# Bluff Head Enterprises, Inc.

## Rhode Island Area Employer-Sponsored Health & Welfare Benefits Survey – 2009

***This survey is designed to be completed in less than 30 minutes*** *for most employer-sponsored plans. Some tips that may help you complete your response more quickly and efficiently:*

- *For our 2008 respondents, if the 2009 response is the same as the previous year you can state "SAME AS LAST YEAR."*
- *Whenever we ask for benefit information, you can attach a current vendor benefit summary in its place.*
- *Whenever we ask for rates and employee exposures if you are fully insured, you can attach a copy of a recent bill.*
- *Whenever we ask for employee contribution information, you can attach a copy of any employee communication about applicable payroll deductions as a substitute (assuming one set of contributions apply to all employees). If different employee contributions apply to different groups of employees (i.e., income sensitive contributions), you can attach a copy of any employee communication explaining your employee contribution structure and indicate the estimated average percentage of your total costs paid by employees.*

*Please return the questionnaire to Bluff Head Enterprises* ***by April 30, 2009****. You can fax your response to (401) 789-3867, mail it to Bluff Head Enterprises, Inc., 105 Main Street, Wakefield, RI 02879 or email it to riareasurvey@bluffhead.com. If you have any questions regarding this survey, please do not hesitate to call us at (401) 782-1250 or (800) 284-9880. Thank you in advance for your participation.*

## Respondent Information

**Company**

Company Name ____________________________________________

Address ____________________________________________

City, State, ZIP ____________________________________________

**Contact**

Contact Name ____________________________________________

Title ____________________________________________

Phone Number (________)___________________________ Fax Number (________) ___________________________

E-mail Address ____________________________________________

**Industry**

☐ Manufacturing
☐ Education
☐ Healthcare
☐ Retail
☐ Government/Municipality
☐ Finance / Insurance
☐ Professional Services (Legal, Accounting)
☐ Other ________________________

**Locations**

Are you multi-sited? ☐ Yes ☐ No

**Number of Employees**

*US*

_____ Total Number of Employees
_____ Total Number of Benefits Eligible Employees

*RI Area Only*

_____ Total Number of Employees
_____ Total Number of Benefits Eligible Employees

**Comments** – We encourage you to share any comments or suggestions you may have regarding this survey.

## Medical Benefits

1. Please provide some basic information regarding your current medical plans.

| | **Plan 1** | **Plan 2** | **Plan 3** |
|---|---|---|---|
| Carrier | ____________ | ____________ | ____________ |
| Plan Name *(Optional)* | ____________ | ____________ | ____________ |

2. *Rates* – If you are fully insured, you may attach a copy of your recent bill(s) instead of completing this question. If your plan is self-insured (including self-insured HRA plans), please list the current COBRA rates.

| | *Monthly Rate* | *Employee Count* | *Monthly Rate* | *Employee Count* | *Monthly Rate* | *Employee Count* |
|---|---|---|---|---|---|---|
| Employee Only | ________ | _____ | ________ | _____ | ________ | _____ |
| Employee + Spouse/One | ________ | _____ | ________ | _____ | ________ | _____ |
| Employee + Child(ren) | ________ | _____ | ________ | _____ | ________ | _____ |
| Employee + Family/Two + | ________ | _____ | ________ | _____ | ________ | _____ |

3. *Employee Contributions* – If you prefer, you can instead attach a copy of any employee communication about applicable payroll deductions (assuming one set of contributions apply to all employees). If different employee contributions apply to different groups of employees (i.e., income sensitive contributions), you can attach a copy of any employee communication explaining your employee contribution structure and indicate the estimated average percentage of your total costs paid by employees.

| | *Per Payroll Deduction Amount* | *Per Payroll Deduction Amount* | *Per Payroll Deduction Amount* |
|---|---|---|---|
| Employee Only | ____________ | ____________ | ____________ |
| Employee + Spouse/One | ____________ | ____________ | ____________ |
| Employee + Child(ren) | ____________ | ____________ | ____________ |
| Employee + Family/Two + | ____________ | ____________ | ____________ |
| *The employee contributions shown above are deducted:* | ☐ Weekly (52 pays)<br>☐ Bi-Weekly (26 pays)<br>☐ Semi-Monthly (24 pays)<br>☐ Monthly (12 pays)<br>☐ Other________ | ☐ Weekly (52 pays)<br>☐ Bi-Weekly (26 pays)<br>☐ Semi-Monthly (24 pays)<br>☐ Monthly (12 pays)<br>☐ Other________ | ☐ Weekly (52 pays)<br>☐ Bi-Weekly (26 pays)<br>☐ Semi-Monthly (24 pays)<br>☐ Monthly (12 pays)<br>☐ Other________ |

4. *Benefits* – You may attach a copy of a current benefit summary of each plan offered instead of completing this question.

| Plan Type | ☐ HMO ☐ POS<br>☐ PPO ☐ Indemnity<br>☐ CDHP | | ☐ HMO ☐ POS<br>☐ PPO ☐ Indemnity<br>☐ CDHP | | ☐ HMO ☐ POS<br>☐ PPO ☐ Indemnity<br>☐ CDHP | |
|---|---|---|---|---|---|---|
| | *In-Network* | *Out-of-Network* | *In-Network* | *Out-of-Network* | *In-Network* | *Out-of-Network* |
| Annual Deductible (Individual) | $_____ | $_____ | $_____ | $_____ | $_____ | $_____ |
| Coinsurance | _____% | _____% | _____% | _____% | _____% | _____% |
| Office Visit Copay (PCP) | $_____ | n/a | $_____ | n/a | $_____ | n/a |
| Office Visit Copay (Specialist) | $_____ | n/a | $_____ | n/a | $_____ | n/a |
| Inpatient Hospital Copay | $_____ | n/a | $_____ | n/a | $_____ | n/a |
| Prescription Drug (retail): | *Retail Copay or Coinsurance* | | *Retail Copay or Coinsurance* | | *Retail Copay or Coinsurance* | |
| Generic | $_____ or _____% | | $_____ or _____% | | $_____ or _____% | |
| Brand Name Preferred | $_____ or _____% | | $_____ or _____% | | $_____ or _____% | |
| Non Preferred | $_____ or _____% | | $_____ or _____% | | $_____ or _____% | |
| Specialty (if applicable) | $_____ or _____% | | $_____ or _____% | | $_____ or _____% | |

| 5. *Renewal Date* | ____________ | ____________ | ____________ |
|---|---|---|---|

6. Total number of eligible employees waiving medical coverage: ________________

7. Do you offer a waiver credit *(a cash payment for waiving coverage)* for medical coverage? ☐ Yes ☐ No

   If "Yes", what is your waiver credit amount (on an annual basis)? $________________

## Dental Benefits

1. Please provide some basic information regarding your current dental plans.

| | Plan 1 | Plan 2 | Plan 3 |
|---|---|---|---|
| Carrier | ____________________ | ____________________ | ____________________ |
| Plan Name *(Optional)* | ____________________ | ____________________ | ____________________ |

2. *Rates* – If you are fully insured, you may attach a copy of your recent bill(s) instead of completing this question. If your plan is self-insured, please list the current COBRA rates.

| | Plan 1 Monthly Rate | Plan 1 Employee Count | Plan 2 Monthly Rate | Plan 2 Employee Count | Plan 3 Monthly Rate | Plan 3 Employee Count |
|---|---|---|---|---|---|---|
| Employee Only | ____________ | _______ | ____________ | _______ | ____________ | _______ |
| Employee + Spouse/One | ____________ | _______ | ____________ | _______ | ____________ | _______ |
| Employee + Child(ren) | ____________ | _______ | ____________ | _______ | ____________ | _______ |
| Employee + Family/Two + | ____________ | _______ | ____________ | _______ | ____________ | _______ |

3. *Employee Contributions* – If you prefer, you can instead attach a copy of any employee communication about applicable payroll deductions (assuming one set of contributions apply to all employees). If different employee contributions apply to different groups of employees (i.e., income sensitive contributions), you can attach a copy of any employee communication explaining your employee contribution structure and indicate the estimated average percentage of your total costs paid by employees.

| | *Per Payroll Deduction Amount* | *Per Payroll Deduction Amount* | *Per Payroll Deduction Amount* |
|---|---|---|---|
| Employee Only | ____________________ | ____________________ | ____________________ |
| Employee + Spouse/One | ____________________ | ____________________ | ____________________ |
| Employee + Child(ren) | ____________________ | ____________________ | ____________________ |
| Employee + Family/Two + | ____________________ | ____________________ | ____________________ |
| *The employee contributions shown above are deducted:* | ☐ Weekly (52 pays)<br>☐ Bi-Weekly (26 pays)<br>☐ Semi-Monthly (24 pays)<br>☐ Monthly (12 pays)<br>☐ Other____________ | ☐ Weekly (52 pays)<br>☐ Bi-Weekly (26 pays)<br>☐ Semi-Monthly (24 pays)<br>☐ Monthly (12 pays)<br>☐ Other____________ | ☐ Weekly (52 pays)<br>☐ Bi-Weekly (26 pays)<br>☐ Semi-Monthly (24 pays)<br>☐ Monthly (12 pays)<br>☐ Other____________ |

4. *Benefits* – You may attach a copy of a current benefit summary of each plan offered instead of completing this question.

| | Plan 1 | | Plan 2 | | Plan 3 | |
|---|---|---|---|---|---|---|
| Plan Type | ☐ Dental PPO<br>☐ Dental Indemnity | | ☐ Dental PPO<br>☐ Dental Indemnity | | ☐ Dental PPO<br>☐ Dental Indemnity | |
| | *In-Network* | *Out-of-Network* | *In-Network* | *Out-of-Network* | *In-Network* | *Out-of-Network* |
| Annual Deductible (Individual) | $________ | $________ | $________ | $________ | $________ | $________ |
| Annual Maximum | $__________ | | $__________ | | $__________ | |
| Coinsurance: | | | | | | |
| Preventive Services | _______% | _______% | _______% | _______% | _______% | _______% |
| Basic Restorative Services | _______% | _______% | _______% | _______% | _______% | _______% |
| Major Restorative Services | _______% | _______% | _______% | _______% | _______% | _______% |
| Orthodontia | ☐ Yes ☐ No | | ☐ Yes ☐ No | | ☐ Yes ☐ No | |
| 5. *Renewal Date* | ____________________ | | ____________________ | | ____________________ | |

6. Total number of eligible employees waiving dental coverage: ________________________

7. Do you offer a waiver credit *(a cash payment for waiving coverage)* for dental coverage? ☐ Yes ☐ No

   If "Yes", what is your waiver credit amount (on an annual basis)? $________________________

## Wellness Program

1. Does your organization currently offer a Wellness Program? ☐ Yes ☐ No
   ***If "No", please proceed to the next section.***

2. What Wellness Program initiatives have you implemented (check all that apply):

| | Initiative | Employee Participation Rate | |
|---|---|---|---|
| ☐ | Health Risk Assessment | _____________% | ☐ Unknown |
| ☐ | Health Coaching | _____________% | ☐ Unknown |
| ☐ | Flu Shots or Flu Shot Reimbursement | _____________% | ☐ Unknown |
| ☐ | Employee Health Fairs | _____________% | ☐ Unknown |
| ☐ | On-Site Fitness or Fitness Reimbursement | _____________% | ☐ Unknown |
| ☐ | On-Site Healthy Lifestyle Classes | _____________% | ☐ Unknown |
| ☐ | Smoking Cessation Program | _____________% | ☐ Unknown |
| ☐ | Weight Loss Management Program | _____________% | ☐ Unknown |
| ☐ | Disease Management (i.e., Asthma, Diabetes, High Risk Pregnancy, etc.) | _____________% | ☐ Unknown |
| | *What is the overall participation in the Wellness Program for your organization?* | _____________% | ☐ Unknown |

3. As a result of your Wellness Program have you experienced:
   a) A reduction in absenteeism? ☐ Yes ☐ No ☐ Undecided
   b) Lower occurrence for short-term disability? ☐ Yes ☐ No ☐ Undecided
   c) Other_____________________________________________________

4. Do you provide employee contribution incentives for employees that participate in the Wellness Program (i.e., lower contributions for non-smokers, premium holiday for wellness participants)?
   ☐ Yes
   ☐ No but we are considering it
   ☐ No and we are not considering it at this time

5. Do you provide other rewards for employees that participate in the Wellness Program (i.e., gift cards, additional paid time off, other de minimis rewards)?
   ☐ Yes
   ☐ No but we are considering it
   ☐ No and we are not considering it at this time

6. Please rank the following in terms of their importance on your wellness program objectives:

| | Very Important | Important | Not Very Important | Not At All Important |
|---|---|---|---|---|
| Improving workforce morale | ☐ | ☐ | ☐ | ☐ |
| Improving worker productivity | ☐ | ☐ | ☐ | ☐ |
| Reducing employee absences due to sickness or disability | ☐ | ☐ | ☐ | ☐ |
| Attracting and retaining employees | ☐ | ☐ | ☐ | ☐ |
| Reducing health care costs | ☐ | ☐ | ☐ | ☐ |
| Improving workplace safety | ☐ | ☐ | ☐ | ☐ |
| Promoting corporate image or brand | ☐ | ☐ | ☐ | ☐ |
| Fulfilling social responsibility | ☐ | ☐ | ☐ | ☐ |

## Plan Information

1. Eligibility Information: What is your minimum hours requirement for medical benefits eligibility?
   ☐ less than 20 hours/week
   ☐ 20-24 hours/week
   ☐ 25-29 hours/week
   ☐ 30-34 hours/week
   ☐ 35-39 hours/week
   ☐ 40 or more hours/week
   ☐ Other: _________________

2. Eligibility Information: What is your waiting period for medical benefits eligibility?
   ☐ None
   ☐ 1 Month / 30 days
   ☐ 2 Months / 60 days
   ☐ 3 Months / 90 days
   ☐ 4-6 Months
   ☐ Other: _________________

## Plan Information (continued)

3. Eligibility Information: Do you allow coverage for domestic partners? ☐ Yes ☐ No
   If "Yes", please indicate all that apply
   - ☐ Same Sex Partner
   - ☐ Opposite Sex Partner
   - ☐ Any Domestic Partner

4. Are you self-insuring all or part of your medical or dental benefits?
   Medical: ☐ Yes ☐ No
   Dental: ☐ Yes ☐ No
   If "Yes", please provide details. For example, do you self-insure the entire medical and/or dental benefit? Do you purchase a high deductible plan on an insured basis and reimburse all or part of that deductible through an HRA account or otherwise?

   ______________________________________________________________________

   ______________________________________________________________________

## Controlling Medical & Dental Costs

1. What was the gross rate of overall increase (if any) in your group benefits in each of the last three years?

| | Medical | Dental |
|---|---|---|
| 2009 vs. 2008 | ______% | ______% |
| 2008 vs. 2007 | ______% | ______% |
| 2007 vs. 2006 | ______% | ______% |

2. What steps have you taken to hold down costs (check all that apply):

| | Within Last Year | Within Last 3 Years |
|---|---|---|
| Changed Carriers | ☐ | ☐ |
| Changed Benefits | ☐ | ☐ |
| Eliminated Benefits | ☐ | ☐ |
| Increased Employee Contributions | ☐ | ☐ |
| Implemented a Consumer-Driven Healthcare Plan (CDHP) | ☐ | ☐ |
| Other ____________________________ | ☐ | ☐ |

3. Do you believe that the cost of group health insurance in Rhode Island would be lower if we had more group health insurers competing in our marketplace? ☐ Yes ☐ No ☐ Undecided

4. How would you rank the following in terms of their contribution to recent dramatic increases in group health insurance costs in Rhode Island?

| | Very Important | Important | Not Very Important | Not At All Important |
|---|---|---|---|---|
| Improvements in medicine that drive up life expectancy | ☐ | ☐ | ☐ | ☐ |
| Lack of competitive carriers offering group health insurance | ☐ | ☐ | ☐ | ☐ |
| An inefficient and wasteful bureaucratic system | ☐ | ☐ | ☐ | ☐ |
| Doctors are making too much money | ☐ | ☐ | ☐ | ☐ |
| Prescription drug manufacturers are making too much money | ☐ | ☐ | ☐ | ☐ |
| Cost sharing from government plans (Medicare, Medicaid, RiteCare, etc.) | ☐ | ☐ | ☐ | ☐ |

5. Please indicate if you offer any of the following. If so, please also indicate the approximate participation percentage of those eligible.

| | | | Participation |
|---|---|---|---|
| Flexible Spending Accounts (FSA) – Health Care | ☐ Yes | ☐ No | ________% |
| Flexible Spending Accounts (FSA) – Dependent Care | ☐ Yes | ☐ No | ________% |
| Health Reimbursement Arrangement (HRA) | ☐ Yes | ☐ No | ________% |
| Health Savings Account (HSA) | ☐ Yes | ☐ No | ________% |

6. Do you think your employees have a good understanding of health insurance costs and cost increases? ☐ Yes ☐ No ☐ Undecided

7. Would you consider a health plan option that offered lower costs, but had fewer participating providers? ☐ Yes ☐ No ☐ Undecided

## Life & Disability Insurance

1. Does your company provide any of the following:

| | | |
|---|---|---|
| Basic Life Insurance – 100% Company Paid | ☐ Yes | ☐ No |
| Basic AD&D Insurance – 100% Company Paid | ☐ Yes | ☐ No |
| Supplemental Employee Life Insurance – 100% Employee Paid | ☐ Yes | ☐ No |
| Supplemental Dependent Life Insurance – 100% Employee Paid | ☐ Yes | ☐ No |
| Voluntary AD&D Insurance – 100% Employee Paid | ☐ Yes | ☐ No |
| Additional Executive Life Insurance – 100% Company Paid | ☐ Yes | ☐ No |
| Basic Long Term Disability (LTD) Insurance – 100% Company Paid | ☐ Yes | ☐ No |
| Supplemental/Voluntary Long Term Disability – 100% Employee Paid | ☐ Yes | ☐ No |

2. Please provide some basic information regarding your current Basic Life & LTD plans. We have broken out the groups by Production, Salaried and Executives. Please limit your response to your company-paid Basic Life Insurance and Basic LTD Insurance.

| | ***Production/Hourly*** | ***Office/Salaried*** | ***Executives*** |
|---|---|---|---|
| Basic Life Insurance Carrier | ____________________ | ____________________ | ____________________ |
| Basic AD&D Insurance Carrier | ____________________ | ____________________ | ____________________ |
| Basic LTD Insurance Carrier | ____________________ | ____________________ | ____________________ |

3. *Rates* – If you prefer, you may attach a copy of your recent bill(s) instead of completing this question.

| | *Monthly Rate* | *Monthly Rate* | *Monthly Rate* |
|---|---|---|---|
| Basic Life *(Rate per $1,000)* | ____________________ | ____________________ | ____________________ |
| Basic AD&D *(Rate per $1,000)* | ____________________ | ____________________ | ____________________ |
| Basic LTD *(Rate per $100 covered monthly payroll)* | ____________________ | ____________________ | ____________________ |

4. *Benefits* – If you prefer, you may attach a copy of your current SPD's or summaries of coverage instead of completing this question.

| | ***Production/Hourly*** | ***Office/Salaried*** | ***Executives*** |
|---|---|---|---|
| **Basic Life Insurance** | | | |
| Benefit | _____ times salary OR<br>$____________ flat amount | _____ times salary OR<br>$____________ flat amount | _____ times salary OR<br>$____________ flat amount |
| Maximum | $__________ | $__________ | $__________ |
| **Basic AD&D Insurance** | | | |
| Benefit | _____ times salary OR<br>$____________ flat amount | _____ times salary OR<br>$____________ flat amount | _____ times salary OR<br>$____________ flat amount |
| Maximum | $__________ | $__________ | $__________ |
| **Basic LTD Insurance** | | | |
| Benefit | _____ % monthly pay OR<br>$____________ flat amount | _____ % monthly pay OR<br>$____________ flat amount | _____ % monthly pay OR<br>$____________ flat amount |
| Monthly Benefit Maximum | $__________ | $__________ | $__________ |
| Elimination Period (see below) | _____ days | _____ days | _____ days |
| Own Occupation Benefit Duration (see below) | _____ months OR<br>☐ to age 65/SSNRA | _____ months OR<br>☐ to age 65/SSNRA | _____ months OR<br>☐ to age 65/SSNRA |

5 Does your company offer retiree life insurance? ☐ Yes ☐ No

*Elimination Period is the period of disability before benefits are paid. Own Occupation Benefit Duration is the period in which benefits are paid when you cannot perform the duties of your own occupation (as opposed to any occupation).*