Employee Benefits Survey

Conducted on behalf

of

AHHRA of Greater New York

Participant Questionnaire

Conducted by:

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Study Background

HRH is conducting a survey of employee benefit programs on behalf of AHHRA of Greater NY. The invited participants include all non-commercial AHHRA members. Your responses will allow us to compile current benchmarking data for healthcare institutions in the New York metropolitan region, and will also help to facilitate a longitudinal study of benefit trends and practices in these institutions.

All facilities participating in the survey will receive a complimentary report of the consolidated results. Individual data will be held by HRH in strictest confidence.

This questionnaire has been designed to be concise and easy to complete Sharon Daffner Bakes of HRH will call you to confirm receipt within the following week and to respond to any questions which may arise.

Completed responses should be returned by July 22nd, 2005 via email or hard copy (mail/fax) to:

sharon.bakes@hrh.com or

Sharon Daffner Bakes
Vice President Health & Welfare HRH
100 Park Ave, 14th Floor
NY, NY 10017.
Phone: 212-907-5962
Fax: 212-907-6392

Thank you for your participation!

About Your Organization

1. **Name of Institution** ____

   List additional facilities which are owned or managed under your organization for employee benefits

   ____

2. **Total Number of Employees**

   Full Time ________________ (In order to be considered full time, an employee must work ____ number of hours/week)

   Part Time ________________ (In order to be considered full time, an employee must work ____ number of hours/week)

   Eligibility/wait period for full time employee________________

   Eligibility/wait period for part time employee________________

   Are part time employees eligible for benefits? ☐ Yes ☐ No

   If yes, is there an hourly threshold? ☐ Yes __hrs/wk ☐ No

   Do part time employees contribute more for benefits? ☐ Yes ☐ No

   Do you offer coverage for Domestic Partners? ☐ Yes ___ same sex ___ opposite sex ☐ No

   ☐ For FT EEs only?

   ☐ For FT and PT benefit eligible EEs

3. **Union Representation** ☐ Yes ☐ No

   A. In general, do the Union groups participate in the same overall benefits plans that non-union groups receive? ☐ Yes ☐ No

   B. If no, benefits differ in: ☐ Benefits provided

   ☐ Level of employee contributions required

   ☐ Other, please specify differences ________________________________

   C. Are certain union groups eligible for the non-union benefit plans?

   ☐ Yes; list which union groups are eligible for the non-union benefit plans, what plans they are eligible for, and which union groups are excluded ____

   ☐ If yes, are union benefits handled by the same administrator?

   ☐ No

Overall Plan Design

4. Please check ("X") the boxes below that describe your overall benefit program:

☐ Employees are enrolled in one benefits program with no benefit options

☐ Employees are allowed to choose from a variety of benefit offerings:

- ☐ Choice of medical programs
- ☐ Choice of dental programs
- ☐ Level of life insurance
- ☐ Level of disability insurance

☐ Employees can participate in reimbursement accounts:

- ☐ Medical reimbursement account
- ☐ Dependent care reimbursement account
- ☐ Employer sponsored HRA's
- ☐ HSA Accounts

☐ Employees participate in a full flexible benefits cafeteria program where employees are given a set amount of "flex credits" or "dollars" and purchase desired benefits

☐ Employees receive on "opt-out" credit if they do not enroll in the medical program

$_____________________ Opt-Out Amount annually

Medical Benefits

5. What type of medical plan do you offer? (Check ("X") all that apply.)

☐ HMO — ☐ Fully Insured — Name of Insurer/Administrator ______________________
☐ Self Insured — Percentage of employees enrolled in HMO __________%

☐ POS (Use of Gatekeeper) — ☐ Fully Insured — Name of Insurer/Administrator ______________________
☐ Self Insured — Percentage of employees enrolled in POS ___________%

☐ POS (No Gatekeeper) — ☐ Fully Insured — Name of Insurer/Administrator ______________________
☐ Self Insured — Percentage of employees enrolled in POS ___________%

☐ PPO — ☐ Fully Insured — Name of Insurer/Administrator ______________________
☐ Self Insured — Percentage of employees enrolled in PTO______%

☐ Other (e.g., Consumer Driven Plan) — ☐ Fully Insured — Name of Insurer/Administrator ______________________
☐ Self Insured — Percentage of employees enrolled in Other __________%

☐ Waive — Percentage of employees waiving coverage ____________%

Medical Benefits – Plan Design

6. **Please complete the following benefit chart to the best of your ability - put N/A where not applicable or answer unknown:**

	HMO	POS		PPO		Other Plans
		IN	OON	IN	OON	
Deductible						
Coinsurance						
Out of Pocket Maximum -Employee -Two Person -Employee/Children -Family						
Office Visit Copayment – PCP						
Office Visit Copayment – Specialist						
Inpatient Hospital Copay/Coins						
Inpatient Surgery Copay/Coins						
Generic Drug Copay						
Formulary Brand Name Drug Copay						
Non-Formulary Brand Name Drug Copay						
Mail order copays						
Total Monthly Gross Premium -Employee -Two Person -Employee/Children -Family	 $ $ $ $	 $ $ $ $		 $ $ $ $		 $ $ $ $
Monthly Employee Paid Portion ($ or %) -Employee -Two Person -Employee/Children -Family	 $ $ $ $	 $ $ $ $		 $ $ $ $		 $ $ $ $

Medical Benefits – Plan Design Changes

7. Please check (X) all that apply:

Plan Change	Plan Change Introduced For Plan Year 2004/05	Plan Change Considered For Plan Year 2005/06
Increase medical deductible		
Increase member-paid coinsurance		
Increase office visit copay		
Implement a tiered office visit copay (PCP vs. specialist)		
Increase emergency room copay		
Implement or increase inpatient hospital copay		
Implement or increase outpatient procedure copay		
Increase prescription drug copays retail and mail order		
Implement separate prescription drug deductible		
Implement other prescription drug plan changes (e.g., exclude "lifestyle" drugs, mandatory generics, etc.)		
Implement a tiered network (preferred hospitals)		
Implement prescription drug carveout plan		
Implement mental health / substance abuse carveout plan		
Eliminate medical plan options		
Offer additional medical plan options		
Change funding from **fully-insured** to **self-insured**		
Change funding from **self-insured** to **fully-insured**		
Introduce Consumer Driven/HSA option		
Introduce full cafeteria plan		

Dental Benefits

8. Dental Benefits

A. Do you offer a dental program to employees? ☐ Yes ☐ No

B. Who is your carrier and how many years have you been with them? ______________________ ________yrs

C. Please indicate which type of dental plans are offered:

Traditional Indemnity _____ DMO _______ PPO _____

Does the annual deductible apply to preventative services? $___________ ____________________
Plan Type

D. What are your coinsurance levels for these services?

	Indemnity	DMO	PPO	
Type I – Preventative	_______%	_______%	_______%	_______%
Type II - Restorative	_______%	_______%	_______%	_______%
Type III - Major Services	_______%	_______%	_______%	_______%
Type IV - Orthodontia	_______%	_______%	_______%	_______%

orthodontia covered for: ☐ children only ☐ coverage for adults ☐ N/A

E. What is the annual benefit maximum? $___________ ____________________
Plan Type

F. What is the lifetime maximum benefit for orthodontia? $_______

G. What is the total gross monthly premium rate:

Employee	$ _________	$ __________	$ __________
Two Person	$ _________	$ __________	$ __________
Employee/Children	$ _________	$ __________	$ __________
Family	$ _________	$ __________	$ __________

H. Please indicate the monthly EMPLOYEE paid portion $ or %:

	Indemnity	DMO	PPO
Individual	__________	__________	__________
Two Person	__________	__________	__________
Adult and Child(ren)	__________	__________	__________
Family	__________	__________	__________

I. Is your plan ______Fully Insured
______Self Insured

J. What was your average renewal increase for the last two years? 2004_______% 2005_______%

K. Have you made changes to your plans over the last two years? ☐ Yes ☐ No
If yes, please specify ____

9. Disability Programs

A. Do you have a long term disability plan? ☐ Yes ☐ No

B. Who is eligible for LTD? (I.E. All F/T ee's):

C. Do you offer different benefit levels based on employee's salary, title, and/or occupation. If yes, please describe (Ei. Class I - All Executives)

Class I _______ Class II _______ Class III _______

D. Is employee paid LTD offered? ☐ Yes ☐ No

E. Employee buy-up LTD offered? ☐ Yes ☐ No

F. What percent of compensation is reimbursed? i.e. 60% of monthly Salary, List by class if applicable

Class I _______ Class II _______ Class III _______

G. What is/are your elimination periods? ____90 days _____180 days _____other

H. What is the monthly maximum benefit? $__________ $__________

I. Do you provide residual disability and return to work Incentives? ☐ Yes ☐ No

J. Does your policy integrate SSI on a Full Family or Individual basis? ________FF ________Indiv

K. Does your policy provide portability? ☐ Yes ☐ No

L. Do you limit benefits for Self Reported conditions? ☐ Yes, ____# month ☐ No

M. What is your pre-existing condition limitation? (i.e.: 3/12; 3/3/12)

N. Do you have an integrated disability management (IDM) program whereby disability and Workers Compensation claims are coordinated? ☐ Yes ☐ No ☐ Considering

O. What changes, if any, have you made to these plans over the past 3 years?

____

____

P. Do you outsource your FMLA administration? ☐ Yes ☐ No

Short Term Disability and DBL

10. Short Term Disability and DBL (NY State mandated Short Term Disability)

A. Do you require that employees pay $.60 per week for their DBL coverage? Yes___ No___

B. Do you have an additional STD program other than DBL, or an enhanced DBL? (check all that apply)

☐ Formal, insured STD program [If checked, please indicate who pays: _____ Employee _____ Employer]

☐ Formal, enhanced DBL program Describe benefit____

☐ Salary continuation (self-insured) Describe benefit____

☐ Sick bank (please indicate below which applies)

___ days accrual/year____ days carry over/year_____ days "banked"____ days maximum "cash out" upon term

Retiree Medical Benefits

11. Retiree Medical Benefits

Do you provide retiree MEDICAL benefits? ☐ **Yes** ☐ **No**

A. Which retirees are covered? ________ under age 65 ________ age 65+

B. Do retirees contribute to the cost of medical coverage? ☐ Yes ☐ No

If Yes, what is the retiree monthly contribution or %?

Pre-65 Retirees

Employee	$ __________
Two Person	$ __________
Employee/Children	$ __________
Family	$ __________

Post-65 Retirees

Employee	$ __________
Two Person	$ __________
Employee/Children	$ __________
Family	$ __________

C. What is the age / years of service eligibility requirement? ________age ________ years of service

D. Do retirees have Qualifying Event rights? ☐ Yes ☐ No

E. What changes have been introduced in the past 2 years?

- ☐ Decreased employee benefit levels
- ☐ Decreased employer paid benefits
- ☐ Changed carriers/administrators
- ☐ Other ____________________________________

F. What changes are under consideration for 2005/06?

- ☐ Decreased employee benefit levels
- ☐ Decreased employer paid benefits
- ☐ Eliminate benefits
- ☐ Change carriers
- ☐ Other ____________________________________

Retiree Dental Benefits

12. Retiree Dental Benefits

Do you provide retiree DENTAL benefits? ☐ Yes ☐ No

A. Which retirees are covered? ________ under age 65 ________ age 65+

B. Do retirees contribute to the cost of dental coverage? ☐ Yes ☐ No

If Yes, what is the retiree monthly contribution?

Pre-65 Retirees

Individual $ __________
Two Person - 2 Adults $ __________
Two Person - Adult and Child(ren) $ __________
Family $ __________

Post-65 Retirees

Individual $ __________
Two Person - 2 Adults $ __________
Two Person - Adult and Child(ren) $ __________
Family $ __________

C. What is the age / years of service eligibility requirement? ________age ________ years of service

D. Do retirees have Qualifying Event rights? ☐ Yes ☐ No

E. What changes have been introduced in the past 2 years?

☐ Decreased employee benefit levels
☐ Decreased employer paid benefits
☐ Other ______________________________

F. What changes are under consideration for 2005/06?

☐ Decreased employee benefit levels
☐ Decreased employer paid benefits
☐ Other ______________________________

Retirement Benefits - Additional Information

13. Retirement Benefits - Additional Information

Do you currently offer, or have you recently offered, an Incentive Retirement Program? ☐ **Yes** ☐ **No**

A. Was it a limited "window" opportunity? ☐ Yes ☐ No

B. Was the incentive in the form of a cash incentive or other subsidy? ☐ Cash $ ________

☐ Subsidy (e.g., medical premium) ________________

C. Were there age / years of service limitations? ________age ________ years of service

D. Do you offer a Defined Benefit Pension Plan? ☐ **Yes** ☐ **No**

What categories of employees are offered the plan? ______________________________

Please describe the Benefit Formula: ______________________________

____

E. Do you offer a 403(b) or similar Defined Contribution Plan? ☐ Yes ☐ No

Are employee contributions required to receive an employer match? ☐ Yes ☐ No

Does the employer contribution differ by class of employees? ☐ Yes ☐ No

If yes, please indicate the % employer contribution for:

Faculty ____________%

Professional ____________%

Classified (Hourly) ____________%

Technology

14. Technology

A. Do you have your own HR intranet website? ☐ Yes ☐ No

B. Do you have your own HR internet website? ☐ Yes ☐ No

C. Do you have customized site dedicated to HR and Benefits? ☐ Yes ☐ No

D. Was your site developed
internally________
external vendor/consultant ________
combination _________

E. Is your site maintained
internally________
external vendor/consultant ________
combination _________

F. What functions does your site provide (check if applicable)

∴ Basic HR policies/EB SPDs descriptions/form _______
∴ HR/Benefit communications and newsletters _______
∴ Open enrollment communications (forms, contributions & changes) _______
∴ Online self-service for open enrollment _______
∴ Self-service for ongoing changes _______
∴ Web links to providers, discounts, nurse hot-lines, etc. _______
∴ Email and communication with employees and other HR peers _______
∴ Vacation and sick time tracking _______

G. Is your technology funded internally or included in or offset by your Broker/Consultant fees?

H. Who is your technology vendor? __________

Wellness Programs

15. Wellness Programs

A. Do you offer an EAP? ☐ Yes ☐ No

B. Is this administered and provided through your own healthcare institution? ☐ Yes ☐ No

If no, provide vendor___________

C. How many years have you offered an EAP? __________yrs

D. Do you feel it is a worthwhile return on investment? ☐ Yes ☐ No

E. Do you provide on-site and/or offsite employee health and wellness resources? ☐ Yes ☐ No

If yes, please list services available:

	On-Site	Off-Site
Educational Seminars	________	________
Yoga	________	________
Gym Access	________	________
Meditation	________	________
Counseling	________	________
Weight Watchers	________	________
Smoke-enders	________	________
Stress Management	________	________
Financial Counseling	________	________
Other	________	________

Tuition Assistance

16. Tuition Assistance

A. Do you have a tuition assistance / remission / waiver program? ☐ **Yes** ☐ **No**

B. What types of employees are eligible for the program? ☐ Full-time EEs ☐ Part-time EEs

C. Is there a years of service requirement? ☐ Yes, ____years ☐ No

D. Who is eligible to take courses under the program? ☐ Employee ☐ Spouse ☐ Children

E. Is the program available only for courses taken at specific learning institutions? ☐ Yes ☐ No

F. Please indicate the expenses covered under the program: ☐ Tuition ☐ Supplies/Books ☐ Other _______

G. Does the program cover a percentage of expenses? ☐ Yes, ____% ☐ No

If yes, what is your cap? $_________

H. Does the program cover expenses at 100% up to a flat dollar amount? ☐ Yes, $_____ ☐ No

I. If your program includes other rules or limitations, please describe them below: (i.e. course grade requirement for reimbursement dollar limit for each degree)

____

____

17. Other Benefits

Do you offer:

	Carrier		
Medical FSA	____________	☐ Yes	☐ No
Dep. Care FSA	____________	☐ Yes	☐ No
Cobra Outsourcing	____________	☐ Yes	☐ No
Vision benefits	____________	☐ Yes	☐ No
529 Programs	____________	☐ Yes	☐ No
Supplemental Employee Life Insurance	____________	☐ Yes	☐ No
Spousal Life Insurance	____________	☐ Yes	☐ No
Child Life Insurance	____________	☐ Yes	☐ No
Voluntary AD&D Insurance	____________	☐ Yes	☐ No
Group Universal Life (GUL) Insurance	____________	☐ Yes	☐ No
Long Term Care benefits	____________	☐ Yes	☐ No
Group Legal benefits	____________	☐ Yes	☐ No
Group Auto and Homeowners Insurance	____________	☐ Yes	☐ No
Pet Insurance	____________	☐ Yes	☐ No
Cancer Insurance	____________	☐ Yes	☐ No
Income Protection	____________	☐ Yes	☐ No
Critical Illness	____________	☐ Yes	☐ No
Financial (mortgage, Credit Union Counseling)	____________	☐ Yes	☐ No

Other benefits (please describe below) such as discount entertainment, health club access or discounts?

____

Vacation, Holiday, Personal, Sick, PTO Policies

18. Vacation, Holiday, Personal, Sick, PTO Policies

A. Provide your PTO days/policies and specify as applicable:

FT:____
____

PT: ____
____

Additional Comments:____
____

B. Do you allow vacation days to accumulate and roll-over from year to year? ☐ Yes ☐ No

C. If yes, what are your limitations?

_________ max roll over days/yr
_________ max number of day accumulated allowed
_________ max number of years permitted to accumulate

D. Do you offer cash incentives for unused PTO sick or vacation days? ☐ Yes ☐ No

E. If yes, please describe your policy and benefit

____
____

Overall Satisfaction

19. Overall Satisfaction

How do you rate your overall satisfaction regarding the following aspects of your benefit plan on a scale of 1-5 (1 is poor 5 is excellent)

1. Quality of benefit plans offered _____
2. Employer contributions ______
3. Scope of plan offerings and variety _____
4. Communications effectiveness _______
5. Employee feedback and satisfaction ______
6. Technology and outsourcing ______