower than the average, making employees in these industries among the least expensive to cover. This is especially true of employees in the retail and construction sectors, who pay 9.2% and 7.3% above the average employee contribution, respectively; employers in these sectors bear even less of the already low costs. Hospitality employees pay approximately the average employee contribution.

Surprisingly, the finance industry eclipsed the government sector (the perennial leader in the highest per-employee costs), paying, on average, $11,842 per employee, a 16% increase from 2014. Aging populations, more dependent coverage, and geographically-driven factors all pushed costs in the finance industry significantly higher this year. Government industry costs are still a concern (particularly since taxpayers foot the bill) because not only do government plans have the third highest average cost per employee ($11,817 or 19.3% higher than average, and a 4.2% increase over 2014), but employee contributions are 45.2% (or $2,105) less than the average employee contribution of $3,333. Even the finance sector makes employees pay more for their pricey plans: $3,493, or nearly 5% more than average.

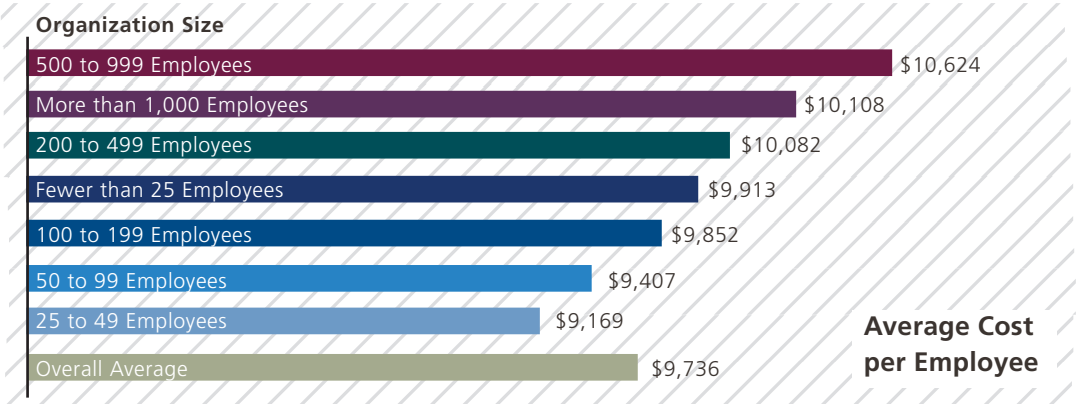
Finance and government employers need to carefully evaluate cost mitigation strategies since their plans are potentially "Cadillac plans," putting them at risk of facing the forthcoming "Cadillac tax."

Employer/Employee Contribution by Industry in 2015

Average Contribution by Industry in 2015	Employer	Employee
Accommodation and Food Services	$4,841	$3,026
Administrative, Support, Waste Management, and Remediation Services	$5,366	$3,562
Agriculture, Forestry, Fishing, and Hunting	$5,853	$3,425
Arts, Entertainment, and Recreation	$5,583	$3,048
Construction	$5,351	$3,587
Educational Services	$7,571	$2,986
Finance and Insurance	$8,349	$3,493
Health Care and Social Assistance	$6,134	$3,164
Information	$6,549	$3,522
Management of Companies and Enterprises	$10,340	$2,531
Manufacturing	$6,499	$3,208
Mining, Oil and Gas Extraction	$6,420	$3,769
Other Services	$6,467	$3,262
Professional, Scientific, and Technical Services	$6,317	$3,595
Public Administration	$9,712	$2,105
Real Estate and Rental and Leasing	$6,874	$3,531
Retail Trade	$5,035	$3,654
Transportation and Warehousing	$5,774	$3,375
Utilities	$8,120	$2,995
Wholesale Trade	$6,017	$3,472

Costs by Organization Size

Average costs by organization size (number of employees) are presented in descending order:



Generally, larger groups (those with 100 to 1,000+ employees) pay more than average per employee due to more generous benefit levels, but those costs have remained virtually flat compared to 2014, due to these employers' ability to negotiate better rates.

Grandmothering and plan design changes (reduced benefits) helped the small groups (25 to 99 employees) stay close to the average per-employee cost, with modest increases over 2014. The very smallest employer groups with less than 25 employees were hit the hardest. They saw a 7% increase in per-employee costs. Without any delay tactics available, and no negotiating power, these groups continue to lack cost containment strategies other than reducing coverage.

The U.S. Census Bureau reports that more than 5 million U.S. companies employ 25 or fewer employees, compared to approximately 600,000 companies with more than 25 employees. Though most health care cost surveys completely omit small businesses, UBA carefully tracks this sector because its cost experiences truly represent those of the vast majority of business owners.

3. OUT-OF-POCKET COST BENCHMARKING SNAPSHOT

Average in-network and out-of-network deductibles, out-of-pocket maximums, copays, and prescription copays for 2014 and 2015 are as follows:

Costs (All Plans)	2015	2014	% Change
Average In-Network Deductible—Single	$2,031	$1,901	6.8%
Average In-Network Deductible—Family	$4,462	$4,256	4.8%
Median In-Network Deductible—Single	$2,000	$1,500	33.3%
Median In-Network Deductible—Family	$4,000	$4,000	--
Average In-Network Out-of-Pocket Maximum—Single	$4,209	$3,883	8.4%
Average In-Network Out-of-Pocket Maximum—Family	$8,875	$8,327	6.6%
Median In-Network Out-of-Pocket Maximum—Single	$4,000	$3,500	14.3%
Median In-Network Out-of-Pocket Maximum—Family	$8,700	$8,000	8.8%
Average Out-of-Network Deductible—Single	$3,869	$3,449	12.2%
Average Out-of-Network Deductible—Family	$8,507	$7,712	10.3%
Median Out-of-Network Deductible—Single	$3,000	$3,000	--
Median Out-of-Network Deductible—Family	$7,000	$6,000	16.7%
Average Out-of-Network Out-of-Pocket Maximum—Single	$9,301	$8,676	7.2%
Average Out-of-Network Out-of-Pocket Maximum—Family	$19,921	$18,679	6.6%
Median Out-of-Network Out-of-Pocket Maximum—Single	$9,000	$8,000	12.5%
Median Out-of-Network Out-of-Pocket Maximum—Family	$18,000	$16,000	12.5%
Median Primary Care Physician Copay	$25	$25	--
Median Specialty Care Physician Copay	$40	$40	--
Median Urgent Care Center Copay	$50	$50	--
Median Emergency Room Copay	$150	$150	--
Median Per Admission Copay	$300	$300	--
Tier 1 Median Prescription Retail Copay in 4-Tier Plan	$10	$10	--
Tier 2 Median Prescription Retail Copay in 4-Tier Plan	$35	$35	--
Tier 3 Median Prescription Retail Copay in 4-Tier Plan	$60	$50	20.0%
Tier 4 Median Prescription Retail Copay in 4-Tier Plan	$100	$100	--

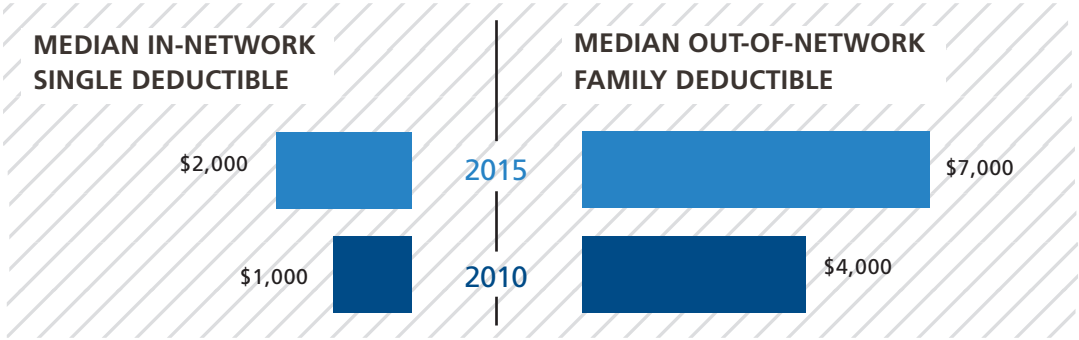
As many analysts projected this past year, premiums continue to rise, forcing many employers to manage this expanding price tag by shifting costs to their employees in the form of higher deductibles, out-of-pocket maximums, and copays for both singles and families.

Median in-network deductibles for singles increased 33% in the past year, while in-network deductibles for families remained unchanged. Interestingly, we observed the reverse for out-of-network deductibles, where the cost for families increased 16.7% and costs for singles remained unchanged.

Significant increases in median in-network out-of-pocket maximums are of note for both singles (14.3%) and for families (8.8%); however again for out-of-network costs, families are bearing larger dollar increases ($2,000) versus singles ($1,000).

Five Year Trends

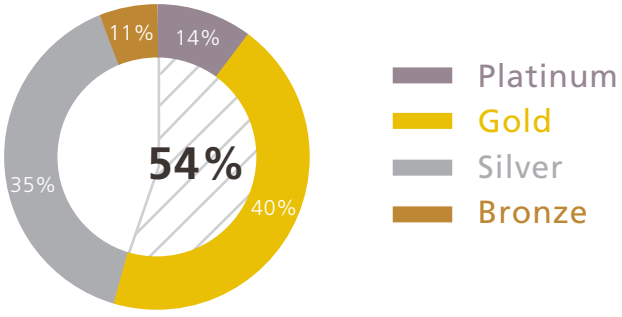
The 2015 increases in out-of-pocket and deductibles for both singles and families noted previously are indicative of the skyrocketing cost trends that we have seen over the past five years. Median in-network single deductibles have doubled, and employees' median out-of-network deductibles increased 50%. The median in-network deductible for families increased 33% and the out-of-network deductible increase was a whopping 75% in just five years.



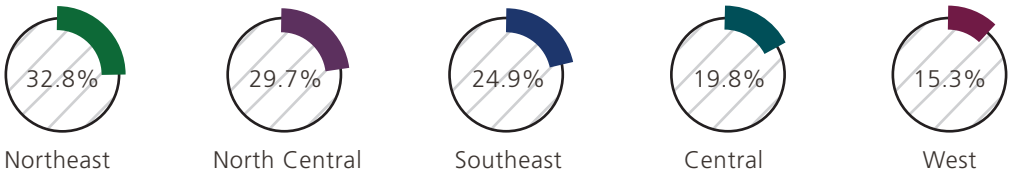
Single employee out-of-pocket maximums for in-network increased 33% and out-of-network increased 50%, while in-network maximums for families rose 45% and out-of-network rose 50%. Because out-of-network expenses are not subject to ACA limitations, we expect to see a similar increase in costs in the future.

4. SPOTLIGHT ON KEY PLAN TRENDS

Trend #1: More than half (54%) of respondents' plans reached gold or higher metal level.

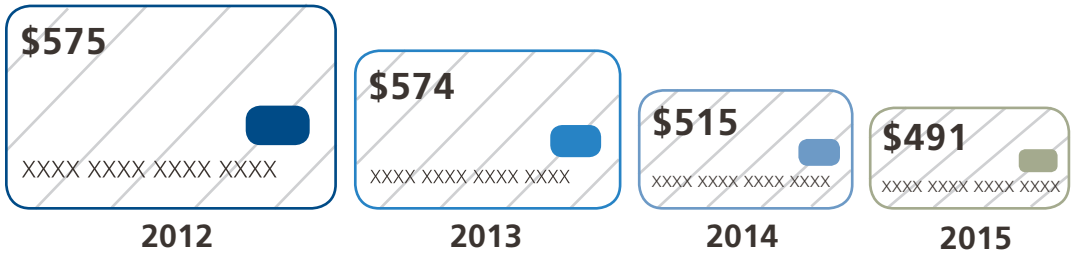


Trend #2: The number of CDHPs continues to grow—up 10.2% from 2012 through 2015. Regionally, consumer-driven health plans account for the following percentage of plans offered.



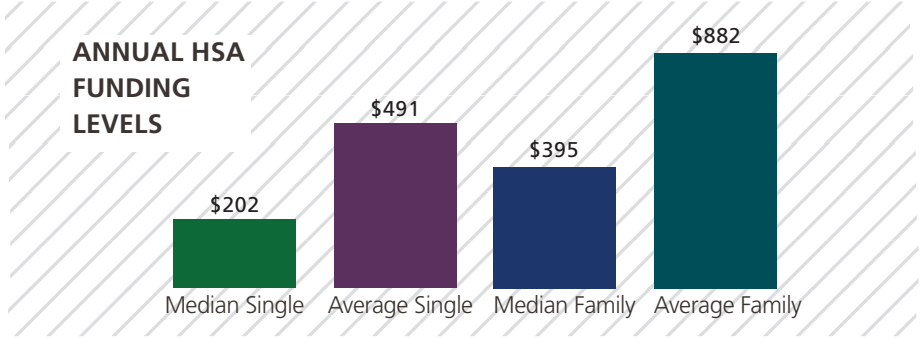
The number of employers offering CDHPs didn't always correlate to the number of employees who chose to enroll in them. Overall, these plans are seeing enrollment increases of more than 39% in the last three years (15.6% to 21.7%). CDHPs see the most enrollment in the Northeast U.S. at 29.2%, an increase of 11.5% over 2014. But the Southeast saw nearly a 23% increase in CDHP enrollment from 2014. (Despite the overall increases, the North Central U.S. saw a 23.5% decrease in CDHP enrollment.)

Average HSA Single Contribution



Trend #3: HSA enrollment is up, despite decreased contributions.

- 23.9% of all plans offered an HSA or HRA, a 29% decrease from 2014.
- The average employer contribution for an HRA was $1,767 for a single employee and $3,472 for a family, up slightly from 2014.
- The average employer contribution to an HSA was $491 for a single employee and $882 for a family (funding for singles decreased more than families from 2014).
- The average single contribution to HSA plans decreased 14.6% from three years ago.
- There was a 10.7% increase in the number of individuals enrolled in HSAs, likely due to the increase in CDHP enrollment.

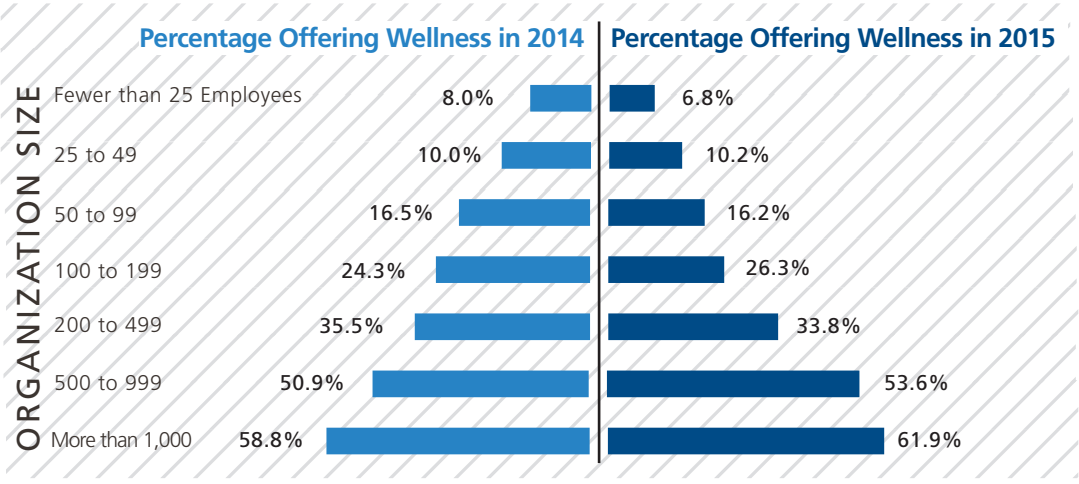


Trend #4: Particular plan types and features are becoming less common.

- Plans offering 100% coinsurance: The number of plans offering 100% coinsurance in-network has dropped over the last two years by more than 9%. In 2015, only 35.3% of plans offered 100% coinsurance in-network for individuals, and only 1.2% of plans offered 100% coinsurance out-of-network.
- Plans with no in-network deductible: The percentage of these plans decreased from 20% in 2014 to 18.2% in 2015 for an individual; for a family, it fell from 20.8% in 2014 to 18.8% in 2015.
- Plans with no out-of-network deductible: The number of these plans remained constant for individuals in 2015 (2.8%) but the number of family plans with no out-of-network deductible decreased to 3.9% in 2015.
- Fee-for-service (indemnity) plans and exclusive provider organizations (EPOs): These have now essentially disappeared from the marketplace, with only 2.8% of employers offering them and only 6.7% of employees enrolled.
- Plans with no out-of-network benefits: Only 18.7% of employees are enrolled in plans that do not offer any benefits for receiving care from out-of-network providers (HMOs and EPOs).

5. WELLNESS PROGRAM DATA

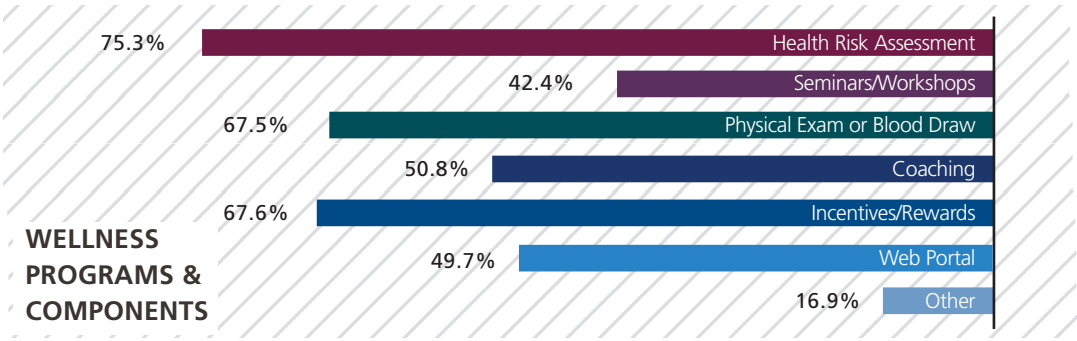
18.9% of all employers offered comprehensive wellness programs, a 2.7% increase over last year. As one might expect, the highest percentage (61.9%) of plans offering wellness benefits came from employers with 1,000 or more employees. The next two largest percentages—53.6% and 33.8%—came from organizations with 500 to 999 employees and 200 to 499 employees, respectively. The lowest percentage (6.8%) of plans offering wellness benefits came from organizations employing fewer than 25 people.



At the time of this report, major lawsuits are pending against employers with particularly robust wellness programs and the regulatory environment is becoming increasingly restrictive. As a result, employers are continuing to pursue wellness programs, but they are being very cautious with program design, avoiding implementing high penalty/incentive programs. Employers are beginning to use the regulations proposed by the Equal Employment Opportunity Commission (EEOC) as their guidelines for program development, and the wellness guide provided by the ACA have re-empowered employers to implement premium differentials for wellness participation and tobacco use.

Employers are encouraged to look beyond immediate return on investment when considering wellness strategies. When designed correctly and communicated properly, wellness programs ultimately lead to healthier employees, higher productivity, reduced absenteeism and a positive impact on overall corporate culture.

Among employers offering wellness programs, 75.3% included health risk assessments, 67.6% offered employee incentives for participation, 67.5% offered biometric screening or physical exams, 50.8% included on-site or telephone coaching for high-risk employees, and 42.4% included seminars or workshops. Compared to 2014, the use of health risk assessments is down 6.2%, while biometric screenings and physical exams are up 6.5% and seminars are up 5.2%.



More and more, employers and wellness consultants are using claims data as a replacement for the health risk assessment. In general, health risk assessments are subjective, which calls their relevance into question. Many employees complain about the content and length of time it takes to complete the assessment, as well as its intrusiveness and the privacy concerns it raises. Nonetheless, using a health risk assessment can have its benefits. The results of a health risk assessment provide users with good feedback regarding their current state of health and often make valuable connections to programs and resources available through carriers or wellness vendors.


Since awareness of personal health is one of the foundations of a good wellness program, most wellness program administrators are driving employees toward biometric screenings and primary care visits. Many employers concerned about the costs of biometric screenings are starting to provide incentives for employees to get their physical exam, which is often covered at 100% as part of their medical benefits. Connecting employees with their primary care physicians is a leading strategy for providing preventive care and setting employees on the road to good health.

Wellness continues to evolve, especially in the ways it connects with employees and assists them in making lifestyle improvements. Changes in the methods of delivery and the tools used in programming are a normal part of growth.

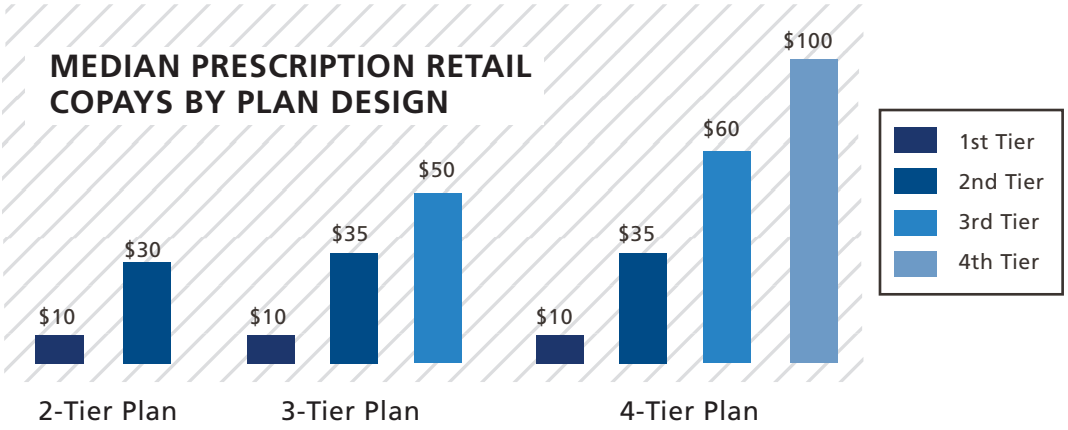
6. PRESCRIPTION PLAN DATA

Copays and Coinsurance Models: Of these models, 61.5% of prescription drug plans utilize only copays, 4.2% utilize only coinsurance, and 30.2% use varying combinations of copays and coinsurance. With a 14% increase in blended copay/coinsurance models, the move away from copay-only models is steady. Some plans may use a copay structure in the first two tiers and then employ a coinsurance model for the higher tiers. Other plans contain a percent-based cost-sharing model to accommodate higher priced "specialty" medications (for example, 20% with a $100 maximum). Coinsurance models are more desirable from a payer's perspective since they are somewhat inflation-proof. As the costs of all drugs go up, a percentage-based model adjusts, whereas a fixed copayment model does not.

Deductibles: When it comes to deductibles, 28.8% of plans treat prescriptions as any other medical expense (subject to plan deductibles and coinsurance). And 10.7% of plans have a separate prescription drug deductible, with a median single employee deductible of $100 and a median family deductible of $300. The ACA will drive a single deductible for medical and prescription drugs, so the option of having a separate prescription drug deductible will largely disappear from the marketplace.

Tiers: Almost half (48.9%) of prescription drug plans utilize three tiers (generic, formulary brand, and non-formulary brand); 4.3% retain a two-tier plan; and 44.1% offer four tiers or more. The number of employers offering drug plans with four tiers or more increased 34% from 2014 to 2015. The fourth tier (and additional tiers) pays for biotech drugs, which are the most expensive. By segmenting these drugs into another category with significantly higher copays, employers are able to pass along a little more of the cost of these drugs to employees. Over the last two years, the number of 4+ tier plans grew 58.1%, making this a rapidly growing strategy to control costs.

Copay Amounts: Median retail copays are $10/$30 for two-tier plans; $10/$35/$55 for three-tier plans; and $10/$35/$60/$100 for four-tier plans. These amounts have remained largely flat from 2014. Generic drugs in the lowest tier generally cost less than $10, so employees are paying all or most of the generic cost with the tier 1 copay. This makes it difficult to raise that amount, especially if employers are concerned about medication adherence. But in four-tier models, the tier 3 copay did increase 20%. Since this tier covers non-formulary brands, copay increases may continue as drug costs in this category soar.



Brand vs. Generics: In 61.8% of plans, employees are required to pay more when they elect brand-name drugs over an available generic drug (a 5.5% increase from 2014); 37.9% of those plans require the added cost even if the physician notes "dispense as written." Only 1% of plans offer no coverage for brand-name drugs if generics are available and 37.2% offer no added cost coverage. While most employers aren't completely penalizing those who choose brand-name drugs, more and more plans are requiring employees to pay higher copays when they elect brand-name drugs. Some plans have a mandated step therapy program that makes sure employees try a lower class alternative before they move to a medication in a higher class (or try a generic or generic equivalent in a particular therapeutic class). Some plans exclude certain drugs altogether. This cost pressure has made employers more aware of drug costs, so many are beginning to educate employees about using benefits cost effectively.

Drug Supplies and Mail Order: More than a third (35.9%) of prescription drug plans provide a 90-day supply at a cost of two times retail copays. Only 3% of plans require a single retail copay for mail order, a 43% decrease from 2014; 4.9% of plans now provide no reduced copay incentive for using mail order, a 22.5% increase from 2014. While mail order benefits are high for specialty drugs, the gap is closing on many maintenance drugs. As the cost escalates, mail order plans can't cover the 90-day cost with a single or even two-times-retail copay. UBA Partners believe that soon mail order will offer only the convenient delivery of these drugs, not cost savings for the employee.

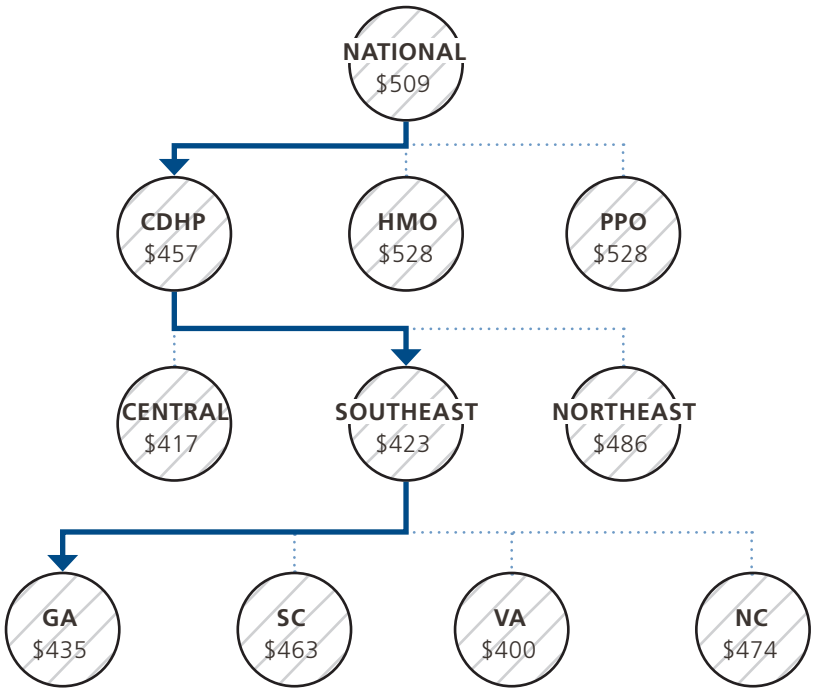
MORE GRANULAR IS MORE ACCURATE

"We're located just outside of Atlanta, Georgia, and we are a midsize design firm competing with other private-sector companies in the state for quality employees. Do you have a way of demonstrating the value of our plan with more focus on my market instead of only national numbers?" ***Yes, we can!***

The size of the 2015 UBA Health Plan Survey provides employers with the data they need to benchmark their plans based on plan type, region, employee size, and industry category. Allowing employers to have access to more granular data gives them the best opportunity to see how their plan stacks up against competitors' plans so they can better understand and communicate the value of their benefits to their employees.

Consider a design firm in Georgia that offers a CDHP. Its premium cost for single coverage is $441 per month. Compare this with the benchmarks for all plans and you can see that it is $68 per month less than the national average. When compared with other CDHPs in the Southeast region, this employer's cost is actually $18 per month more expensive than the average. This employer's cost appears to be higher or lower compared with national and regional benchmarks, depending on which benchmark is used. Yet this employer's cost is actually higher than its closest peers' costs when using the state-specific benchmark, which in Georgia is $435. Bottom line, this employer's monthly single premium is actually $6 more than its competitors in the state.

If you were an employer in Georgia with a CDHP, how would your plan compare with more granular data? The illustration demonstrates how a key piece of health plan information can change and become more relevant to a specific employer as it becomes more granular.



ABOUT THIS SURVEY

Data in the 2015 UBA Health Plan Survey are based on responses from 10,804 employers sponsoring 18,186 health plans nationwide. This unparalleled number of reported plans is nearly three times larger than the next two of the nation's largest health plan benchmarking surveys combined. The resulting volume of data provides employers of all sizes more detailed—and therefore more meaningful—benchmarks and trends than any other source.

The scope of the survey allows regional, industry-specific, and employee size differentials to emerge from the data. In addition, the exceptionally large number of plans represented allows for both a broader range of categories by plan type than traditionally reported and a larger number of respondents in each category. Historically, these types of benchmark data were unavailable to small and midsize employers.

For larger employers, the survey provides benchmarking data on a more detailed level than ever before. By using these data, the independent benefit advisory firms that comprise UBA can help employers more accurately evaluate costs, contrast the current benefit plan's effectiveness against competitors' plans, and adjust accordingly. This gives employers a distinct competitive edge in recruiting and retaining a superior workforce.

HOW WE CONDUCT OUR HEALTH PLAN SURVEY

Respondents to the survey compose a nonprobability sample, in which a factor other than probability—employers' shared contact with UBA, in this case—determines which population sample elements will be included.

Using a nonprobability sample does not mean the sample is unrepresentative of the larger employer population. It simply means UBA cannot formally calculate sampling error, a less consequential source of total error than human error. The full survey provides highly accurate benefit data for employers within narrow industry, size, and regional subsets.

We devote significant resources to reducing errors, individually reviewing and validating the data from each health plan respondent. All questionable data were either verified, re-recorded or eliminated.

Additionally, we compared key variables from the 2015 UBA Health Plan Survey with those of three national employer health benefit benchmark surveys that are widely considered to contain accurate population representations. We have consistently produced results well within comparable and acceptable credibility ranges.

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ALASKA
The Wilson Agency, LLC - Anchorage

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BAGNALL - Phoenix
Benefit Intelligence, Inc. - Mesa
Fendley & Sons Employee Benefit Consultants - Flagstaff
Matsock and Associates - Phoenix

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California Corporate Benefits Insurance Services - San Diego
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Johnson & Dugan Insurance Services Corporation - Daly City
KBI Benefits, Inc. - Cupertino
The LBL Group - Santa Ana
Maniaci Insurance Services, Inc. - Palos Verdes
OakBridge Advisors, Inc. - Newport Beach
The Vita Companies - Mountain View

COLORADO
Cherry Creek Benefits - Greenwood Village
VolkBell - Fort Collins, Longmont

CONNECTICUT
Group Insurance Associates - Woodbridge
Kuveke Benefits, LLC - Ridgefield

FLORIDA
The Clemons Company - Panama City
Coordinated Benefits Group - Jacksonville
Earl Bacon Agency, Inc. - Tallahassee
GCD Insurance Consultants, Inc. - Tampa
The Gehring Group - Palm Beach Gardens
K&P Benefits Consulting Group - Bradenton
Leading Edge Benefit Advisors, LLC - Ft. Myers
Reames Employee Benefits Solutions, Inc. - Daytona Beach
Selden Beattie Benefit Advisors, Inc. - Coral Gables
Sihle Insurance Group, Inc. - Altamonte Springs
The Stoner Organization, Inc. - St. Petersburg

GEORGIA
Alexander & Company - Tifton, Woodstock
Arista Consulting Group - Alpharetta
The Benefit Company - Atlanta
Gary G. Oetgen, Inc. - Savannah
Providence Insurance Group, Inc. - Marietta

HAWAII
Atlas Insurance Agency, Inc. - Honolulu

ILLINOIS
Benefitdecisions, Inc. - Chicago
Byrne, Byrne and Company - Chicago
Coordinated Benefits Company - Schaumburg
Mesirow Financial - Chicago
RJLee & Associates, LLP - Moline
R.W. Garrett Agency, Inc. - Lincoln
Williams-Manny Insurance Group - Rockford

INDIANA
Benefits 7, Inc. - Evansville, Vincennes
LHD Benefit Advisors, LLC - Indianapolis
The Shaner Agency, Inc. - Merrillville

IOWA
Frank Berlin & Associates - West Des Moines
TrueNorth Companies, LLC - Cedar Rapids

KANSAS
Creative Planning Benefits. LLC - Leawood

KENTUCKY
Benefit Insurance Marketing - Lexington
Schwartz Insurance Group - Louisville

LOUISIANA
Becker Suffern McLanahan, Ltd. - Mandeville
Dwight Andrus Insurance - Lafayette

MAINE
Acadia Benefits, Inc. - Bangor, Portland

MARYLAND
Insurance Solutions - Annapolis

MASSACHUSETTS
Borislow Insurance - Methuen
EBS Capstone - Newton
The Gaudreau Group - Wilbraham
Sullivan Benefits - Worcester

MICHIGAN
44North - Cadillac, Grand Rapids, Manistee, Marquette
BenePro - Royal Oak
Keyser Insurance Group - Kalamazoo
Pappas Financial - Farmington Hills
Saginaw Bay Underwriters - Saginaw
Walton Insurance Group - Jackson

MINNESOTA
Cleveland Company - Minneapolis
Horizon Agency, Inc. - Eden Prairie
Johnson Insurance Consultants - Duluth
SevenHills Partners, Inc. - Saint Paul

MISSISSIPPI
Executive Planning Group, P.A. - Jackson

MISSOURI
Bryant Group, Inc. - St. Louis
Employee Benefit Design, LLC - Springfield
Winter-Dent & Company - Columbia, Jefferson City

NEBRASKA
Swartzbaugh-Farber & Associates, Inc. - Omaha

NEVADA
Benefit Resource Group, LLC - Reno
National Healthcare Access, Inc. - Las Vegas

NEW HAMPSHIRE
Granite Group Benefits, LLC - Manchester
Melcher & Prescott Insurance - Laconia

NEW JERSEY
Chadler Solutions - Fairfield, Flemington
Innovative Benefit Planning, LLC - Cinnaminson
Katz/Pierz, Inc. - Cherry Hill

NEW YORK
Brio Benefit Consulting, Inc. - New York
Chadler Solutions - Yonkers
HR Benefit Advisors, Ltd. - Buffalo, Rochester
McDermott & Thomas Associates - Staten Island
Paradigm Benefits, Inc. - Utica

NORTH CAROLINA
Dennis Insurance Group - Greensboro
ECM Solutions - Charlotte
GriffinEstep Benefit Group, Inc. - Wilmington
JRW Associates, Inc. - Raleigh

OHIO
ClearPath Benefit Advisors LLC - Columbus
HORAN - Cincinnati, Dayton
Kaminsky & Associates, Inc. - Maumee
National Healthcare Access, Inc. - Youngstown
Schwendeman Agency, Inc. - Marietta
Todd Associates, Inc. - Beachwood

OKLAHOMA
Benefit Plan Strategies - Tulsa
Dillingham Benefits, LLC - Oklahoma City

OREGON
Davidson Benefits Planning, LLC - Tigard
KPD Insurance, Inc. - Springfield

PENNSYLVANIA
Commonwealth Benefits Group - Dillsburg
Cowden Associates, Inc. - Pittsburgh
Lillis, McKibben, Bongiovanni & Company - Erie
L.R. Webber Associates, Inc. - Duncansville
Lehigh Valley Benefits Group, Inc. - Allentown
The MEGRO Benefits Company - Conshohocken
Power Kunkle Benefits Consulting - Wyomissing
Roller Consulting Company, Inc. - Conshohocken
TJS Insurance Group - Pittsburgh

SOUTH CAROLINA
ECM/Ferguson Solutions - Greenville
KeenanSuggs BowersElkins, LLC - Columbia

TENNESSEE
Collier Insurance - Memphis
Insurance Consulting Group, Inc. - Memphis
Russ Blakely & Associates - Chattanooga
Trinity Benefit Advisors - Knoxville

TEXAS
AMCORP - San Antonio
Brinson Benefits, Inc. - Dallas, Fort Worth
Brinson-RFG, Inc. - Austin
Carlisle-Corrigan Benefits, LLC - Corpus Christi
CSG Companies - Fort Worth
First Harbor - Houston
iaCONSULTING - Abilene, Lubbock
Kainos Partners, Inc. - Jersey Village
Shepard Walton Life - Austin, Harlingen, McAllen
TrueNorth Companies - Fort Worth
Upshaw Insurance Agency - Amarillo

UTAH
Fringe Benefit Analysts, LLC - Layton

VERMONT
The Richards Group - Bellows Falls, Brattleboro, Norwich, Rutland, Williston

VIRGINIA
D & S Agency - Roanoke
Managed Benefits, Inc. - Glen Allen
Tower Benefit Consultants, Inc. - Virginia Beach

WASHINGTON
Albers & Company, Inc. - Tacoma

WEST VIRGINIA
Schwendeman Agency, Inc. - Parkersburg

WISCONSIN
Diversified Insurance Services, Inc. - Brookfield
Hemb Insurance Group, LLC - Madison
Hierl Insurance, Inc. - Appleton, Fond du Lac

WYOMING
Wyoming Benefits & Services, Inc. - Casper

CANADA
Selectpath Benefits & Financial, Inc. - London, Point Edward, Ont.

UNITED KINGDOM
Churchills International Consulting, Ltd. - Edingley, Notts.

UBA PARTNER FIRM SERVICES

Services provided by UBA Partner Firms include, but are not limited to:

- Consultative and Strategic Plan Design Analysis
- Health and Welfare Plan and Qualified Plan Brokerage
- Renewal Pricing Evaluation and Plan Cost Forecasting
- Medical Stop Loss, IBNR, and Reserve Calculations
- Health Care Cost-Containment Strategies
- International Medical Insurance and Travel Insurance Solutions
- Medical Claims Analysis and Individual Predictive Modeling
- Actuarial Consulting: Medical, Retiree Medical, and Pension Plans
- FSA, HRA, HSA, and COBRA Administration
- HR Consulting
- HIPAA Compliance Solutions
- Health Care Claims Auditing Solutions
- Worksite Marketing Programs and Voluntary Product Placement
- Executive Compensation and Benefits Planning
- Personal Financial Planning and Asset Management
- Customized Employee Benefits Website and Document Library
- Web-Based Employee Enrollment and Benefit Communication Systems
- Daily Benefits and HR Updates, Legislative Guides, Document Center, and Links Library
- Merger and Acquisition Due Diligence
- Compliance Webinars, Alerts, and Quarterly Newsletters
- ACA Resource Center
- Private Exchange Solutions
- Wellness Consulting
- Employee Assistance Programs
- Total Compensation Statements
- Prescription Drug Management Solutions
- Stop loss captive

HOW TO OBTAIN ADDITIONAL DATA, RESOURCES, AND EXPERTISE

Data in the 2015 UBA Health Plan Survey are based on responses from 10,804 employers sponsoring 18,186 health plans nationwide. The resulting volume of data provides employers of all sizes more detailed—and therefore more meaningful—benchmarks and trends. No other benchmarking survey mirrors 99% of businesses in the U.S. as accurately as the UBA Health Plan Survey.

The scope of the survey allows regional, industry-specific, and employee size differentials to emerge from the data. In addition, the exceptionally large number of plans represented allows for both a broader range of categories by plan type than traditionally reported and a larger number of respondents in each category. Historically, these types of benchmark data were unavailable to small and midsize employers.

ABOUT UBA

United Benefit Advisors is the nation's leading independent employee benefits advisory organization with more than 200 offices throughout the United States, Canada, and the United Kingdom. As trusted and knowledgeable advisors, UBA Partners collaborate with more than 2,000 fellow professionals to deliver expertise, thought leadership, and best-in-class solutions that positively impact employers and make a real difference in the lives of their employees and families. Employers, advisors, and industry-related organizations interested in obtaining powerful results from the shared wisdom of our Partners should visit UBA online at www.UBAbenefits.com.

SHARED WISDOM. POWERFUL RESULTS.®

With the shared knowledge and expertise of thousands of other UBA benefits professionals, UBA Partner Firms can meet the needs of any size business. UBA Partners help more than 36,000 employers design competitive medical plan strategies to clearly identify cost savings opportunities and encourage employee acquisition and retention. UBA Partners educate nearly 2 million employees and their families to become better health care consumers and lead healthier lives, easing the strain on health care claims and costs. UBA Partners saved employers, on average, 6% on the most recent medical plan renewals.

OUR MISSION

At UBA, we believe in service and genuine sharing through mutual trust. Our culture is one of honesty, transparency, and making others better. It is defined by the values of integrity, collaboration, care for others, innovation, and operational excellence.

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