

2007 Employer Health Care Benefits Report

A Publication for all Benefit Managers

In its fifth edition, The Benecon Employer Health Care Benefits Report continues to track important issues for employers and their benefit plans. This analysis from our Actuarial and Compliance Divisions is the most authoritative source of employee benefit plan information, including regional inflation rates and cost trends specific to the Central Pennsylvania marketplace. Pulling together data from surveys, large employers, reinsurance programs, insurance company actuaries and underwriters, we are able to identify inflation rates and trends long before others.

Benecon helps employers make informed decisions. Employee benefit plans have always been important in helping employers attract and retain the most highly qualified and skilled workers, but employee retention is now becoming a more sig-

nificant issue. Many employers are finding it difficult to balance their need to retain skilled employees and to deal with the needs of an aging workforce with the need to continue to control the cost of their benefit plans.

While balancing these priorities and trying to anticipate market and regulatory changes that will affect their benefit plans, many employers are finding it has become even more difficult to develop appropriate benefit plans for their employees.

The Benecon Employer Health Care Benefits Report addresses these issues by bringing employers the information needed to make informed decisions about their benefit plans, helping them to understand market trends and to stay on top of relevant legislative and regulatory changes.

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2007 Employer Report

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

GET FUTURE REPORTS

This report is available to those employers who participated in our benefit survey. To participate in future surveys, visit www.benecon.com or call Benecon at 888-400-4647.

About the Benecon Report and Survey

Introduction and Background

This 2007 Report presents the most insightful analysis of inflation trends you will find. Our consistently accurate analysis is the most authoritative source of regional inflation rates and cost trends specific to the regional market place. Pulling together data from surveys, large employers, reinsurance programs, insurance company actuaries and underwriters, as well as quote activity from the 3,000 employers who purchase insurance through our broker distribution network, we are able to identify inflation rates and trends long before others.

National Surveys and Reports

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

Express Scripts
BenefitNews.com
Towers Perrin
Watson Wyatt
Milliman Benefits Perspective
National Business Group on Health

Kaiser Family Foundation
The Segal Company
Hewitt Associates
Wall Street Journal
Mercer

Regional Sources

In addition to national data, regional sources are reviewed to compile this report. Regional sources include:

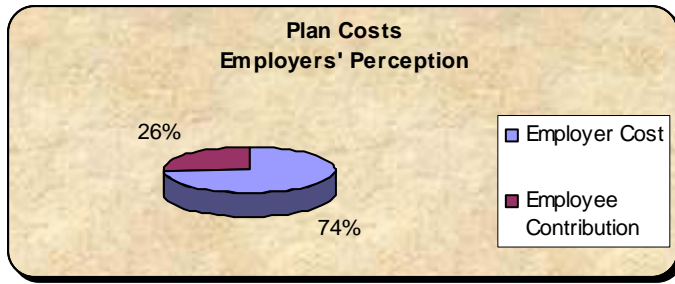
- (1) Benecon Data Base. This database includes a proprietary data set gathered from our own client base.
- (2) The Benecon employee benefits survey instrument used to collect data from interested employers.
- (3) Regional Insurance Company Information. Benecon interviews Central Pennsylvania actuaries and underwriters and monitors the trend factors used by major carriers and managed care companies in the Central Pennsylvania market.
- (4) Lancaster County Business Group on Health and the Lancaster Chamber of Commerce—Annual Employer Surveys. These organizations survey many of Central Pennsylvania's larger employers about their health care benefits, employee contributions, strategies to contain costs, and views on health care issues.



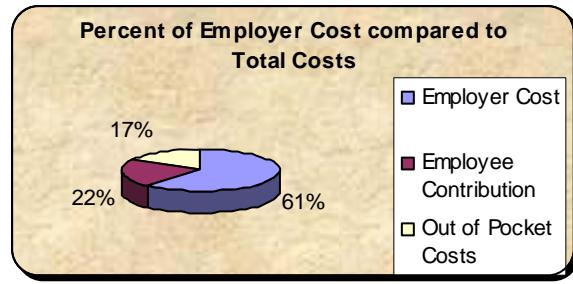
Follow the Money

A Different Perspective on Sharing Health Care Costs with Employees

Choosing plan designs with higher deductibles and co-pays, along with increasing employee contribution rates are the two predominant ways employers try to control their own costs and to pass costs back to plan participants. These trends and benchmarks are highlighted throughout this report. Yet, the entire process of designing a benefit strategy is disjointed without an understanding of the whole picture.



Employers perceive they are paying 74% of the insurance company premium or self-funded cost.



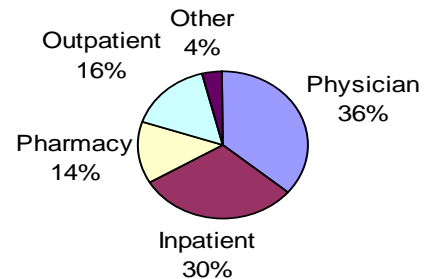
Yet, employers are actually picking up only 61% of total costs. Employees pick up their payroll contribution plus significant out of pocket costs.

The typical cost of care for a family of four in a PPO program.

Total Cost of Medical Care	
Employer Cost	\$ 8,909
Employee Contribution	\$ 3,171
Employee Out of Pocket	\$ 2,420
Total	\$ 14,500

Figures obtained from Milliman Medical Index 2007

This pie chart shows the components of the total cost of \$14,500.

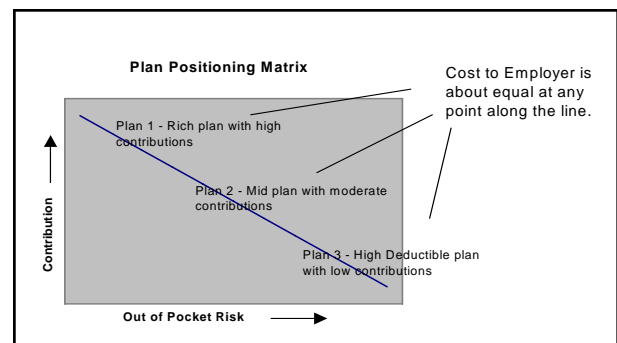


Plan Design Balancing: How the three components of cost should be balanced to produce desired results.

It's often difficult for employers to understand the global impact of their contribution and plan design choices without a little sophisticated help from their consultant. We urge employers to quantify their employees' total out of pocket expense, including both contributions and copayments/coinsurance.

Plan design balancing is a technique where the employer designs a series of plan options, each of which locks in the employer cost at the same level relative to the employee. For example, if the target cost portion for the employer is 61%, as shown in the chart in the upper right, then the employer could offer three plan options which balance both employee contributions and anticipated out-of-pocket costs. These options allow employees to choose the design that best works in their circumstances.

Unfortunately, too many employers don't understand the magnitude of cost shift when they change plan design and increase contributions.

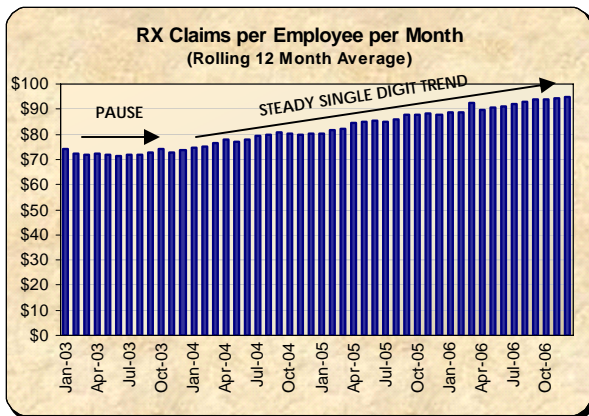
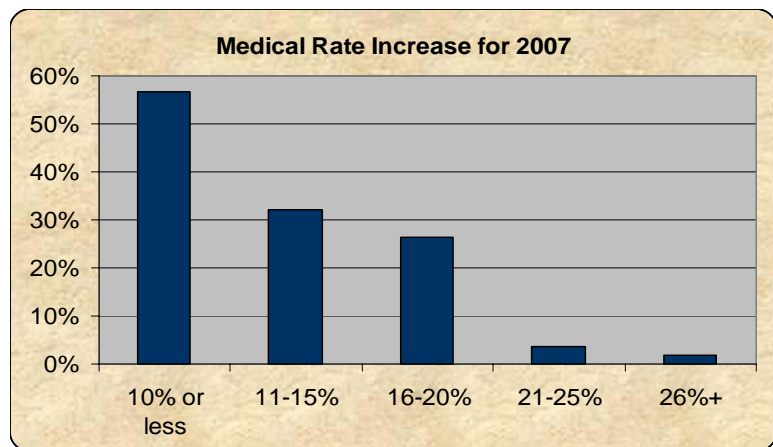


Regional Premium, Claims, and Trend Measures

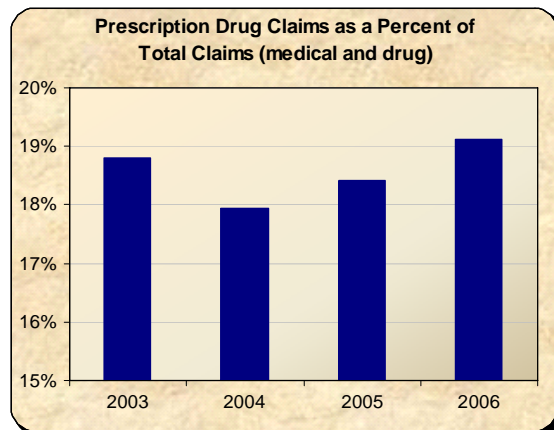
Average Premium Rates and Contributions				
Tier	Rate	2004	2005	2006
Single	Premium	\$273	\$339	\$355
	Contribution	\$38	\$54	\$55
Family	Premium	\$758	\$885	\$1,075
	Contribution	\$192	\$316	\$325

These figures represent a different mix of employers in each of the three years, so percentage increases are not particularly useful. Nonetheless, it is helpful to see average costs, and average employee contribution rates over a three-year period for some comparison to a benchmark.

As we predicted in our prior report, ("We expect dramatic change in this chart for 2006 and beyond"), the frequency of low medical premium increases has increased significantly. We are now seeing over half the premium changes at single digit increases, with many decreases.



Following double-digit inflation prior to 2003, our graph shows the pause period that marked the turn in Rx trend line. Since the pause, we see steady inflationary trend at single digits.



Our data continues to show prescription costs representing 18% to 20% of total plan costs. Note, Milliman reports prescription costs are 14% to 15% of total claims nationwide.



Regional Plan Design Benchmarks and Trends

As shown to the right in CHART 1, we continue to see an increase in \$20 and \$25 primary care office visit co-pays. \$10 co-pays now represent only a small fraction of plans.

CHART 2 below shows a dramatic drop in zero deductible plans. The standard has moved to \$250 or \$500.

CHART 3, coinsurance, shows less dramatic shift away from 100% plans to 80% plans.

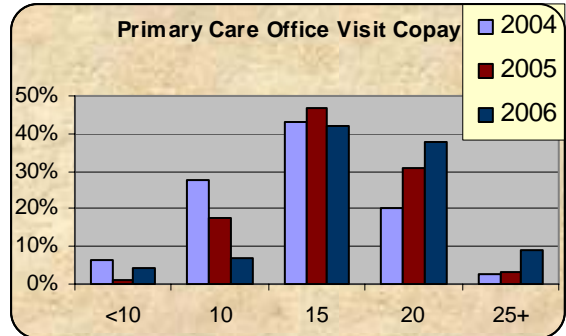


CHART 1

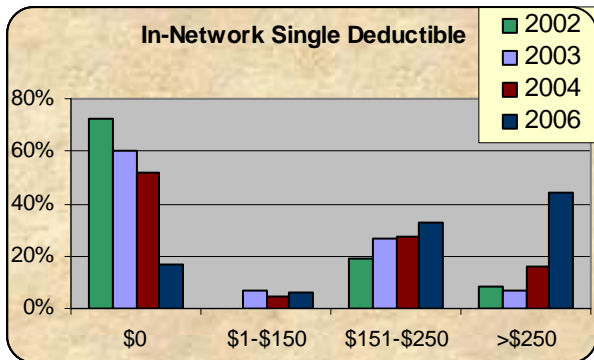


CHART 2

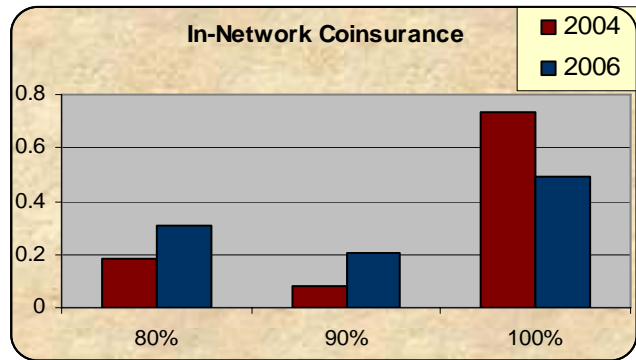


CHART 3

CHARTS 4 and 5 below show slow migration to higher co-pay prescription drug plans.

However, other market trends are eroding the traditional co-pay model, resulting in waived copays for specific diseases or more use of deductibles and coinsurance. We expect future editions of the Health Care Benefits Report will highlight these changes.

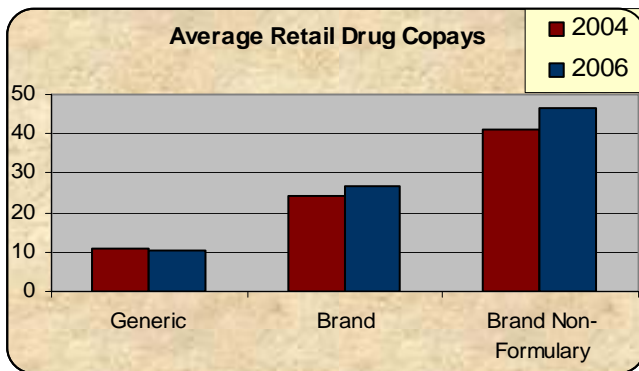


CHART 4

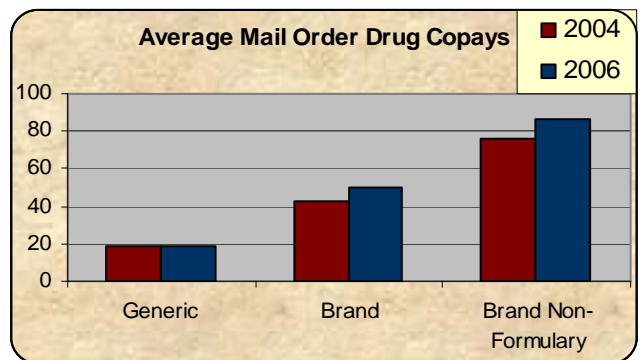


CHART 5



2007 Employer Report

Consortiums

The Future of Employer Health Plan Purchasing?

The group purchasing concept involves aggregation of smaller risks into a larger purchasing group. This leads to savings in health plan costs through greater credibility, reduced administrative fees, and use of funding arrangements available to large groups.

Here's how the concept works:

Risk Management Strategy

A custom risk management strategy can be implemented for either self-funded or fully insured clients that spreads high volatility risk over a larger pool. However, each member must be rated individually to retain client accountability for the majority of its own claims. A good goal is to gain 100% credibility for the group, request custom pool points within standard insurance practice, and develop underwriting concessions that are commensurate with the volume of business.

Advanced Stop Loss Protection

If self-funded, buying an appropriate amount of stop loss protection allows more stability and substantial buying power. This is important, especially to

mid-size employers currently subject to large swings in year-to-year costs. The consortium should obtain volume discounts plus reduction of the other loads and margins used to estimate claim costs.

Consortium Member Advantages

- Lower rates
Use the mass of the purchasing group to negotiate appropriate program designs and cost structures including both risk mechanics and volume discounts. Our strategies are designed to provide longer-term savings and stability.
- Distinct benefit plans
Consortiums can dictate unique programs that allow employers to pursue their own plan design strategies without forcing them to subsidize other members who may be less aggressive in controlling costs.
- Flexibility of funding options
Consortiums can operate whether self-funded or full insured. Under the self-funded model, multiple claim administrators and service vendors can even be used.

Commitment

Purchasing groups gain strength with consistency, a track record, and demonstrated commitment. Sharing in a joint purchase will even out over time to everyone's advantage and savings will accrue over multiple years. These concepts are undermined if members view group purchasing as a strategy to earn a one-year price advantage and then get out. High turnover and anti-selection can destroy the purchasing block and dissolve negotiating power with the carriers.

Strength in Numbers

The success of the group purchasing model will result in enhanced negotiating power and "key client" status if these core principals are followed.

Can Private Consortiums Operate in Pennsylvania?

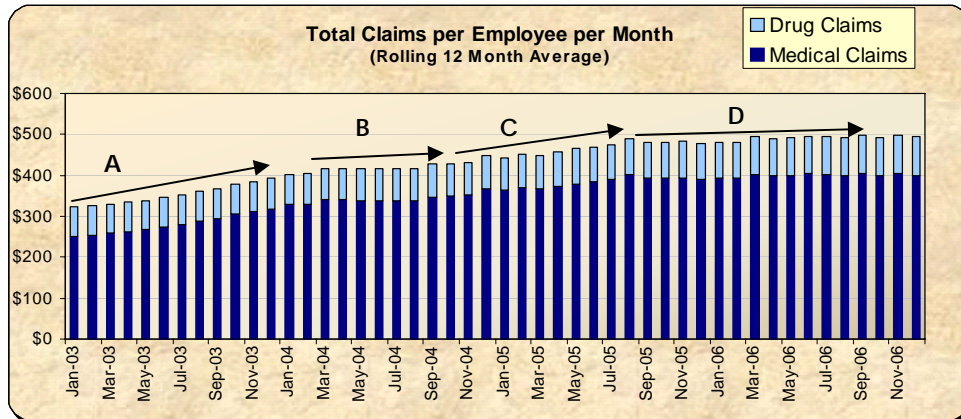
Spotlight on Legal Issues by Judy Griffith, Esq.

Private, non-public employers are currently prohibited from sharing risk in a self-funded consortium in Pennsylvania. Operating consortiums in Pennsylvania have traditionally been public entities (municipalities and school districts) protected by state law that exempts them from Insurance Department prohibition on risk sharing.

However, there are still options for private employers to join together to create buying power. First, fully insured initiatives are legally sanctioned, although difficult to negotiate with insurers. Alternatively, groups of self-funded employers are capable of approaching vendors as a purchasing block, ready to buy stop loss coverage if the vendor offers prices acceptable to everyone in the group. Each member of the group buys its own policies, sponsors its own plan, and pays its own claims. There is no explicit sharing of risk. Rather, they have simply joined together to get the same good deals that are available to larger single employers.



Regional Trend Report and Outlook
A Benecon Exclusive



The graph above provides a visual portrait that ties together all the results and trends in this report and prior reports, and helps to explain the low and negative increases we are now seeing in the market (See sidebar).

Period A - This is the end of the double-digit inflation era of 1997 through 2003.

Period B - This shows the dramatic pause in 2004 that was missed by the national media, but picked up by Benecon and reported in our 2005 report. As illustrated on Page 5, this was heavily influenced by an abrupt change in Rx trend.

Period C - A brief uptick in trend occurred in early 2005.

Period D - Trend lines have been relatively flat all during 2006.

What's Coming?

Historically, claim trends have followed a rather severe cycle over the last 40 years. Pauses in inflation such as we have here have never lasted more than three years. Using that rule of thumb, trend is due to increase again in 2008. On the other hand, the prior high trend period lasted 6 or 7 years (1997-2003) and drove prices quite high. It could be the historic cycles are now lasting longer - 5 to 6 years - before dramatically turning.

In the local market, we see these factors allowing another year to 18 months of low trend:

- The hospital building spree of the first half of the decade has cooled, and hospital prices are quite fat.
- Large surpluses made by insurance companies will probably loosen their negotiating posture with physicians and relieve pressure in that arena.
- Employer activity with wellness and similar initiatives, although not necessarily a wise investment from an ROI perspective, may suppress claim activity while the cost of those programs is run through other budget lines.

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

Where do negative rate renewals come from?

A very interesting thing has been happening in the group health insurance market. In 2006, many employers were delighted with single digit rate increases, while some experienced a rate decrease. In the latter half of 2007 and into 2008, insurance companies will be defending another set of low rate increases and rate decreases as not low enough from employers and their brokers who are wondering where all the money went.

Insurance is a tough business. Rates are set well in advance of when they are seen by employers and are set using assumed trend factors. If trend is actually more or less than that assumed by the insurance company, they could either experience large gains or huge losses. Either way, carriers need to make price corrections to get back on track.

These price corrections lead to renewal changes that seemingly contradict the professed trend factor. That's why they can deliver a 5% rate cut at the same time they say trend is 10%.

Understand the Broad Picture

Inflationary pressures on claim costs and utilization for employee benefit programs began to build during 1997 after several years of very low inflation from 1993 to 1996. After six years of relentless increase, inflationary pressures on claim costs peaked during 2004. For the next two years, 2005 and 2006, inflation eased, undercutting the momentum of insurance company premium trends already imbedded in their price structures. The result was surprising gains for the insurers, followed by an unprecedented number of zero or negative rate changes during 2006, 2007, and continuing into 2008.



Federal Legislative and Regulatory Update—*Judy Griffith, Esq.*



Below is a summary of significant pending and approved federal legislation and regulations affecting employee health and welfare plans:

Cafeteria Plans

The IRS has issued proposed cafeteria plan regulations that replace prior guidance and proposed rules. These regulations set detailed requirements for nondiscrimination testing, provide administrative guidance on information required in cafeteria plan documents, and describe who may participate in these plans. Also included are details on the operations of Flexible Spending Accounts. The IRS is accepting comments on the new regulations until November 5, 2007. When finalized, the rules will apply to plan years beginning on or after January 1, 2009.

HIPAA Non-Discrimination and Wellness Regulations

The final HIPAA Non-Discrimination and Wellness Regulations became effective for plan years beginning on or after July 1, 2007. These regulations clarify and finalize the proposed regulations which prohibit discrimination in terms of benefits, premiums or eligibility based on any health related factor. The wellness regulations permit rewards (such as waived co-pays or reduced premium contributions) for individuals who participate in a wellness plan that meets regulatory criteria.

Health Reimbursement Arrangements

Medical reimbursements from an HRA or similar plans are taxable if the plan permits a beneficiary other than the participant's spouse or dependent to use up the account balance following the death of the participant, according to a recent IRS ruling. For plans that have this provision, the ruling is effective for plan years beginning after December 31, 2008.

Health Savings Accounts

The IRS issued final regulations in 2006 that clarify the comparability requirements for contributions made by employers to HSAs. The DOL also issued guidance on conditions that an HSA must meet to avoid ERISA. These include voluntary participation and limited employer involvement.

Electronic Notices

Group health plan sponsors can now provide creditable

coverage disclosure notices and other employee benefits notices electronically to plan participants. The regulations, which became effective on January 1, 2007, allow employers to provide notices electronically to individuals who have the ability to access the employer's electronic information system on a daily basis as part of their work duties. The employer must also inform plan participants that the participants are responsible for providing a copy of the electronic disclosure to their Medicare-eligible dependents who are covered under the group health plan. Creditable Coverage Disclosure Notices should be distributed to Medicare-eligible individuals by November 15th of each year.

TRICARE

Effective January 1, 2008, group health plan sponsors cannot offer TRICARE-eligible employees financial or other incentives not to enroll, or terminate their enrollment, in a group health plan that would provide primary coverage. TRICARE is the federal government's health care program for certain active and retired service members and dependents. The law applies to employers with 20 or more employees, including state and local governments.

Tax Exemption for Children of Divorced, Separated, or Living Apart Parents

The IRS has issued proposed regulations that provide guidance and clarification regarding the definition of "custodial parent" and include special rules for parents living apart who were never married to each other. Taxpayers who claim a child as a tax dependent can cover the child tax-free under the employer's group health plan, pay for that coverage under a cafeteria plan, and be reimbursed for their qualified medical expenses under a health care flexible spending account (FSA). Only the custodial parent can submit expenses for the child to a dependent care spending account. These proposed regulations do not affect an employer's ability to define "dependent" for eligibility purposes. Employers could continue to define the term more broadly than the definition for federal income tax purposes.

FMLA: A Report on the Department of Labor's Request for Information

Last December, the DOL began a review of the Family and Medical Leave Act (FMLA) and its regulations and published a Request for Information (RFI). The RFI asked

(Continued on page 9)



Federal Legislative and Regulatory Update

(Continued from page 8)

the public for comments on the effectiveness of FMLA regulations. More than 15,000 responses were received. According to the report, which was released in June 2007, there is general agreement that family and medical leave is good for workers and their families, is in the public interest, and is good for workplace policy. However, employees often expressed a desire for more time off, paid benefits, and coverage for additional family members. Employers were concerned about their ability

to manage business operations with reduced staff and control attendance issues, particularly when unscheduled, intermittent leave is taken for chronic health conditions. Many employees still do not fully understand their rights under the law or the procedures they must follow when requesting FMLA leave. The DOL says it has more work to do to further educate employees and employers regarding their rights and responsibilities under the law. A complete copy of the report is available at <http://www.dol.gov/esa/whd/fmla2007report.htm>.

Pennsylvania Legislative Update

Below is a summary of significant pending and approved Pennsylvania legislation affecting employee health and welfare plans:

Prescription for Pennsylvania

In January, Governor Ed Rendell unveiled his health reform plan designed to increase access to affordable health care coverage for all Pennsylvanians, improve the quality of care available in the state, and bring health care costs under control for employers and employees. Goals of the plan include:

- Cover All Pennsylvanians (CAP) program: improve access to basic health care by lowering costs, making it easier for small businesses to offer health coverage to their employees and the uninsured to purchase it through the insurance market.
- Further enhance access to health care by enabling nurses, midwives, physician assistants, pharmacists, and other licensed health care providers to practice to the fullest extent of their education, training, and skills. *Bill passed by the General Assembly on 7/20/07.*
- Focus on improving patient safety by eliminating hospital-acquired infections and targeting avoidable medical errors. *Bill passed by the General Assembly on 7/20/07.*
- Promote the use of a successful nationally-proven model that manages treatment of chronic conditions such as heart and lung disease, diabetes, and asthma. *Governor Rendell signed an executive order in May*

establishing a Chronic Care Management Commission.

- Promote a common-sense payment system that rewards wellness and stops paying for unnecessary or ineffective medical services.
- Promote consumer incentives that reward healthy lifestyles.

HSAs

In June, the Pennsylvania House Republican Health Care Task Force offered an alternative to Governor Rendell's CAP program. State Representative Scott Boyd says the goal of the plan is to keep the private sector involved in the delivery of health care by expanding the use of HSAs. The plan includes a 25% tax credit for small businesses that contribute to an employee's HSA and a 50% tax credit for HSA contributions for family High Deductible Health Plans.

Insurance Purchasing Cooperative Legislation

PA legislators have introduced bills to allow for insurance purchasing cooperatives. In June, State Representative Eugene DePasquale introduced H.B. 1551 that would permit small businesses to pool together to purchase group health insurance at reduced rates. Under the measure, two or more companies that employ between two and 50 employees would be able to pool their resources to purchase group insurance. In March, Senator Stewart Greenleaf introduced similar legislation.

2007 Employer Report

The Lancaster Bridge Project A Patient Self-Management Project



Benecon's Rick Burd, Senior Vice President of the Actuarial Division, is leading the local project that is part of a nationwide effort to launch Patient Self-Management (PSM) programs providing education and treatment for

employees with chronic health conditions. Rick is a board member of a Lancaster County employer coalition that focuses on cost and quality issues of local employer-sponsored healthcare. The group identifies emerging trends in healthcare, communicates them through educational programs, and works to facilitate local solutions.

What is Patient Self-Management?

PSM programs team employees who have chronic health conditions like diabetes, hypertension, and high cholesterol, with pharmacists in their communities who act as personal health coaches and motivate patients to control their diseases. The pharmacists develop treatment plans in collaboration with primary care physicians and other care providers.

The programs consist of:

- Patient self-enrollment
- Monthly coaching sessions with community pharmacists
- Coordination with primary care physicians
- Financial incentives by employer sponsors
- Data reporting by insurers or administrators
- Data collection and analysis by national researchers.

More than disease management programs, which react to crisis, PSM programs encourage employees to voluntarily enroll to more effectively manage their chronic conditions and take responsibility for decisions regarding their care.

With proactive treatment, under the guidance of a pharmacist, chronic conditions can be controlled so that patients feel better, are more productive at work, use fewer illness days, and spend less time in the hospital. Rick Burd believes, "Wellness programs work to keep employees healthy, while PSM reaches the sickest of the sick. Together, they create a powerful influence in the workplace."

The Asheville Project

The concept began in 1996 when the City of Asheville, NC sought to provide education for its employees with chronic health problems. The project resulted in improved AIC levels for diabetic patients, lower total health care costs, fewer sick days, and increased satisfaction with pharmacists' services. From Asheville, the project went national when the American Pharmacists Association (APhA) Foundation, with support from GlaxoSmithKline, promoted the concept nationwide.

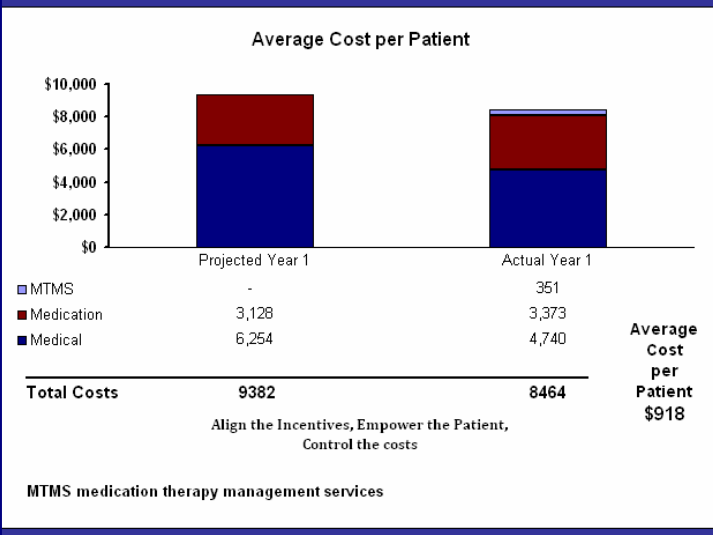
Lancaster Link

Lancaster was one of the first multi-employer sites in the nation to launch a Patient Self-Management program. This program is sponsored by the Lancaster County Business Group on Health. Over 90 participants from 10 employers are currently enrolled. Local independent pharmacists organize their own provider networks and sponsor appropriate training. Major insurance carriers also participate with fully insured employers by providing data, administrative support, and price discounts. Capital BlueCross, Highmark Blue Shield, HealthAmerica & HealthAssurance, Lancaster General Hospital, and Ephrata Community Hospital provide support for the Lancaster project.

Ten Cities Challenge

Following the success of programs like the one in Lancaster, the APhA Foundation has promoted a Ten Cities Challenge to find 10 communities willing to sponsor multi-employer programs like Lancaster's. The Pittsburgh Business Group on Health (PBGH) has already accepted the challenge and now sponsors a similar program.

Patient Self-Management Program for Diabetes:
First-Year Cost Savings



The chart to the left shows the savings experienced during the first year of the Asheville diabetes program by participants in the 5-site pilot program, which included large self-funded employers located in Georgia, North Carolina, Ohio and Wisconsin. This data was taken from the Pharmacy Times June 2005 Supplement entitled "Beyond Asheville."



Industry Guidelines Issued Regarding ROI Measurements

Disease management (DM) is a system of coordinated healthcare intervention and communication designed to help people with chronic conditions proactively manage their health. The idea is to spend more money and time today caring for people with long-term illnesses so you don't spend more later on emergency treatment or long hospital stays.

Studies show that 50% of people with chronic conditions are not taking their medications or receiving regular medical care to manage their disease, primarily because of the costs involved.

Most employers want to see a quantifiable return on investment (ROI) before investing in a DM program. The problem is that calculating the value of disease management programs is a complicated process. The factors that must be considered include claims and utilization data, employee attendance, productivity, and health status. Currently, there is no single universal standard for calculating ROI. Some experts suggest there will never be a methodology that is 100% accurate.

There are several methods commonly used to estimate DM ROI. One way is to compare the results for a group receiving DM to some other group. Another way is to compare the rate of change in health costs before disease management to the rate of change in health costs after the program.

These methods are fraught with problems. Participants who are eligible for a DM program are usually the very sick. With chronic illnesses, patients who are hospitalized one year will most likely not be hospitalized the next year. Therefore, their costs will be lower the following year. This trend occurs without intervention by a DM program. Another problem is the rate of employee turnover. If the same employees are not incurring costs in both years of the study, it is difficult to determine whether the DM was a true factor in reducing claims.

So, how do you really measure the value of the intervention? The Disease Management Association of America (DMAA) recently published guidelines to address this issue. Factors include 1)

an internal or external comparison group that is equivalent to the intervention group; 2) a 12-month measurement period and a review of claims over the prior 12 months; 3) use of both medical and pharmacy claims; and 4) evaluation of a non-chronic population to calculate trend.

Employers need to pay attention to these industry standards and be skeptical of ROI claims made by vendors.

Recommendations:

- Consider and review the strategy for each of about a half dozen chronic conditions.
- Maximize use of carrier programs.
- Beware of advertised ROI and review against recently published guidelines.
- Consider using actuarial tools (predictive modeling) that identify members with specific health conditions, monitor health status of the group, and assess quality of health care provided.
- Consider "value based" plan designs and active self-management programs.

Meet our Actuarial and Compliance Professionals

Richard H. Burd, FSA, MAAA, is Senior Vice President of Benecon's Actuarial Division. Rick has over 30 years of actuarial experience working with group medical plans and other employee benefit programs. Prior to joining The Benecon Group in 2001, he was Vice President and Corporate Actuary for Educators Mutual Life Insurance Company.

Joseph Molinar is Benecon's Actuarial Analyst, responsible for a broad range of actuarial and technical support functions. Joe is a graduate of York College of Pennsylvania with a B.S. in Mathematics. He is pursuing the ASA designation with the Society of Actuaries.

Judy Griffith, Esq. is Benecon's Director of Compliance and an employee benefits attorney with diversified experience in group insurance, compliance, employee benefit contracts, and managed care contracting. Prior to joining the Benecon Group, Judy operated her own employee benefits consulting firm. Judy is a graduate of Villanova Law School.

Donna Swinford is a Compliance Analyst who assists with compliance questions and issues, creates plan and HIPAA documents, prepares 5500 forms, and is creating a library of notices and forms. She received an M.B.A. from Kutztown University. Donna has over 20 years of experience in claims supervision, HIPAA Privacy and Security, training, and quality control.

Danielle Omans, Compliance Specialist, is responsible for research, writing, and editing external publications and plan documents, client visits, and seminar development. She has a B.A. in Journalism from Penn State University and extensive experience in employee benefits communication and human resources.



2007 Employer Report

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The Benecon Employer Survey Continues its Success in Predicting Market Trends

Readers of this report should not have been surprised by any of the changes occurring in medical and prescription drug trends:

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

In its 2005 Report, Benecon anticipated that beginning in 2005, Rx trends would drop below medical trends for the first time in over a decade.

In its 2005 Report, Benecon noted that mail-order usage is not always the solution to increasing drug costs, and that most of the cost reduction is given to the employees rather than the employer.

In the article, "Comparison of Mail-Order with Community Pharmacy in Plan Sponsor Cost and Member Cost in Two Large Pharmacy Benefit Plans," in the March 2007 issue of the *Journal of Managed Care Pharmacy*, the following conclusion was noted:

"Overall, savings from lower unit pricing through the mail-order channel benefited the member and did not translate into significant cost reductions for the plan sponsor. In both pharmacy benefit plans, the plan sponsor either realized small savings or incurred slightly higher costs when paying for drugs in the top therapeutic categories through the mail-order channel. Some generic drug prices are higher through the mail-order pharmacy than through the community pharmacy, and one of the two plans in this study paid higher net costs after member cost share for generic drugs through mail order."

2007 Research Report from the *Journal of Managed Care Pharmacy* validates the findings of the 2005 Benecon Employer Health Care Benefits Report.

About The Benecon Group

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

Headquartered in Central Pennsylvania, the professional consulting staff of the **Consulting Division** and the **Actuarial Division** serve the needs of larger employers on a fee for service basis. The **Municipal Division** manages group purchasing cooperatives for municipalities. In addition, the **Broker Services Division** serves as a marketing distribution point for major insurance companies: Capital BlueCross, Highmark Blue Shield, HealthAmerica, United Health Care, Aetna, and others. The **Compliance Division** provides guidance relating to regulatory and legal issues for our entire array of customers.

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