UBA United Benefit Advisors

UBA HealthPlanSurvey

2016 EXECUTIVE SUMMARY

Benefit Plan Design and Cost Benchmarking Key Results

UBA United Benefit Advisors PARTNER FIRM

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INTRODUCTION

Employer interest in benchmark data has become increasingly important over the past decade, as the cost of providing health care benefits continues to skyrocket, and companies look for new ways to manage those costs. Looking at an employer's costs compared to national and regional benchmarks, and by group size or industry, can provide eye-opening data that is crucial for effectively evaluating total compensation, competing for talent, and retaining a motivated workforce. Practically speaking, benchmarking data drives negotiation strategies, plan design decisions and employee communications.

Since 2005, United Benefit Advisors has surveyed and advised thousands of employers across the nation regarding their health plan offerings, their benefits decisions in the face of significant legislative and marketplace changes, and the impact of these changes on their employees and businesses. The 2016 UBA Health Plan Survey includes the largest number of responses and plans in the history of our survey—19,557 health plans, sponsored by 11,524 employers—and no other benchmarking survey mirrors 99% of businesses in the U.S. as accurately as the UBA Health Plan Survey. While many surveys focus on costs of a handful of large employers, UBA carefully tracks employers of all sizes and types so the data truly represents the cost experiences of the vast majority of business owners.

This year's Executive Summary explores the latest medical cost management trends. Employers and their advisors have astutely held costs in check during the last few tumultuous years—leveraging bargaining power, grandmothering and other protections, balanced with strategic plan design changes. This year is no different, but employers are more prominently focusing on deductibles (particularly out of network), out-of-pocket maximums, prescription drug coverage, and lower cost CDHP and HMO plans over other cost levers tapped in previous years. I encourage employers to begin by understanding these overall trends and then seek the help of a UBA Partner to conduct a more detailed study of your exact plan compared to industry, state, regional, and group size benchmarking data to help you make the best renewal decisions. Knowledge is power, and as we like to say, there's power in our Partners.

In health,

Les McPhearson

CEO, United Benefit Advisors

For more information on how the 2016 survey was conducted, its scope and who participated, see page 23, "About This Survey."

TREND CHECKLIST

Below is a list of the top trends revealed by the 2016 UBA Health Plan Survey. The trends result from the complex legislative changes employers face and their ongoing efforts to manage health care costs.

✓ Cost-shifting, plan changes and other protections work to hold rates steady.

- Increased prevalence and enrollment in lower-cost CDHP and HMO plans.
- "Grandmothered" employers continue to have the options they need to select cheaper plans (ACA-compliant community-rated plans versus pre-ACA composite/health-rated plans) depending on the health status of their groups.
- The Protecting Affordable Coverage for Employees (PACE) Act protects employers with 51 to 99 employees from higher-cost plans.
- Increased out-of-network deductibles and out-of-pocket maximums, as well as prescription drug cost shifting, are among the plan design changes influencing premiums.
- UBA Partners leverage their bargaining power.

✓ Overall costs vary significantly by industry and geography.

- Retail, construction and hospitality employees cost the least to cover; government employees (the historical cost 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).

✓ Plan design changes strain employees financially.

- Employee contributions are up, while employer contributions toward total cost are down.
- Although copays are holding steady, out-of-network deductibles and out-of-pocket maximums are rising.
- Employers' contributions to health savings accounts (HSAs) decreased.
- Pharmacy benefits have more tiers and coinsurance, shifting more prescription drug costs to employees.

✓ PPOs, CDHPs 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.

✓ Overall, wellness program adoption holds steady, but program design is changing.

- Health risk assessments continue to decline, while chronic condition coaching is on the rise.

✓ Metal levels drive plan decisions.

- Most plans are at the gold or platinum metal level. In the future, we expect this to change since it will be more difficult to meet the ACA metal level requirements and still keep rates in check.

✓ Key trends to watch in 2017:

- Slow, but steady: increase in self-funding for all group sizes, decrease in employees electing dependent coverage, increase in plan options, and mail order pharmaceutical programs more for convenience than cost savings.
- Cautious trend: increased CDHP prevalence/enrollment.
- Rapidly emerging: increase of five-tier prescription drug plans, increased out-of-pocket maximums.

SURVEY HIGHLIGHTS & KEY FINDINGS

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

1. Health Plan Options—More than half (53.4%) of all employers offer one health plan to employees, while 28.3% offer two plan options, and 18.3% offer three or more options. The percentage of employers now offering three or more plans (up 4.5% from last year) is of particular interest since it represents nearly a 22.7% 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. Not only do employees get more options, but employers also can introduce lower-cost plans that may attract enrollment, lower their costs and meet ACA affordability requirements.

2. Health Plan Costs—The average annual health plan cost per employee for all plan types is $9,727, a slight decrease from 2015, when the average cost was $9,736. Though overall costs are holding nearly steady, employers are shifting more of the cost to employees, lowering their share from $6,403 in 2015 to $6,350 this year. Employees have seen their average costs edge up from $3,333 in 2015 to $3,378 this year. Factors holding rates steady (as discussed further in this report) include increased prevalence/enrollment in lower-cost CDHP and HMO plans; increased out-of-network deductibles and out-of-pocket maximums; "grandmothering" and the PACE Act, which protect some groups (though not all) from moving to higher-cost plans; reduced prescription drug coverage; and UBA Partners' negotiating power.

Plan Type	Total Cost	Employee Cost	Employer Cost
PPO	$10,134	$3,520	$6,614
HMO	$8,886	$3,186	$5,700
POS	$10,248	$4,207	$6,041
CDHP	$9,391	$2,979	$6,412
EPO	$10,141	$3,567	$6,574
All Plans (Average)	$9,727	$3,378	$6,350

The table above shows the cost breakdown for different plan types. Here is a closer look at data for these plan types.

Health maintenance organizations (HMOs)—HMOs are 9% less costly than the average plan, and their costs actually have decreased 6% from last year. This produces significantly more savings from last year when HMOs were only 3% less expensive than the average plan. However, HMO prevalence and enrollment has remained flat for the last three years, indicating that neither employers nor employees are flocking to these offerings.

Consumer-directed health plans (CDHPs)—Conversely, CDHP plans costs have risen 2% from last year. So while they are still 3.5% less costly than the average plan, they offered more savings last year when they were 5.6% less than the average plan. However, CDHP prevalence and enrollment has grown (as discussed further in this report), indicating interest among both employers and employees.

Preferred provider organizations (PPOs)—PPOs continue to cost more than the average plan—4% more this year, up from 3% last year. Despite this, PPOs still dominate the market in terms of plan distribution and employee enrollment (though they have seen a 4% decrease in prevalence and a 9.2% decrease in enrollment in three years).

TOP 5 INDUSTRIES BY HIGHEST AVERAGE TOTAL COST

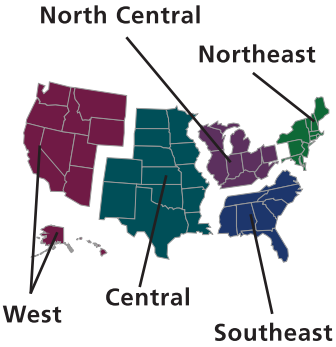
1. *Government/Education/Utilities - $11,443*
2. *Finance and Insurance - $10,414*
3. *Professional/Technology - $9,950*
4. *Manufacturing - $9,922*
5. *Health Care - $9,410*

Point of service (POS) plans—Only 1.7% higher than the average plan cost last year, POS plans are a full 5.2% more expensive than average this year. Representing a very small percentage of the market, POS plans have seen no growth in three years.

When it comes to the employer/employee cost split, employers cover the highest percentage of CDHP costs (68%—though sometimes this is due to decreased employer funding of the health savings accounts that often are part of these plans), versus 65% of PPO costs, 64% of HMO costs, and 59% of POS costs.

3. Costs and Contributions by Industry—Total costs per employee for the retail, construction, and hospitality sectors are 4.3% to 10.7% lower than the average, making employees in these industries among the least expensive to cover. This is typically due to the lower average age among this workforce combined with less rich plans. It's noteworthy, however, that this year these perennial cost leaders didn't have the same savings as last year when they were 8.6% to 21.2% less expensive than average, indicating that costs are rising even in this sector. Employees in the retail and construction sectors pay 6.5% and 7.1% above the average employee contribution, respectively, so employers bear even less of the already low costs in these industries; hospitality employees pay slightly less than the average employee contribution. The government sector again has the priciest plans, costing on average $11,443 per employee. In addition to offering the richest plans, government employers also passed on the least cost to employees—government employees' average contribution is 21% less than average. But this actually includes a significant increase—their contributions, which were 45.2% below average last year, jumped 26.6%. This change may demonstrate that even government employers can't continue to fund their historically generous offerings, particularly in light of the Cadillac tax.

4. Out-of-Pocket Costs—Median in-network deductibles for singles and families across all plans remain steady at $2,000 and $4,000, respectively. (There was, however, an increase in PPO deductibles as mentioned in this report.) When out of network, families again are being hit hardest; their median deductible has risen from $6,000 in 2014 to $7,000 in 2015 to $8,000 in 2016. Singles, who had seen no increase for two years at a $3,000 median out-of-network deductible, are now seeing a 13.3% increase to $3,400. Both singles and families are facing continued increases in median in-network out-of-pocket maximums (up $440 and $300, respectively, to $4,400 and $9,000). 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 to $20,000 in 2016, while singles are holding steady at $9,000.



5. Premium Increases—Premium renewal rates (the comparison of similar plan rates year over year) have increased an average of 5.9% for all plans—up from last year's 5.6% increase. Some smaller groups, hard hit last year, are finding temporary protection with grandmothering and the PACE Act (depending on their state) this year. Other groups are keeping premiums in check by raising out-of-pocket costs for employees and turning to lower-cost CDHP and HMO plans. Average premiums for all employer-sponsored plans are $509 for single coverage and $1,236 for family coverage. For an employee electing single coverage, employers cover 71% of the monthly premium; meanwhile, employers only are covering 54% of a family premium.

6. Prevalence of Plan Type by Region—PPO plans, most prevalent in the Central U.S., generally dominate nationwide, except in the Northeast where CDHPs are most prevalent. CDHP plans have increased 14.2% in prevalence over the last five years.

Plan Type	Northeast	Southeast	North Central	Central	West
PPO	23.4%	43.2%	50.9%	60.2%	44.8%
HMO	20.6%	14.7%	12.0%	7.6%	33.5%
POS	10.5%	14.6%	4.1%	8.1%	6.7%
CDHP	34.4%	26.6%	32.5%	21.0%	14.2%
EPO	10.8%	0.6%	0.6%	2.8%	0.8%

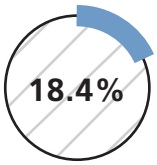
7. Enrollment by Plan Type by Region—PPO plans have the greatest enrollment in the Central U.S., while the Southeast has seen the biggest PPO enrollment gains, 18.7% since last year. HMO enrollment is down across most of the country, but is on the rise in the Central and Western regions. CDHP enrollment, meanwhile, is highest in the Northeast U.S. at 34.9%, an increase of 19.5% from last year and 63.8% over the last five years. Though 54% of U.S. employees are enrolled in PPO plans and only 26.4% are enrolled in CDHP plans, CDHP plan enrollment has increased 69.2% over five years.

Plan Type	Northeast	Southeast	North Central	Central	West
PPO	33.0%	56.4%	55.4%	63.1%	56.7%
HMO	15.2%	11.7%	8.0%	7.1%	24.4%
POS	8.2%	7.9%	2.7%	5.9%	2.1%
CDHP	34.9%	20.9%	32.9%	21.8%	15.1%
EPO	8.3%	2.8%	1.1%	1.6%	1.5%

8. Dependent Coverage—45.2% of all covered employees elect dependent coverage, a 5.4% decrease over the last two years. UBA believes this continued decrease is a trend to watch, since many experts believe higher costs will lead to decreased employer contributions toward dependent coverage. Generally, the larger the group size, the greater the percentage of employees with dependent coverage. Health care employers have the highest percentage of employees with dependent coverage (51%), while the technology sector has the least (37%). Regionally, North Central employers have the highest percentage of employees with dependent coverage (52.1%).

9. Spouse/Partner Coverage—57.3% of all employers provide no domestic partner benefits, the first decrease (6.5%) seen in four years. This may be due to the Supreme Court's decision in *Obergefell v. Hodges*, which legalized same-sex marriage. As a result, many employers are covering legal spouses only. More than one-third (35.8%) of all plans provide coverage for both same-sex and opposite-sex domestic partners, a 19.3% increase from last year. Larger employers (1,000+ employees) provide the most same-sex domestic partner coverage, with 48.5% of their plans offering this benefit. The hospitality and technology industries, as well as employers in the West, also provide the most same-sex domestic partner coverage (46.7%, 46% and 67.9%, respectively).

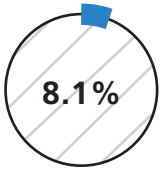
10. Infertility Services—In 2016, plans are slightly more apt to offer only evaluation benefits or no infertility coverage at all. A little more than one-third (35.7%) of all plans provided no benefits for infertility services (a 4.4% increase from last year). Meanwhile, 37.5% of plans provided benefits for evaluation only (a 2.2% increase), and 26.9% provided benefits for evaluation and treatment (a 7.2% decrease). Surprisingly, HMO plans tend to lead in infertility care, with 40% providing "full" (that is, evaluation and treatment) infertility benefits. Larger groups (500+ employees), the health care and hospitality industries, and Northeast employers also have the highest percentage of plans offering full infertility care (31.3%, 30.4% and 59.1%, respectively).



11. Comprehensive Wellness Programs—18.4% of all employers offer comprehensive wellness programs, nearly the same as last year. Of these employers, 72.5% include health risk assessments, 67.7% offer employee incentives for participation, 67% offer biometric screenings or physical exams, 54.6% include on-site or telephone coaching for high-risk employees, and 38.8% include seminars or workshops. The use of health risk assessments continues to decrease, dropping 10.5% in three years. Compared to 2015, telephone coaching for high-risk employees is up 7.5% and seminars/workshops are down 8.5%. Wellness programs are most prevalent among Northeast employers, CDHP plans, plans sponsored by health care employers, and larger groups (100 to 1,000+ employees)—25.5%, 26.7%, 30.6%, and 24.9% to 60.3%, respectively.

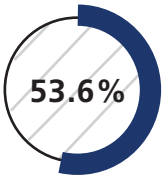
12. Bonuses to Waive Coverage—Fewer employers are offering bonuses to waive coverage, but for those that do, the bonus amount is on the rise. Only 2.8% of employers offered a bonus to employees to waive medical coverage in 2016, a 20% decrease from three years ago. The average annual single bonus in 2016 is $1,884, a 12% increase from last year. Opt-outs are under increasing scrutiny by multiple federal agencies. In particular, the Centers for Medicare and Medicaid Services (CMS) has begun looking into whether opt-outs, even when offered to all employees, violate the prohibition to offer incentives to Medicare-eligible employees or their spouses to leave the group health plan. In addition, the IRS is issuing regulations to make unconditional opt-outs part of the affordability calculation (which hurts employers), and opt-outs cannot be used to pay for individual premiums. This increased scrutiny has led employers to drop opt-outs before they become a compliance problem.

13. Grandfathering—The percentage of grandfathered plans continues to decline. Only 5.9% of plans are considered grandfathered plans, compared to 8% in 2015. Grandfathering allows 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 Affordable Care Act (ACA). Typically, plans lose their grandfathered status by making changes that reduce benefits or increase the employee's cost for benefits. Although grandfathered health plans have no regulatory expiration, the strict limitations on acceptable changes to plans and employee cost of coverage lead to a natural tendency for employers to drop their grandfathered plan once it is no longer financially or practically feasible.



14. Grandmothering—Similarly, just 8.1% of plans are considered "grandmothered," compared to 17% in 2015. Grandmothering continues to provide some small employers the option to temporarily maintain a pre-ACA health plan, but is in its sunset years. Only 35 states recognize grandmothered plans, and the last grandmothered plans expire in December 2017, due to regulation.

15. Self-Funding—Overall, 12.5% of all plans are self-funded, up from 12.2% in 2015, while slightly less than two-thirds (62.9%) of all large employer (1,000+ employees) plans are self-funded. Self-funding has always been an attractive option for large groups, but 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. Self-funding may be particularly attractive to small employers with healthy groups since fully insured community-rated plans under the ACA don't give them any credit for a healthy population.



16. Prescription Drug Plans—For the first time, prescription drug plans with four or more tiers are exceeding the number of plans with one to three tiers. More than half (53.6%) of prescription drug plans have four or more tiers, while 46.4% have three or less. Increased tiering defrays the cost of more expensive drugs, so it's not surprising that it's a rapidly growing cost control strategy. Employers are also moving away from copay-only payment structures, favoring coinsurance and blended copay/coinsurance models to further contain costs. A little more than half (54.5%) of prescription drug plans utilize copays only, down from 61.5% last year, while nearly 40% of plans have coinsurance/blended models, an increase of nearly 16% from last year. Median retail copays have remained unchanged: $10/$30 for two-tier plans, $10/$35/$60 for three-tier plans, and $10/$35/$60/$100 for four-tier plans.

IN DEPTH ON THE ISSUES

IMPACT OF THE ACA

This section delves deeper into the major findings of the 2016 survey and explores some of their implications for the future of health care plans and the possible consequences for employers and employees.

As the sixth year of ACA implementation and regulation draws to an end, employers continue to change their plan designs in order to offer benefits that both meet federal regulations and appeal to their employees. In this section, we look at some of the key impacts of the ACA.

Plan Type	Renewal Rate Increase
CDHP	5.4%
PPO	6.1%
HMO	5.5%
POS	6.9%
EPO	5.1%
Overall Average	5.9%

Premium Rate Trends

Premium renewal rates (the comparison of similar plan rates year over year) have increased an average of 5.9% for all plans—up from last year's 5.6% increase. Some smaller groups, hardest hit last year, are finding temporary protection this year through grandmothering and the PACE Act (depending on their state).

Grandmothering provides some small employers the option to maintain a pre-ACA health plan. Although not every state allows grandmothering of policies and not all insurance carriers offer the option in those states endorsing it, there are still some employers in the 35 states that allow grandmothering who are able to be composite rated (rates based on the health status of the group), which protects young, healthy groups in particular. Grandmothered groups with older, unhealthy populations could still move to community-rated ACA-compliant plans, which were generally less costly for them, giving all groups the flexibility to save money. Though this grandmothered group is shrinking (8.1% of all plans), these employers have helped to keep overall average increases in check. They could, however, see increases next year, when their plan costs will begin to reflect the expiration of grandmothering (the last grandmothered plans expire in December 2017, due to regulation).

The PACE Act protects some employers with 51 to 99 employees from community rating and its associated rate increases. Community rating, which affects the small group and individual markets, is a policy in which personal factors used by an insurer to determine premium rates are very limited in scope and are not based on the health status of the group's employees. 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 the PACE Act amended the ACA to keep the small employer definition of 50 or fewer employees and allow states to move to 100 if they wish—a factor which determines whether a plan must be composite or community rated. States like California chose to define small employers as those with 100 or fewer employees, limiting protections and options for small groups.

Employers not under the protection of grandmothering or the PACE Act have kept premiums in check by raising deductibles and out-of-pocket maximums for employees, reducing prescription drug coverage, and turning to lower-cost CDHP and HMO plans (as described in this report). Average premiums for all employer-sponsored plans are $509 for single coverage and $1,236 for family coverage. For an employee electing single coverage, the employer covers, on average, 71% of the monthly premium, and only 54% of a family premium.

Looking closely at a handful of employers and their experiences year over year under the ACA, there has been no protection from significant health care cost increases over time under the law. Even if employers succeeded in keeping some plan costs contained or features unchanged, they (and their employees) have seen consistent cost increases or decreased benefits in other areas of their plan design.

Five over Five: Analysis of Five Employers over Five Years of the ACA

Employer Profile: Company in South Carolina, approximately 200 employees
Plan Type: Fully insured, non-grandmothered PPO high-deductible health plan, with HSA
Plan Design: Higher than average deductibles and out-of-pocket maximums than a standard PPO plan, but in line with average high deductible plans
Benefit Strategy: Keep the high deductible plan without increasing out-of-pocket costs for employees.
Cost Impact: Average single premiums increased 49% and average family premiums increased 37.6% over five years.

Employer Profile: Company in Texas, approximately 100 employees
Plan Type: Fully insured, non-grandmothered HMO with no HSA or HRA
Plan Design: Average deductibles and above-average out-of-pocket maximums
Benefit Strategy: Keep premiums flat.
Cost Impact: Average single and family premiums decreased 1.7% and 1.8%, respectively, however, out-of-pocket maximums and deductibles increased significantly over five years (for example, median in-network single deductibles rose 33.3% and median in-network out-of-pocket maximums rose 42.9%). Plus, employer costs rose 433%.

Employer Profile: Company in California, approximately 45 employees
Plan Type: Fully insured, non-grandmothered HMO with no HSA or HRA
Plan Design: Below-average out-of-pocket maximums, no in-network deductible, below average copays
Benefit Strategy: Keep in-network out-of-pocket costs low, and premium increases modest.
Cost Impact: Average single and family premiums increased approximately 16% over five years. Deductibles and out-of-pocket maximums remained unchanged. However, employees pay 100% of cost for any out-of-network health claims.

Employer Profile: Company in California, grew from 65 to 100 employees
Plan Type: Fully insured, non-grandmothered HMO with no HSA or HRA
Plan Design: Below-average out-of-pocket maximums, no in-network deductible, below average copays
Benefit Strategy: Keep the plan design the same with no changes in deductibles and out-of-pocket maximums
Cost Impact: Average single and family premiums increased approximately 37% over five years. Although the plan design has remained unchanged, premiums today are significantly above average.

Employer Profile: Company in Iowa, grew from more than 24,000 to 31,000 employees
Plan Type: Non-grandfathered, self-funded PPO, with no HSA or HRA
Plan Design: Standard and premium plan options, both with below-average deductibles and out-of-pocket maximums
Benefit Strategy: Keep premiums low for singles and keep out-of-pocket costs low for everyone.
Cost Impact: Under the standard plan, single deductibles and out-of-pocket maximums remained unchanged and well below average, but premiums for singles increased 32% over five years. Families under the standard plan kept largely the same low deductibles and out-of-pocket maximums, but their average premiums rose 64.8% over five years. Under the premium plan, deductibles and out-of-pocket maximums for singles and families were higher than under the standard plan, but still significantly below average. However, average single premiums increased 14.7% and family premiums increased 43% over five years.

Looking at premium changes among different size groups, most groups are experiencing slightly increased premiums, but the smallest employers (who were hit hardest last year) are seeing a rare decrease. Average single premiums in companies with fewer than 25 employees decreased 4.1%, going from $540 in 2015 to $518 in 2016 (still above average, and a 12% increase over five years). The decrease didn't extend to families, however. Average family premiums in these groups rose from $1,221 in 2015 to $1,245 in 2016

(above average, and an 11.8% increase over five years)—likely due to age rating under the ACA, which is driving average family costs up (compared to flat family rates under composite rating), and younger dependents finding coverage elsewhere, leaving an older, more costly population.

Regionally, most groups are experiencing slightly increased premiums, although California has enjoyed an 11.4% decrease in average single premiums. The Golden State's single premiums have dropped from $595 in 2015 to $527 in 2016 (average family premiums did not decrease, going from $1,298 in 2015 to $1,306 in 2016). The state's employers are moving away from more expensive PPO plans (UBA finds a 9% decrease in these plans in this region) and toward lower-cost HMO plans (a 6.8% increase). Combined with an 8% increase in HMO enrollment—along with cost shifting and grandmothering likewise affecting the rest of the country—these changes sparked the premium decreases. Although their premiums are still higher than average, California tends to be a trendsetter, making this a trend to watch overall, keeping in mind that cost-saving strategies like cost shifting should be taken with a grain of salt, given the increased burdens they place on employees.

UBA Partners also help keep premiums in check by bringing their bargaining power to bear for 11,524 employers with 19,557 plans nationwide. Comparing proposed rates from carriers to final rates, UBA Partners offered approximately 44% 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 and region, UBA Partners were able to offer above-average savings in the health care industry and among Northeast employers.

What Does the Future Hold for Rate Trends?

Although ACA implementation is well underway, continued regulatory guidance will shape plan design and costs going forward. The industry is still awaiting federal guidance on non-discrimination for fully insured group health plans, which could affect plan design. Similarly, Cadillac tax implementation remains on the horizon, but has been delayed to 2020, versus the original implementation date of 2018. Many employers are expected to trim down their group health plans or consumer-based accounts once it is understood how plan value will be calculated.

Federal agencies also confirmed that, beginning in 2016, self-only cost-sharing limitations 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 is $6,550 for high-deductible health plans (HDHPs) and $6,850 for non-HDHPs.

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 the way employers select their cost-sharing limits. Plans can still have an aggregate family deductible as long as it is less than the self-only out-of-pocket limit. In practice, the new self-only cost-sharing limitations will affect plans with a family out-of-pocket maximum that is over the self-only limit.

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.

Although overall costs have held steady, employers have lowered their share of the bill from $6,403 in 2015 to $6,350 this year, while employees have watched their average costs edge up from $3,333 in 2015 to $3,378 this year. The good news for employees is median in-network deductibles for singles and families are holding steady at $2,000 and $4,000, respectively. On the other hand, out-of-network deductibles are spiking. Families again have been hit hardest: their median out-of-network deductible has jumped from $6,000 in 2014 to $7,000 in 2015 to $8,000 in 2016. Singles, who had been holding steady for two years at a $3,000 median out-of-network deductible, have seen a 13.3% increase to $3,400. Since deductible increases help employers avoid premium increases, we will likely see this trend continue, especially as insurance carriers are required to meet the ACA metal levels.



Both singles and families also are seeing continued increases in median in-network out-of-pocket maximums (up $440 and $300, respectively, to $4,400 and $9,000). 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, to $20,000 in 2016, while singles have remained steady at $9,000. Out-of-network expenses are not subject to ACA limitations, so they'll likely continue to skyrocket with more plans eliminating out-of-pocket maximums for non-network services. Looking at deductibles and out-of-pocket costs just among the ever-dominant PPO plans, in-network and out-of-network deductibles for families and singles are generally below average (see chart). However, the median in-network single deductible for PPO plans has jumped 50%, going from $1,000 in 2015 to $1,500 in 2016, a significant increase given that nearly half of all employees enroll in PPO plans.

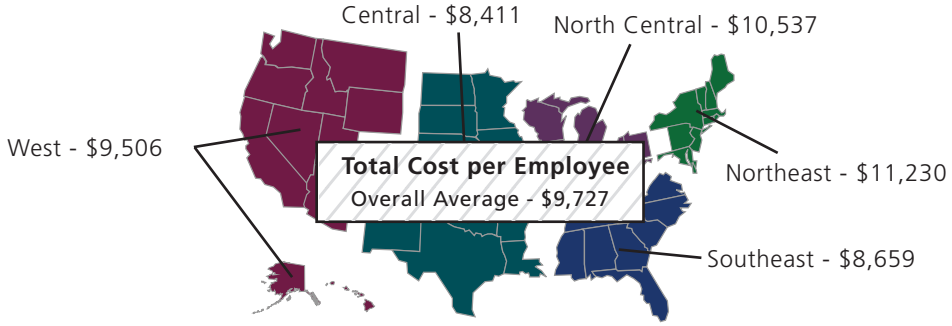
PPO	In-Network Benefits	Out-of-Network Benefits
Single Deductible	$1,500	$3,000
Family Deductible	$3,000	$6,000
Single Out-of-Pocket Maximum	$4,000	$8,000
Family Out-of-Pocket Maximum	$9,000	$18,000

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, especially given the regional or state-by-state nature of health care and insurance.

Costs by Region

Overall costs per employee are relatively flat: $9,727 in 2016, a slight decrease from the average cost in 2015 of $9,736. However, regional cost averages vary, making it essential to benchmark both nationally and regionally. For example, 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 lower deductibles, contain more state-mandated benefits, and feature higher in-network coinsurance, among other factors. Compared to last year, regional costs have edged up a modest 1.4% to 2.7% with the exception being the West, which is enjoying a 6.4% decrease in costs due to a shift away from more expensive PPO plans to more cost-effective HMO plans. When looking regionally at employee contributions toward these costs, on average employees pay $3,378 of the total cost, but in the Northeast, employees pay nearly 16% more than average, while employees in the North Central U.S. pay 8% less than average.





Costs by Industry

Costs by industry also vary, making it important for employers to benchmark by industry.

Industry	Average Cost per Employee
Government, Education, Utilities	$11,443
Financial, Insurance, Real Estate	$10,414
Professional, Scientific, Technology Services	$9,950
Manufacturing	$9,922
Health Care, Social Assistance	$9,410
Wholesale, Retail	$9,312
Construction, Agriculture, Transportation	$9,178
Information, Arts, Accommodations & Food	$8,688
All Plans	$9,727

Total costs per employee for the retail, construction, and hospitality sectors are 4.3% to 11.3% lower than average, making employees in these industries among the least expensive to cover. This is typically due to the lower average age among this workforce combined with less rich plans; however, it's noteworthy that this year these perennial cost leaders didn't have the same savings as last year when they were 8.6% to 21.2% lower than average, indicating that costs are rising even in this sector. Employees in the retail and construction sectors pay 6.3% and 6.8% above the average employee contribution, respectively, so employers bear even less of the already low costs in these industries; hospitality employees pay slightly below the average employee contribution.

On the other end of the cost spectrum, the government sector has the priciest plans ($11,443 per employee). In addition to offering the richest plans, government employers also pass on the least cost to employees, whose average contributions are more than 23% less than average. Surprisingly, these employees are experiencing sticker shock this year since they've seen a 26.6% increase in their contributions, which were 45.2% below average last year. This change may demonstrate that even government employers can't continue to fund their historically generous offerings, especially when taxpayers are footing the bill and their pricey plans are potentially at risk of facing the forthcoming Cadillac tax.

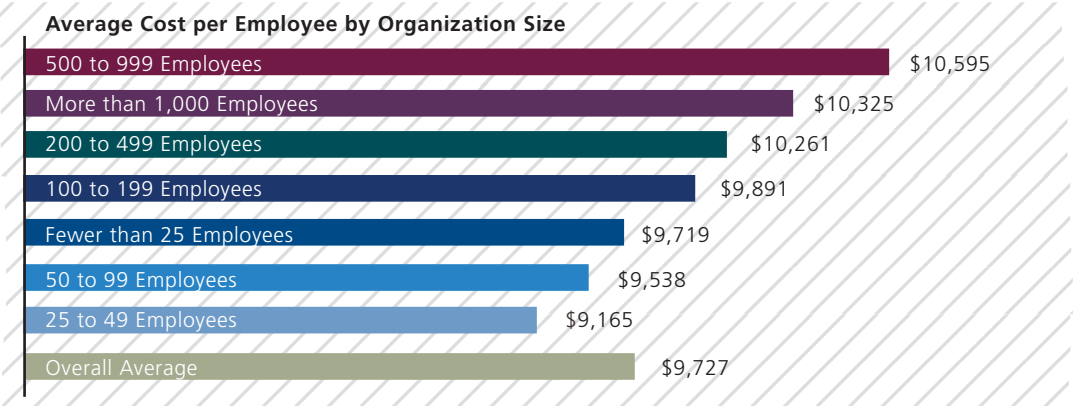
Employer/Employee Contribution by Industry in 2016

Average Contribution by Industry in 2016	Employer	Employee
Construction, Agriculture, Transportation	$5,560	$3,618
Wholesale, Retail	$5,716	$3,596
Professional, Scientific, Technology Services	$6,402	$3,548
Financial, Insurance, Real Estate	$6,978	$3,436
Manufacturing	$6,664	$3,258
Information, Arts, Accommodations & Food	$5,452	$3,237
Health Care, Social Assistance	$6,200	$3,210
Government, Education, Utilities	$8,778	$2,665
All Plans	$6,350	$3,378

Costs by Organization Size

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 2015 due to these employers' ability to negotiate better rates and the fact that, unlike small groups, they are not required to comply with age and community rating, which drives costs higher.

For small groups, grandmothering and the PACE Act have helped contain or even slightly decrease costs. Employers not under the protection of grandmothering or the PACE Act, meanwhile, have kept premiums in check by raising deductibles and out-of-pocket-maximums for employees, reducing prescription drug coverage, and turning to lower-cost CDHP and HMO plans.



Employees' share of the annual cost directly correlates to employer size—the larger the group, the less employees typically pay. Employees at the smallest employers (fewer than 25 employees) pay on average 41% of the total cost, while employees at the largest employers pay 27% of the total cost.

OUT-OF-POCKET COST BENCHMARKING SNAPSHOT

Average in-network and out-of-network deductibles, out-of-pocket maximums, copays, and prescription copays for 2015 and 2016

Costs (All Plans)	2016	2015	% Change
Average In-Network Deductible—Single	$2,127	$2,031	4.7%
Average In-Network Deductible—Family	$4,632	$4,462	3,8%
Median In-Network Deductible—Single	$2,000	$2,000	—
Median In-Network Deductible—Family	$4,000	$4,000	—
Average In-Network Out-of-Pocket Maximum—Single	$4,407	$4,209	4.7%
Average In-Network Out-of-Pocket Maximum—Family	$9,165	$8,875	3.3%
Median In-Network Out-of-Pocket Maximum—Single	$4,440	$4,000	11.0%
Median In-Network Out-of-Pocket Maximum—Family	$9,000	$8,700	3.4%
Average Out-of-Network Deductible—Single	$4,128	$3,869	6.7%
Average Out-of-Network Deductible—Family	$9,068	$8,507	6.6%
Median Out-of-Network Deductible—Single	$3,400	$3,000	13.3%
Median Out-of-Network Deductible—Family	$8,000	$7,000	14.3%
Average Out-of-Network Out-of-Pocket Maximum—Single	$9,611	$9,301	3.3%
Average Out-of-Network Out-of-Pocket Maximum—Family	$20,358	$19,921	2.2%
Median Out-of-Network Out-of-Pocket Maximum—Single	$9,000	$9,000	—
Median Out-of-Network Out-of-Pocket Maximum—Family	$20,000	$18,000	11.1%
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	$200	$150	33.3%
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	$60	—
Tier 4 Median Prescription Retail Copay in 4-Tier Plan	$100	$100	—

As many analysts projected this past year, premiums continue to rise, prompting many employers to manage this expanding price tag by shifting costs to their employees.

Having experienced significant median in-network deductible increases for singles last year, employers overall chose to keep the median single and family in-network deductibles flat this year at $2,000 and $4,000, respectively. A more detailed look at the median deductibles within plan types, however, reveals that the median in-network deductible on an employer-sponsored PPO health plan has increased 50%, from $1,000 to $1,500 in 2016, which is particularly noteworthy given nearly half of all employees enroll in PPO plans.

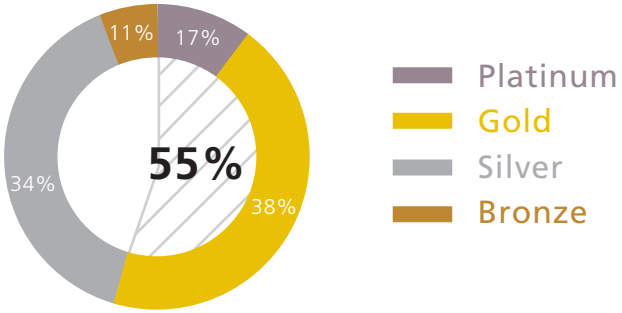
Out-of-network deductibles have also spiked. Singles, who had been holding steady for two years at a $3,000 median out-of-network deductible, saw a 13.3% increase to $3,400. Families, after seeing a 16.7% increase last year, have been hit again. Their median out-of-network deductible has risen from $6,000 in 2014 to $7,000 in 2015 to $8,000 in 2016.

Further, both singles and families are seeing continued increases in median in-network out-of-pocket maximums (up $440 and $300, respectively, to $4,400 and $9,000), following similar increases last year (14.3% for singles, 8.8% for families). Expect this trend to continue, as raising out-of-pocket maximums is a preferred cost containment strategy over raising copays or other cost levers, especially since the impact is minimal for employees who can stay in-network. Median out-of-network out-of-pocket maximums have skyrocketed for families, going from $16,000 in 2014 to $18,000 in 2015 to $20,000 in 2016; singles, however, have held steady at $9,000.

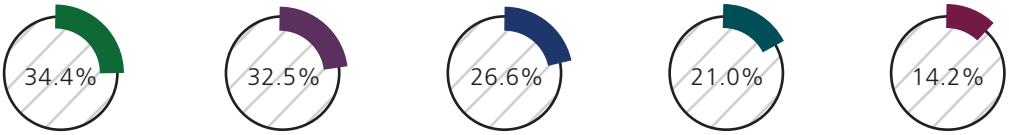
Copays, on the other hand, have remained virtually unchanged again this year (except for median emergency room copays, which have risen from $150 in 2015 to $200 this year). Employers are reticent to increase copays and are looking at other cost levers instead (such as deductibles and out-of-pocket maximums discussed here, as well as increased share of premium and decreased prescription drug benefits as discussed elsewhere in this report).

SPOTLIGHT ON KEY PLAN TRENDS

Trend #1: More than half (55%) of respondents' plans reached gold or higher metal level, up from 54% last year. While gold and platinum plans are more likely to have the lower out-of-pocket maximums (versus the maximum allowed by law, which is found more on silver and bronze plans), deductibles can take a hit as a result (as they did this year) in order to avoid premium hikes and still meet the ACA metal level. Gold and platinum plans tend to reflect pre-ACA benefit levels, so employers are actively trying to keep these levels for as long as possible. If the overall costs can't continue to be managed, or the employee financial burden becomes too great, we could see an increase in silver and bronze plans in the future.



Trend #2: Growth in CDHPs—25.7% of all plans are CDHPs, 14.2% more than five years ago. Regionally, CDHPs account for the following percentage of plans offered.



CDHPs have increased in prevalence in all regions except the West, which saw the number of these plans decrease by 7.2% from 2015. The North Central U.S. saw the greatest increase (9.4%) in the number of CDHPs offered.

Employers offering the most CDHPs	Employers avoiding CDHPs
Northeast and North Central employers	Western employers
Employers with 50-199 or 1,000+ employees	Employers with fewer than 25 employees
Finance, government and technology employers	Construction, hospitality and retail employers

When it comes to enrollment, 26.4% of employees enroll in CDHP plans overall, an increase of 21.7% from last year and nearly 70% from five years ago, when enrollment levels were only at 15.6%. CDHPs see the most enrollment in the Northeast U.S. at 34.9%, an increase of 19.5% over 2015 and 63.8% over the last five years. However, in the Northeast, CDHP prevalence and enrollment are nearly equal; CDHP prevalence doesn't always directly correlate to the number of employees who choose to enroll in them. Though the West saw a decrease in the number of CDHPs offered, there was an 18.9% increase in the number of employees enrolled. The 9.4% increase in CDHP prevalence in the North Central U.S. garnered a surprising 46.2% increase in enrollment.

CDHP interest among employers isn't surprising given these plans are 3.5% less costly than the average plan. Employees typically pick up 32% of the cost, slightly below the 35% average employee contribution rate among all plans, making them an attractive choice for many employees as well. But like all cost benchmarks, plan design plays a major part in understanding value. The UBA survey finds the average CDHP benefits are as follows:

CDHP	In-Network Benefits	Out-of-Network Benefits
Single Deductible	$2,600	$5,000
Family Deductible	$5,200	$10,000
Coinsurance Percentage	100%	60%
Single Out-of-Pocket Maximum	$5,000	$10,000
Family Out-of-Pocket Maximum	$10,000	$20,000

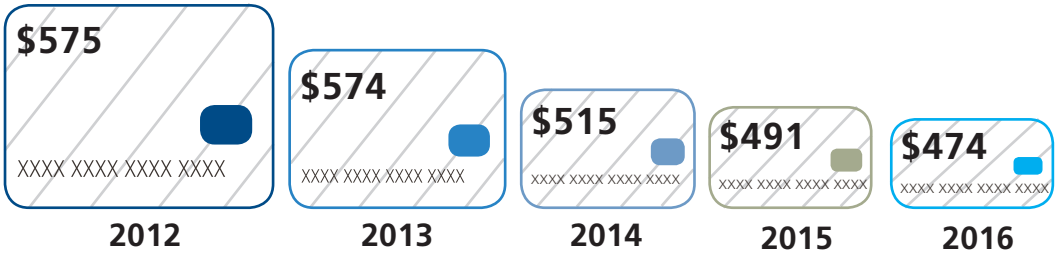
Although CDHP prevalence and enrollment are on the rise overall, there have been regional spikes and dips in this trend every year (for example, the move away from CDHPs to HMOs in the West this year and a CDHP decrease in the Southeast last year). Given the higher than average out-of-pocket costs of CDHPs, this turbulence indicates that employers and employees are still determining the value and success of these plans, making it a cautious upward trend to watch. For employers struggling with the cost of health care in relation to the affordability requirements for applicable large employers, CDHPs can help provide a middle ground.

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

Survey results show that 35.1% of all plans offer a health savings account (HSA) or health reimbursement account (HRA), which is up from 34% in 2015, a 3.2% increase.

An HSA is offered in 24.6% of plans, a 21.8% increase from five years ago. HSA enrollment is at 17%, a 25.9% increase from 2015, and nearly a 140% increase from five years ago. The average employer contribution to an HSA is $474 for a single employee (down 3.5% from 2015 and 17.6% from five years ago) and $801 for a family (down 9.2% from last year and 13.7% from five years ago).

Average HSA Single Contribution



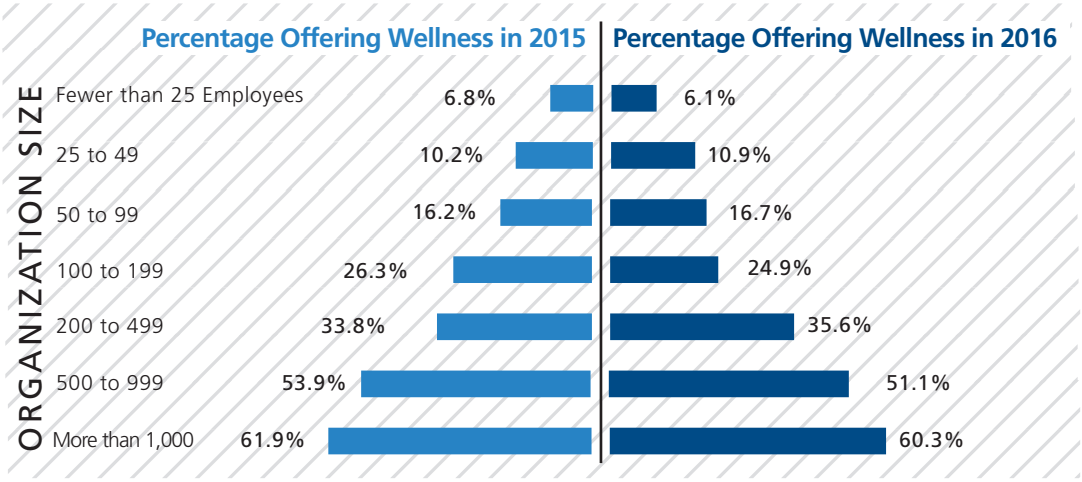
The prevalence of HRAs has remained flat over the last five years at 10.5%, with HRA enrollment at 10.7%, up 23% from five years ago. The average employer contribution for an HRA is $1,810 for a single employee and $3,545 for a family, up approximately 2% from 2015.

As employers seek to find affordable health benefit options for their workforce, a continued drive to HRAs, or CDHPs with HSAs, is expected. These plan designs are often provided at a lower cost than more traditional plan arrangements. HRAs tend to be more complex to implement, hence their flatter growth rate, while HSAs are typically easier to understand and are therefore increasing in prevalence and enrollment at higher rates.

	2015	2016
HSA Enrollment	13.5%	17.0%
HRA Enrollment	8.7%	10.7%

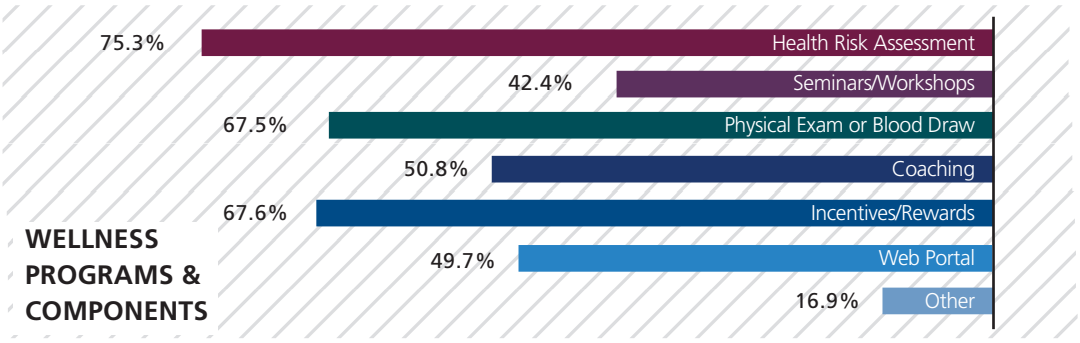
WELLNESS PROGRAM DATA

Wellness programs are offered by 18.9% of all employers, 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. Despite the resulting compliance concerns, employers continue to offer wellness programs because of the powerful benefits associated with properly designed and communicated programs: healthier employees, higher productivity, reduced absenteeism, and positive impact on company culture. They are being very cautious with program design, and 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 has re-empowered employers to implement premium differentials for wellness participation and tobacco use. However, many are likely wary of the EEOC's new guidance regarding wellness programs that include health risk assessments, biometric screenings and medical exams. How those regulations influence plan design remains to be seen.

Among employers offering wellness programs, 72.5% include health risk assessments, 67.7% offer employee incentives for participation, 67% offer biometric screenings or physical exams, 54.6% include on-site or telephone coaching for high-risk employees, and 38.8% include seminars or workshops. The use of health risk assessments continues to decrease, dropping 10.5% in three years. Compared to 2015, telephone coaching for high-risk employees is up 7.5% and seminars/workshops are down 8.5%.



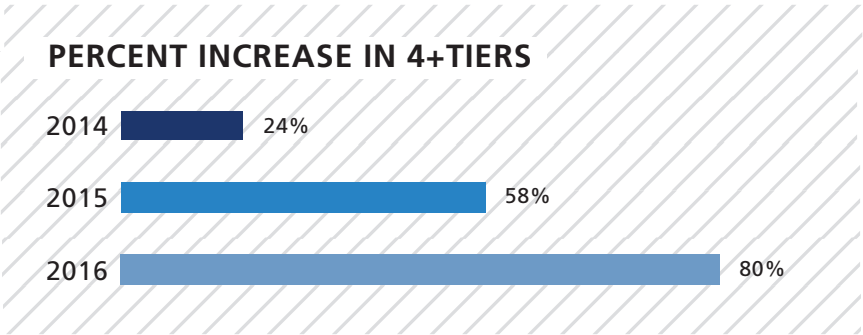
Regulations aside, employers and wellness consultants are increasingly using claims data as a replacement for the health risk assessment. In general, health risk assessments are subjective, which calls their relevance into question. Many employees complain about the content and length of time it takes 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 10% to 20% percent of employees typically drive 70% to 80% of the high cost claims, supporting those with chronic or high-risk conditions is as important as keeping the healthy employees healthy. As a result, an increase in telephonic coaching for high-risk employees is a growing component of wellness programs. Wellness programs continue to evolve, especially in the ways they connect with employees and assist them in making lifestyle improvements. Changes in the methods of delivery and the tools used in programming are a normal part of growth.

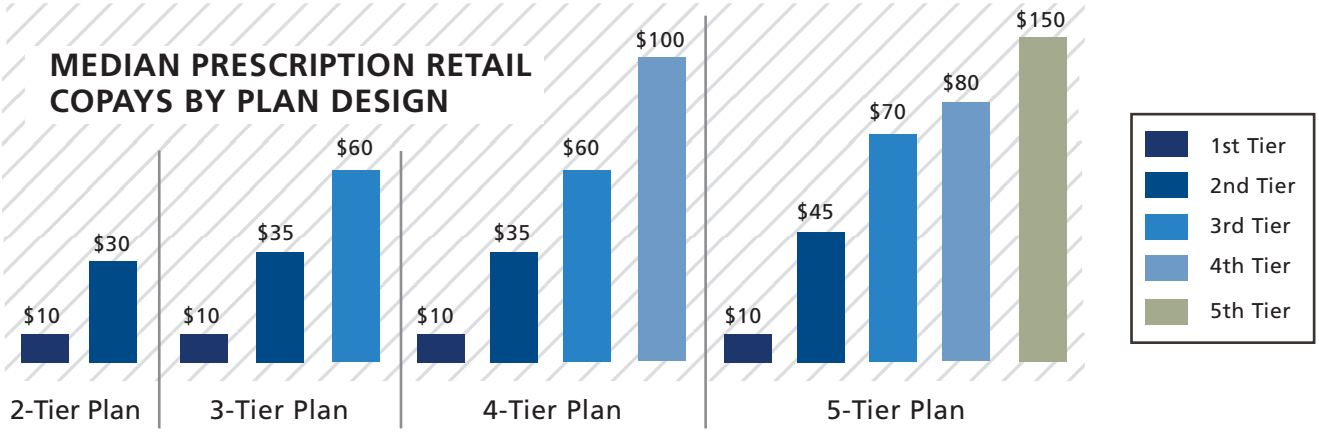
PRESCRIPTION PLAN DATA

Copays and Coinsurance Models: 54.5% of prescription drug plans use copays only, down 11.4% from last year (61.5%), while nearly 40% of plans have coinsurance/blended models, an increase of nearly 16% from last year. Breaking down coinsurance-only models versus blended copay/coinsurance models, 6.9% of plans use only coinsurance—a 64.3% increase from last year (4.2%). Meanwhile, 33% of plans use a blended copay/coinsurance model, up slightly from last year (30.2%). In blended copay/coinsurance models, 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 an employer'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. With coinsurance or blended copay/coinsurance models on the rise after being virtually nonexistent five years ago, the move away from a copay-only plan design continues.

Tiers: 40.7% of prescription drug plans use three tiers (generic, formulary brand and non-formulary brand), down 16.8% from 2015 (48.9%). For the first time, the percentage of four-tier plans (41.6%) surpasses the percent of three-tier plans. And with a rapidly emerging 10% of plans using five tiers and 2% using six tiers, a whopping 53.6% of plans offer four tiers or more, a 21.5% increase from last year and nearly a 55.5% increase in just two years. The fourth and additional tiers pay for biotech drugs, which are the most expensive. By segmenting these drugs into other categories with significantly higher copays, employers are able to pass along a little more of the cost of these drugs to employees. Over the last three years, the number of 4+ tier plans grew nearly 80%, making this a rapidly growing strategy to control costs. Meanwhile, only 3% of plans use two tiers and just 2.7% of plans use a single tier.



Copay Amounts: Median retail copays are $10/$30 for two-tier plans; $10/$35/$60 for three-tier plans; and $10/$35/$60/$100 for four-tier plans. These amounts have remained largely flat since 2014. Generic drugs in the lowest tier generally cost the least, so employees are often 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 three-tier models, the tier 3 copay did increase from $50 to $60, likely in an effort to control the soaring costs of non-formulary brand drugs. The first UBA-reported median copays for five-tier plans are $10/$45/$70/$80/$150.



Brand vs. Generic: In 62.7% of plans, employees are required to pay more when they elect brand-name drugs over an available generic drug (a 7% increase from 2014); 39.1% of those plans require the added cost even if the physician notes "dispense as written." And 34% of plans offer no added cost coverage for brand name drugs (down 8.6% from last year). 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 require they 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 (36.3%) of prescription drug plans provide a 90-day supply at a cost of two times retail copays, while only 3.9% of plans require a single retail copay for mail order. Meanwhile, 4.2% of plans now provide no reduced copay incentive for using mail order (keep in mind that some states prohibit mail order incentives). 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.

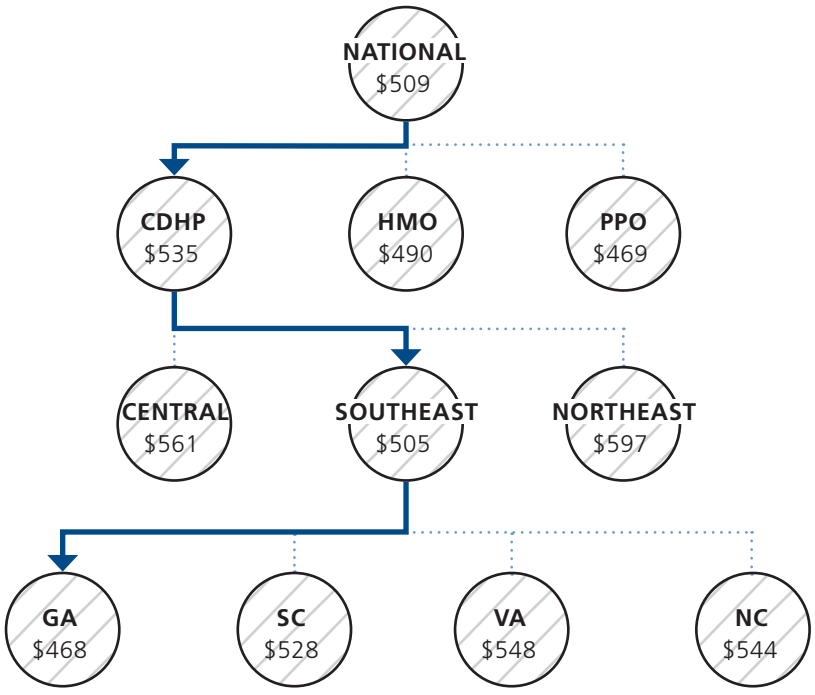
MORE GRANULAR IS MORE ACCURATE

"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 2016 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 manufacturing plant in Georgia that offers a PPO. Its premium cost for single coverage is $507 per month. Compare this with the benchmarks for all plans and you can see that it is $2 per month less than the national average. When compared with other PPOs in the Southeast region, this employer's cost is actually $2 more 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 $468. Bottom line, this employer's monthly single premium is actually $39 more than its competitors in the state.

If you were an employer in Georgia with a PPO, 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 2016 UBA Health Plan Survey are based on responses from 11,524 employers sponsoring 19,557 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 2016 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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Beneflex Insurance Services, LLC - Santa Barbara
Brooks Jucha & Associates - San Diego
California Corporate Benefits Insurance Services - Poway
Fredericks Benefits - Redlands
Hanna Global Solutions - Concord
Horstmann Financial and Insurance Services - Fresno
Innovative Cost Management Services - San Jose
Johnson & Dugan Insurance Services Corporation - Daly City
KBI Benefits, Inc. - Cupertino
Maniaci Insurance Services, Inc. - Palos Verdes
The Vita Companies - Mountain View

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

Connecticut
Blueprint Benefit Advisors - Hamden
Kuveke Benefits, LLC - Ridgefield

Florida
The Clemons Company - Panama City
Coordinated Benefits Group - Jacksonville
Earl Bacon Agency, Inc. - Tallahassee
GCD Insurance Consultants, Inc. - Tampa
K&P Benefits Consulting Group - Sarasota
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
Snellings Walters Insurance - Atlanta

Hawaii
Atlas Insurance Agency, Inc. - Honolulu

Idaho
Fredriksen Health Insurance, LLC - Boise

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

Indiana
Benefits 7, Inc. - Evansville, Vincennes
The DeHayes Group - Fort Wayne
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 Associates, Inc. - Laurel, Rockville, Towson
Insurance Solutions - Annapolis, Prince Frederick

Massachusetts
Borislow Insurance - Methuen
EBS - Newton
The Gaudreau Group - Wilbraham
Sullivan Benefits - Marlboro

Michigan
44North - Cadillac, Grand Rapids, Marquette, Saginaw
BenePro - Royal Oak
Comprehensive Benefits, Inc. - Southfield
Keyser Insurance Group - Kalamazoo
Saginaw Bay Underwriters - Saginaw
Strategic Services Group, Inc. - Rochester Hills
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 - Jefferson City, Columbia

Nebraska
Swartzbaugh-Farber & Associates, Inc. - Omaha

Nevada
Benefit Resource Group, LLC - Reno

New Hampshire
Granite Group Benefits, LLC - Manchester
Melcher & Prescott Insurance - Laconia

New Jersey
Innovative Benefit Planning, LLC - Moorestown
Katz/Pierz, Inc. - Cherry Hill

New York
Austin & Co., Inc. - Albany
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
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
Lehigh Valley Benefits Group, Inc. - Allentown
Lillis, McKibben, Bongiovanni & Co. - Erie
The MEGRO Benefits Company - Conshohocken
Power Kunkle Benefits Consulting - Wyomissing
Roller Consulting Company, Inc. - King of Prussia
TJS Insurance Group - Pittsburgh

South Carolina
ECM/Ferguson Solutions - Greenville
McLaughlin & Smoak Benefits - Mt. Pleasant

Tennessee
Collier Insurance - Memphis
Insurance Consulting Group, Inc. - Memphis
Paradigm Group, LLC - Nashville
Russ Blakely & Associates - Chattanooga, Knoxville
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
iaCONSULTING - Abilene, Lubbock
Insgroup, Inc. - Houston
Kainos Partners, Inc. - Jersey Village
Shepard & Walton Employee Benefits - Austin, Harlingen, McAllen
TrueNorth Companies - Fort Worth
Upshaw Insurance Agency - Amarillo

Utah
Davis Pacific Benefits - Salt Lake City
Fringe Benefit Analysts, LLC - Layton
McDermott Company & Associates - South Jordan

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

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

Washington
Albers & Company, Inc. - Tacoma
GHB Insurance - Olympia

West Virginia
Schwendeman Agency, Inc. - Parkersburg

Wisconsin
Diversified Insurance Solutions, 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

UBA Partner Firms offer a wealth of other services. The list below provides an overview of the categories of products and services that they can provide. Additional details on the items listed, including pricing information, can be obtained by contacting your nearest UBA Partner Firm.

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

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 2,100 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.

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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.

United Benefit Advisors
280 East 96th Street
Suite 250
Indianapolis, IN 46240
www.ubabenefits.com

United Benefit Advisors, LLC
20 W. Wacker Drive, Suite 500
Chicago, IL 60606
312.416.3600