



2010 BENEFIT PLAN SURVEY

1. Which best describes your organization?

- Public Company
 Privately Owned Company
 Not-for-Profit
 Government

Which best describes your type of business?

- | | | | |
|---|---|---|--|
| <input type="checkbox"/> Advertising/Marketing | <input type="checkbox"/> Defense | <input type="checkbox"/> Legal | <input type="checkbox"/> Retail |
| <input type="checkbox"/> Architect/Engineering | <input type="checkbox"/> Distribution | <input type="checkbox"/> Manufacturing | <input type="checkbox"/> Social Services |
| <input type="checkbox"/> Arts and Entertainment | <input type="checkbox"/> Education | <input type="checkbox"/> Pharmaceutical | <input type="checkbox"/> Transportation |
| <input type="checkbox"/> Business Services | <input type="checkbox"/> Financial Services | <input type="checkbox"/> Printing/Graphic
Communications | <input type="checkbox"/> Wholesale |
| <input type="checkbox"/> Communications/Media | <input type="checkbox"/> Healthcare | <input type="checkbox"/> Publishing | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Computers/Technology | <input type="checkbox"/> Hotel/Hospitality | <input type="checkbox"/> Real Estate | _____ |
| <input type="checkbox"/> Construction | <input type="checkbox"/> Insurance | | |

2. How many full-time employees are in your organization? _____

How many full-time employees are covered under your medical plan(s)? _____

How many people (including you, if applicable) work in your HR Department? _____

3. Do you provide medical benefits for:

- | | | | |
|------------------------|--|----------------------------|---|
| ◆ Part-Time Employees? | <input type="checkbox"/> Yes <input type="checkbox"/> No | ◆ Retirees? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | If yes, how many? _____ | | If yes, how many? _____ |
| | Minimum Required Hours Per Week _____ | ◆ Union Employees? | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A |
| | | | If yes, how many? _____ |
| ◆ Domestic Partners? | <input type="checkbox"/> Yes <input type="checkbox"/> No | ◆ International Employees? | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A |
| | If yes, how many? _____ | | If yes, how many? _____ |

What percentage of your employees cover dependents under your medical plan(s)? _____ %

What is your annual employee turnover rate? _____ %

4. Please rank the five most important **goals** of your employee benefits program. (Number 1 indicates your most important goal.)

- | | |
|---|--|
| ___ Attract New Employees | ___ Proactively Address the Diverse Needs of Employees |
| ___ Control Employee Benefits Costs | ___ Provide Employees with Financial Security |
| ___ Educate Employees About Healthcare | ___ Reduce Employee Absenteeism |
| ___ Effectively Communicate Benefits Information to Employees | ___ Reduce HR Administrative Workload |
| ___ Improve the Health and Fitness of Employees | ___ Retain Employees |
| ___ Increase Employee Job Satisfaction | ___ Support Organizational Initiatives |
| ___ Increase Employee Productivity | ___ Other _____ |

5. Which **strategies/tactics** have you implemented to achieve your employee benefits goals? Which **strategies/tactics** do you plan to implement within the next 12 months? (Check all that apply.)

Have Implemented	Plan to Implement		Have Implemented	Plan to Implement	
<input type="checkbox"/>	<input type="checkbox"/>	Provide Competitive but Not Excessive Benefits	<input type="checkbox"/>	<input type="checkbox"/>	Educate Employees on Retirement Plan
<input type="checkbox"/>	<input type="checkbox"/>	Provide Superior Benefits	<input type="checkbox"/>	<input type="checkbox"/>	Offer Retirement Planning Services
<input type="checkbox"/>	<input type="checkbox"/>	Enhance Employee Communication Campaign	<input type="checkbox"/>	<input type="checkbox"/>	Provide a Common System for HR/Benefits Administration
<input type="checkbox"/>	<input type="checkbox"/>	Revise Contribution Strategy	<input type="checkbox"/>	<input type="checkbox"/>	Outsource Benefits Administration Processes
<input type="checkbox"/>	<input type="checkbox"/>	Offer a Wider Array of Voluntary Benefits	<input type="checkbox"/>	<input type="checkbox"/>	Create or Expand an Employee Benefits Website
<input type="checkbox"/>	<input type="checkbox"/>	Promote Healthcare Consumerism	<input type="checkbox"/>	<input type="checkbox"/>	Provide Web-Based Employee Self-Service Tools
<input type="checkbox"/>	<input type="checkbox"/>	Introduce a High Deductible Health Plan with an HSA or HRA	<input type="checkbox"/>	<input type="checkbox"/>	Other _____
<input type="checkbox"/>	<input type="checkbox"/>	Introduce Wellness Initiatives	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/>	<input type="checkbox"/>	Introduce or Enhance Work/Life Benefits Programs			

6. Which **tactics** have you implemented to offset increased healthcare costs? Which **tactics** do you plan to implement within the next 12 months? (Check all that apply.)

Have Implemented	Plan to Implement		Have Implemented	Plan to Implement	
<input type="checkbox"/>	<input type="checkbox"/>	Audit Claims Payment and Provider Fraud	<input type="checkbox"/>	<input type="checkbox"/>	Modify Retiree Health Benefits
<input type="checkbox"/>	<input type="checkbox"/>	Base Contributions on Smoking Cessation, HRA or Wellness Compliance	<input type="checkbox"/>	<input type="checkbox"/>	Modify Rate Tier Structures
<input type="checkbox"/>	<input type="checkbox"/>	Change Broker/Consultant	<input type="checkbox"/>	<input type="checkbox"/>	Negotiate Large Out-of-Network Claims
<input type="checkbox"/>	<input type="checkbox"/>	Change Carriers	<input type="checkbox"/>	<input type="checkbox"/>	Negotiate with Carrier
<input type="checkbox"/>	<input type="checkbox"/>	Change Funding Arrangements	<input type="checkbox"/>	<input type="checkbox"/>	Offer Alternative Plans
<input type="checkbox"/>	<input type="checkbox"/>	Conduct Dependent Eligibility Audit	<input type="checkbox"/>	<input type="checkbox"/>	Offer Buy-Out Incentive
<input type="checkbox"/>	<input type="checkbox"/>	Consolidate Plan Offerings	<input type="checkbox"/>	<input type="checkbox"/>	Offer Consumer Directed Model
<input type="checkbox"/>	<input type="checkbox"/>	Eliminate Working Spouse Liability	<input type="checkbox"/>	<input type="checkbox"/>	Offer Flexible Benefits
<input type="checkbox"/>	<input type="checkbox"/>	Evaluate Disease Management Program Effectiveness	<input type="checkbox"/>	<input type="checkbox"/>	Offer Value-Based Plan Design
<input type="checkbox"/>	<input type="checkbox"/>	Increase Contributions	<input type="checkbox"/>	<input type="checkbox"/>	Promote Wellness Initiative
<input type="checkbox"/>	<input type="checkbox"/>	Increase Individual Stop-Loss Coverage	<input type="checkbox"/>	<input type="checkbox"/>	Reduce Unnecessary Care
<input type="checkbox"/>	<input type="checkbox"/>	Increase Waiting Periods	<input type="checkbox"/>	<input type="checkbox"/>	Reduce/Revise Benefits
<input type="checkbox"/>	<input type="checkbox"/>	Minimize Insurance Taxes	<input type="checkbox"/>	<input type="checkbox"/>	Replace Employer-Paid Benefits with Voluntary Benefits
<input type="checkbox"/>	<input type="checkbox"/>	Modify Eligibility Rules	<input type="checkbox"/>	<input type="checkbox"/>	Other _____

7. How many employees are enrolled in each type of medical plan you offer? (Indicate whether they are in a Fully Insured, Minimum Premium or Self-Insured funding arrangement.)

Type of Plan	# Fully Insured	# Minimum Premium	# Self-Insured
Indemnity			
Consumer Directed (CDHP)			
PPO			
POS			
HMO			
EPO			

◆ How many employees waived coverage? _____

◆ Is there a buy-out option for employees waiving coverage? Yes No

◆ If there is a buy-out option, what is the payment per year? \$ _____ per year

8. On your last medical renewal:

◆ What was the **initial** rate change requested by your carrier(s) for each of your plans? (For Self-Insured plans, please indicate the change in claim dollars.)

	Example	Plan 1	Plan 2	Plan 3	Plan 4
Type of Plan	POS				
% Change	+12%				

◆ What was the **final** rate change for each of your plans? (For Self-Insured plans, please indicate the change in claim dollars.)

	Example	Plan 1	Plan 2	Plan 3	Plan 4
Type of Plan	POS				
% Change	+8%				

9. What percentage of the medical plan costs do your employees contribute to the premium?

	Example	Plan 1	Plan 2	Plan 3	Plan 4
Type of Plan	HMO				
Employee	15%				
Employee + Spouse	20%				
Employee + Child(ren)	20%				
Family	25%				
Part-Time Employee	50%				

- ◆ Do you sponsor a Health Savings Account (HSA)? Yes No
- ◆ Do you sponsor a Health Reimbursement Arrangement (HRA)? Yes No
- ◆ Do you contribute toward any of these funds? Yes No

10. Including both employer and employee contributions, what is the average annual cost per employee for medical coverage?

\$ _____ per employee

Calculation for Fully Insured Plans: Total Annual Premium ÷ Number of Covered Employees

(For example: \$2,000,000 premium ÷ 200 employees = \$10,000 per employee)

Calculation for Self-Insured Plans: [Self-Funded Claims + Fixed Costs] ÷ Number of Covered Employees

11. What are your Rx claims as a percentage of total claims in your plan with the most participants? _____ %

How have you managed rising Rx costs? (Check all that apply.)

- | | |
|---|---|
| <input type="checkbox"/> Conducted Pharmacy Benefit Management Audit | <input type="checkbox"/> Moved Rx Coverage to a Specialty Pharmacy Benefit Vendor |
| <input type="checkbox"/> Covered Selected OTC Drugs | <input type="checkbox"/> Promoted Mail Order |
| <input type="checkbox"/> Implemented a Deductible | <input type="checkbox"/> Promoted Use of Generic Drugs |
| <input type="checkbox"/> Implemented a Formulary | <input type="checkbox"/> Renegotiated Discounts with PBMs |
| <input type="checkbox"/> Implemented Coinsurance | <input type="checkbox"/> Required Precertification for Certain Drugs |
| <input type="checkbox"/> Implemented Drug-Specific Dispensing Limits | <input type="checkbox"/> Utilized a Multiple Tier Rx Plan |
| <input type="checkbox"/> Increased Copays | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Mandated Use of Certain Drugs Before Covering More Costly Drug | |

12. Which of the following benefits do you offer to your employees? Who is responsible for the cost of these plans?

What percentages of eligible employees participate? (Complete all that apply.)

Benefit	Employer Pays All	Employer Pays Partially	Employee Pays All	Not Offered	% Participating
AD&D	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Adoption Assistance Program	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Day Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Defined Pension Benefit Plan	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Dental	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Dread Disease Insurance/Critical Illness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Employee Assistance Program (EAP)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Enhanced Short Term Disability	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Group Life Insurance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Long Term Care (LTC)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Long Term Disability (LTD)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Payroll Deducted Auto/Homeowner	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Prepaid Legal Services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Retiree Medical	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Retirement Planning Services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Supplemental Life Insurance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Supplemental LTD	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Transportation/Parking Reimbursement	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Travel Accident	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Tuition Reimbursement Program	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
	Offered	Not Offered	% Participating		
Flexible Spending Account (FSA)	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Section 529 College Savings Plan	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Traditional 401(k) or 403(b) Plan	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Roth 401(k) or 403(b) Plan	<input type="checkbox"/>	<input type="checkbox"/>	_____		

Do you offer an executive benefits program? Yes No

If yes, which of the following benefits do you offer to your executives? (Check all that apply.)

- | | |
|--|--|
| <input type="checkbox"/> 401(k) Mirror Plan | <input type="checkbox"/> Non-Qualified Deferred Compensation Plan |
| <input type="checkbox"/> Disability Income | <input type="checkbox"/> Split Dollar Life Insurance Plan |
| <input type="checkbox"/> Executive Bonus Plan | <input type="checkbox"/> Supplemental Executive Retirement Plan (SERP) |
| <input type="checkbox"/> Long Term Care (LTC) | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Medical Expense Reimbursement Plan (MERP) | |

13. Of the methods you have used, please rank the effectiveness of the following benefits communication methods on a scale of 1 to 4. (1 = Not Effective, 4 = Very Effective.)

	Not Effective 1	Somewhat Effective 2	Effective 3	Very Effective 4
Email	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Employee Letters	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Employee Surveys	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Focus Groups	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Group Employee Meetings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Health/Benefit Fairs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Internet/Intranet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Newsletters	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
One-on-One Employee Meetings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Payroll Stuffers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Personalized Employee Benefit Statements	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Webcasts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

14. Which of the following outcomes do you believe a health and wellness program can achieve for your organization?
(Check all that apply.)

- | | |
|--|--|
| <input type="checkbox"/> Attract Employees | <input type="checkbox"/> Increase Employee Retention |
| <input type="checkbox"/> Create an Environment that Supports Healthy Behaviors | <input type="checkbox"/> Increase Productivity |
| <input type="checkbox"/> Create Positive Return on Investment | <input type="checkbox"/> Lower Premium Costs |
| <input type="checkbox"/> Improve Employee Health and Well-Being | <input type="checkbox"/> Reduce Employee Absenteeism |
| <input type="checkbox"/> Increase Disease Management Participation | <input type="checkbox"/> Reduce Lifestyle Health Risks |
| <input type="checkbox"/> Increase Employee Morale | <input type="checkbox"/> Other _____ |

15. Do you actively promote or plan to promote a wellness initiative?

- Actively Promote Plan to Promote Do Not Actively Promote or Plan to Promote

◆ If you actively promote or plan to promote a wellness initiative, what types of programs do you offer or plan to offer?
(Check all that apply.)

	Currently Offer	Plan to Offer		Currently Offer	Plan to Offer
At-Home Biometric Testing	<input type="checkbox"/>	<input type="checkbox"/>	Online Wellness Services	<input type="checkbox"/>	<input type="checkbox"/>
Disease Management Program	<input type="checkbox"/>	<input type="checkbox"/>	On-Site Biometric Testing	<input type="checkbox"/>	<input type="checkbox"/>
Employee Assistance Program	<input type="checkbox"/>	<input type="checkbox"/>	On-Site Body Mass Index (BMI) Testing	<input type="checkbox"/>	<input type="checkbox"/>
Fitness Program	<input type="checkbox"/>	<input type="checkbox"/>	On-Site Nurse/Physician	<input type="checkbox"/>	<input type="checkbox"/>
Flu Shots	<input type="checkbox"/>	<input type="checkbox"/>	On-Site Physicals	<input type="checkbox"/>	<input type="checkbox"/>
Health Coach	<input type="checkbox"/>	<input type="checkbox"/>	Preventive Screening	<input type="checkbox"/>	<input type="checkbox"/>
Health Education Program	<input type="checkbox"/>	<input type="checkbox"/>	Smoking Cessation Program	<input type="checkbox"/>	<input type="checkbox"/>
Health Fairs	<input type="checkbox"/>	<input type="checkbox"/>	Stress Management Program	<input type="checkbox"/>	<input type="checkbox"/>
Health Risk Assessment	<input type="checkbox"/>	<input type="checkbox"/>	Weight Loss Program	<input type="checkbox"/>	<input type="checkbox"/>
Nutrition Program	<input type="checkbox"/>	<input type="checkbox"/>	Wellness Competitions	<input type="checkbox"/>	<input type="checkbox"/>

16. Do you offer or plan to offer any type of incentives to encourage employee participation in your wellness initiative?

- Currently Offer
- Plan to Offer
- Do Not Currently Offer or Plan to Offer

If you currently offer or plan to offer an incentive, what types of incentives do you offer or plan to offer? (Check all that apply.)

- | | |
|--|---|
| <input type="checkbox"/> Cash | <input type="checkbox"/> Rebates for Fitness or Diet Programs |
| <input type="checkbox"/> Flexible Benefit Coupons | <input type="checkbox"/> Recognition/Awards |
| <input type="checkbox"/> Gift Cards | <input type="checkbox"/> Reduction in Contribution or Copays |
| <input type="checkbox"/> Paid Time Off | <input type="checkbox"/> Special Reserved Parking Space or Paid Parking |
| <input type="checkbox"/> Raffles, Drawings, Prizes | <input type="checkbox"/> Other _____ |

Thank you for taking the time to complete C&B's 2010 Benefit Plan Survey.

In appreciation of your valuable input, C&B would like to offer you a **\$15 Gourmet Coffee Gift Card**. To receive your gift, complete the contact information below and return the completed survey via standard mail or fax.

Please print.

Name: Mr. Mrs. or Ms. (circle one) _____

Title: _____

Organization: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

E-mail: _____



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