2012/2013 Employer Focus

• Managing costs while maintaining a benefits package that
  • Supports organizational attraction and retention goals
  • Helps employees and their dependents become or stay healthy

• Preparing for health care reform
Managing Costs
Managing Costs

Most Effective Steps to Control Health Care Costs

- Consumer-directed health plan: 43% (Most Effective), 13% (Second Most Effective), 5% (Third Most Effective)
- Wellness initiatives: 19% (Most Effective), 21% (Second Most Effective), 21% (Third Most Effective)
- Increased employee cost-sharing: 9% (Most Effective), 16% (Second Most Effective), 11% (Third Most Effective)
- Disease/condition management: 6% (Most Effective), 15% (Second Most Effective), 9% (Third Most Effective)
- Pharmacy benefit design changes: 6% (Most Effective), 11% (Second Most Effective), 6% (Third Most Effective)
- Care management: 4% (Most Effective), 9% (Second Most Effective), 9% (Third Most Effective)
- Specialty drug management: 4% (Most Effective), 5% (Second Most Effective), 5% (Third Most Effective)
- Health care navigators or advocates: 4% (Most Effective), 10% (Second Most Effective)
- Dependent eligibility audit: 3% (Most Effective), 10% (Second Most Effective)
- Utilization management: 4% (Most Effective), 4% (Second Most Effective)
- Quality-focused tier networks: 3% (Most Effective), 3% (Second Most Effective)
- Vendor/data integration: 1% (Most Effective)
- Other: 3% (Most Effective), 4% (Second Most Effective)

Managing Costs

• Plan Design and Employee Contributions

• Consumerism

• Wellness

• Medical Homes

• Accountable Care Organizations
Managing Costs – Plan Design and Employee Contributions

2013 Employee Cost-Sharing Tactics

Employee percentage contribution to the premium cost: 41% (Small Increase), 16% (Medium Increase), 3% (Large Increase)

In-network deductibles: 22% (Small), 10% (Medium), 8% (Large)

Out-of-network deductibles: 15% (Small), 8% (Medium), 10% (Large)

Out-of-pocket maximums: 15% (Small), 9% (Medium), 8% (Large)

Copay/coinsurance for primary care: 8% (Small), 1% (Medium)

Copay/coinsurance for specialist care: 7% (Small), 4% (Medium)

Managing Costs – Plan Design and Employee Contributions

Use of Centers of Excellences and Second Opinion Services

Centers of Excellence for transplants

- Offer service, and differentiate cost-sharing: 28%
- Offer service, but don't differentiate cost-sharing: 56%

Centers of Excellence for selected conditions other than transplants

- Offer service, and differentiate cost-sharing: 30%
- Offer service, but don't differentiate cost-sharing: 46%

Second opinion services

- Offer service, and differentiate cost-sharing: 7%
- Offer service, but don't differentiate cost-sharing: 42%

High performance networks

- Offer service, and differentiate cost-sharing: 10%
- Offer service, but don't differentiate cost-sharing: 32%

Patient-centered medical home

- Offer service, and differentiate cost-sharing: 6%
- Offer service, but don't differentiate cost-sharing: 22%

Managing Costs – Plan Design and Employee Contributions

Direct Contracting with Providers

- Surgical Centers of Excellence
  - Currently: 11%
  - Considering: 21%

- Patient-centered medical home (PCMH)
  - Currently: 11%
  - Considering: 18%

- Intensive outpatient services (e.g., high cost or chronic cases)
  - Currently: 3%
  - Considering: 20%

Managing Costs – Plan Design and Employee Contributions

Prevalence of On-Site Health Clinics

45%

46%

9%

Managing Costs – Plan Design and Employee Contributions

Services Provided at On-Site Health Clinics

- Acute care: 61% (All clinics), 9% (Most clinics), 12% (Some clinics)
- Health improvement programs: 48% (All clinics), 6% (Most clinics), 24% (Some clinics)
- Occupational health: 61% (All clinics), 12% (Some clinics)
- Primary care: 35% (All clinics), 19% (Most clinics)
- Chronic care management: 30% (All clinics), 20% (Most clinics)
- Pharmacy services: 23% (All clinics), 23% (Most clinics)
- On-site employee assistance programs: 16% (All clinics), 23% (Most clinics)
- Selected specialty care: 10% (All clinics), 20% (Most clinics)

Coverage of Treatments for Obesity and Severe Obesity

- **Gastric bypass surgery**: 79%
- **Laparoscopic adjustable gastric band surgery**: 70%
- **FDA-approved medications**: 49%
- **Non-surgical treatments for adults who are obese, other than drugs**: 43%
- **Physician-recommended treatments for children identified as obese**: 40%

Managing Costs – Plan Design and Employee Contributions

Programs for Overweight Employees, Spouses and Children

- On-site weight management programs led by trained medical personnel:
  - Employees: 9%
  - Spouses or Domestic Partners: 3%
  - Children: 3%

- Community programs with company administrative or financial support:
  - Employees: 52%
  - Spouses or Domestic Partners: 18%
  - Children: 6%

- Support groups for weight management at work:
  - Employees: 44%
  - Spouses or Domestic Partners: 5%
  - Children: 4%

- Online weight management tools:
  - Employees: 68%
  - Spouses or Domestic Partners: 51%
  - Children: 21%

- Telephonic or online health coaching for weight management:
  - Employees: 78%
  - Spouses or Domestic Partners: 64%
  - Children: 31%

Managing Costs – Plan Design and Employee Contributions

Employee Cost-Sharing Strategies for Pharmacy

Managing Costs – Plan Design and Employee Contributions

Pharmacy Benefit Management Techniques

- **Step therapy**: 65% (2013) vs. 72% (2012)
- **Prior authorization**: 71% (2013) vs. 76% (2012)
- **Quantity limits**: 70% (2013) vs. 72% (2012)
- **Three-tier design**: 51% (2013) vs. 59% (2012)
- **Mandatory mail-order for maintenance drugs**: 45% (2013) vs. 51% (2012)
- **Dose optimization**: 33% (2013) vs. 43% (2012)
- **Mandatory generic substitution**: 39% (2013) vs. 37% (2012)
- **Four-tier design**: 16% (2013) vs. 21% (2012)
- **Mandatory formulary**: 14% (2013) vs. 17% (2012)
- **Separate deductible for pharmacy benefits**: 13% (2013) vs. 16% (2012)
- **Other**: 5% (2013) vs. 8% (2012)

Managing Costs – Plan Design and Employee Contributions

Specialty Pharmacy Benefit Management Techniques

- Prior authorization: 64% (2013), 64% (2012)
- Step therapy: 49% (2013), 58% (2012)
- Utilization management: 49% (2013), 58% (2012)
- Quantity limits: 36% (2013), 49% (2012)
- Dose optimization: 37% (2013), 48% (2012)
- Preferred network: 42% (2013), 44% (2012)
- Mandatory mail-order for maintenance drugs: 29% (2013), 40% (2012)
- Carve out health plan: 27% (2013), 40% (2012)
- Four-tier or higher formulary: 16% (2013), 13% (2012)
- Other: 1% (2013), 1% (2012)

Managing Costs – Value-Based Design

What is Value-Based Benefit Design?

- Encourages the use of services when the clinical benefits exceed the cost
- Discourages the use of services when the clinical benefits do not justify the cost
- Recognizes that clinical benefits depend on patient characteristics
- Uses a clinically-sensitive approach to cost-sharing

**Example:** Lowering copays on generic insulin from $15 to $0 and preferred brand insulin from $30 to $15.

**Result:** Higher overall treatment initiation rates and lower discontinuation rates in the year after benefit design changes

Managing Costs – Health Care Consumerism

- Health Care Consumerism advocates patients’ involvement in their own health care decisions
  - Encourages health information empowerment and the transfer of knowledge
  - Patients can be informed and therefore more involved in the decision-making process
  - Attempts to promote public understanding of basic organ function, the processes of chronic disease, and the beginnings of how to best prevent these diseases
- Care Consumerism in employer-sponsored health plans encourages plan participants to make cost and value-based decisions on their health care
Managing Costs – Health Care Consumerism

Evolution of Health Care Consumerism

1st Generation
Focus: Reduce discretionary spending
• Consumer-driven health plans with HSAs/HRAs

2nd Generation
Focus: Change behavior
• Consumer-driven health plans with HSAs/HRAs
• Education to change consumer purchasing behavior
• Emergence of decision support tools
• Inclusion of wellness as a component of consumerism

Future Generations
Focus: Personalized health
• Potential regulatory changes that could expand use of HSAs
• Predictive/personalized health (includes biomarker and genomics testing)
• Provider charge transparency
• Real time feedback on health status, lifestyle and health concerns
### Managing Costs – Consumer-Driven Health Plans

**41% of employers offer a CDHP and employee adoption is growing**

<table>
<thead>
<tr>
<th>Year</th>
<th>Conventional</th>
<th>HMO</th>
<th>PPO</th>
<th>POS</th>
<th>CDHP/HSA</th>
</tr>
</thead>
<tbody>
<tr>
<td>1988</td>
<td>73%</td>
<td>16%</td>
<td>11%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1993</td>
<td>46%</td>
<td>21%</td>
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<td>7%</td>
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<tr>
<td>1996</td>
<td>27%</td>
<td>31%</td>
<td>28%</td>
<td>14%</td>
<td></td>
</tr>
<tr>
<td>1999</td>
<td>10%</td>
<td>28%</td>
<td>38%</td>
<td>24%</td>
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<tr>
<td>2002</td>
<td>4%</td>
<td>27%</td>
<td>51%</td>
<td>18%</td>
<td></td>
</tr>
<tr>
<td>2005</td>
<td>3%</td>
<td>21%</td>
<td>61%</td>
<td>15%</td>
<td></td>
</tr>
<tr>
<td>2008</td>
<td>20%</td>
<td>58%</td>
<td>12%</td>
<td>8%</td>
<td></td>
</tr>
<tr>
<td>2011</td>
<td>17%</td>
<td>55%</td>
<td>10%</td>
<td>17%</td>
<td></td>
</tr>
</tbody>
</table>

Managing Costs – Consumer-Driven Health Plans

Availability of CDHPs Among Employers

<table>
<thead>
<tr>
<th>Year</th>
<th>Full Replacement</th>
<th>As an Option</th>
</tr>
</thead>
<tbody>
<tr>
<td>2009 (N=60)</td>
<td>7%</td>
<td>55%</td>
</tr>
<tr>
<td>2010 (N=68)</td>
<td>10%</td>
<td>53%</td>
</tr>
<tr>
<td>2011 (N=69)</td>
<td>20%</td>
<td>41%</td>
</tr>
<tr>
<td>2012 (N=75)</td>
<td>17%</td>
<td>56%</td>
</tr>
<tr>
<td>2013 (N=78)</td>
<td>19%</td>
<td>54%</td>
</tr>
</tbody>
</table>

Managing Costs – Consumer-Driven Health Plans

Prevalence of Consumer-Directed Health Plan Types

- HDHP with HSA: 79% (2013), 75% (2012)
- HDHP with HRA and FSA: 29% (2013), 16% (2012)
- HDHP with HRA: 13% (2013), 13% (2012)
- Other plan type with HRA: 13% (2013), 5% (2012)
- HDHP with FSA: 13% (2013), 13% (2012)
- Lower deductible health plan that promotes consumerism: 5% (2013), 5% (2012)
- HDHP without a health account: 4% (2013), 4% (2012)

Managing Costs – Consumer-Driven Health Plans

Price Transparency Tools for Employees

- No: 65%
- Yes, through a 3rd party vendor: 21%
- Yes, through our health plan: 14%

Managing Costs – Wellness

- Encourage employees to take an active role in managing and improving their health
- Identify and build lifestyle initiatives targeted specifically to the risk factors evident in your employee population
- Create realistic wellness goals that each individual employee can achieve
- Inspire employees to achieve established goals through an incentive design that includes both extrinsic and intrinsic motivations
Managing Costs – Wellness

1. Biometric Screenings
2. Health Assessment
3. Coaching, Lifestyle Management and Disease Management

Wellness Program Components
Managing Costs – Workplace Wellness Trends

Employer Wellness Programs Offered

- Weight Management: 62%
- Smoking Cessation: 70%
- Physical Activity: 70%
- Web-based Health Portal: 87%
- Health Assessment: 72%
- Lifestyle Coaching: 51%
- Spousal Benefits: 62%

Source: Kaiser Family Foundation, 2011 Employer Health Benefits Annual Survey, Mid-size Employers (1,000 – 4,999 Employees)
Managing Costs – Workplace Wellness Trends

HRA Completion and/or Biometric Screening Participation

- Receive Financial Incentives: 60% Currently, 16% Considering
- Allowed into Preferred Plan: 6% Currently, 21% Considering
- Required for Health Insurance Coverage: 15%

Managing Costs – Workplace Wellness Trends

Financial Incentives Encouraging Healthy Lifestyles

- Incentives for participating in programs: 48%
- Incentives based upon tobacco-use status: 44%
- Incentives based upon achievement of specific health outcomes: 29%
- Surcharges for non-participation in programs: 22%
- Incentives based upon progressing toward specific health outcomes: 19%

Managing Costs – Workplace Wellness Trends

Median Incentive Amounts for Healthy Lifestyles, 2011-2013

Patient-Centered Medical Home

- An approach to providing comprehensive and integrated primary patient care, which is being driven by the concept that primary care decreases mortality, morbidity and per capita expenditures while increasing patient satisfaction

- Team-based, coordinated approach to patient care with “whole person” orientation

- Primary Care Physician is main patient contact and coordinates care among team members (specialists, etc.)

- Intended to increase quality and safety of patient care and broaden access to care

- Physician care supported by Health Information Technology integration (eRx, patient registry)
Managing Costs – Accountable Care Organizations

- **Accountable Care Organizations (ACO)**
  - A group of coordinated health care providers which provides care to an assigned population of patients.

  - Payment and care delivery model ties provider payments to quality metrics and reductions in the total cost of care for the assigned population of patients.

  - Accountable to the patients and the third-party payer for the quality, appropriateness, and efficiency of the health care provided.

- **Atlanta Example** – Piedmont Physicians and Cigna have partnered to form an ACO
Health Care Reform
2012-2013:

- Patient–centered outcomes research fee
  - $1 per average life for plan years ending between October 1, 2012 and September 30, 2013; and
  - $2 per covered life for plan years ending between October 1, 2013 and September 30, 2014
- Must report total cost of employer-sponsored health care in Box 12 on calendar year 2012 Form W-2 distributed in January 2013
- Non-grandfathered plans are required to provide additional wellness and detection screenings in the first plan year that begins on or after August 1, 2012
2012 – 2013:

- Separate SBC for each benefit package – not required for stand alone dental and vision benefits, certain health FSAs, HRAs and retiree only plans

- Group Health Plans must provide the SBC:
  - During initial enrollment and annual enrollment beginning with the first open enrollment period on or after September 23, 2012
  - HIPAA special enrollment
  - Upon request
    - Following a material modification
2012 – 2013:

- State notification to the HHS regarding whether the state will operate a Health Benefit Exchange
- Health FSA contributions limited to $2,500 per plan year
- Increase Medicare Part A tax for highly paid individuals
- Notice to Employees of Health Benefit Exchanges in 2014
Summary of Benefits

• Format requirements
  • Four double-sided pages using 12-point font
  • Stand-alone document or part of SPD
  • Provided in paper format or electronically
  • Non-English alternatives must be provided in counties where 10% or more are literate in the same non-English language

• Distribution timing
  • When first eligible
  • When renew coverage (for example, at annual enrollment)
  • Within seven days of a request
  • 60 days before the effective date of a mid-year material modification of coverage
Summary of Benefits

• Required information:
  • Uniform definitions of terms ("Uniform Glossary")
  • Description of coverage for each category of benefits
  • Description of any limitations on coverage
  • Cost sharing provisions (such as deductibles and copays)
  • Renewability and continuation of coverage provisions
  • "Coverage examples" illustrating common benefits scenarios
  • Statement that SBC is a summary and should not be consulted for contract provisions

• Contact number and Internet address for additional documents to obtain or review
  • Provider network
  • Prescription drug coverage
  • Uniform Glossary
Internal or External Production of SBC Documents

- 62% Vendor
- 32% Internally
- 6% Combination

W-2 Reporting

• Must be distributed in January 2013 for calendar year 2012

• Total cost of health care reported in box 12 of W-2

• Calculating total cost:
  • COBRA Applicable Premium Method – COBRA premium less 2%
  • Premium Charged Method – Premium charged for fully-insured
  • Modified COBRA Premium Method – Total COBRA premium if employer subsidizes premium

• Not required to report:
  • Health reimbursement arrangements (HRAs)
  • Salary reductions to a flexible spending arrangement
  • Stand-alone dental or vision plans
  • EAPs or wellness programs if no premium for COBRA continuation
Non-Grandfathered Status

Plan features that need to be included if non-grandfathered:

- In- and Out-of-network emergency services must be the same
- Internal and external appeals process
- Preventive care services at no cost to member
- Add coverage for clinical trials (2014)
- Wellness incentives can increase to 30% (2014)
Employer Actions to FSA Limit Beginning in 2013

94%
Yes, we had to (or will) reduce our limit to $2,500

2%
No, our limit was already at or below $2,500

4%
No, we do not offer FSAs to employees

Grandfathered Plans

Percentage of Firms and Covered Workers Enrolled in Plans Grandfathered under the Affordable Care Act, by Firm Size, 2011

Employers Keeping Grandfathered Plan Status

- Yes: 27%
- No, none of my benefit options kept grandfathered status in 2012: 57%
- No, will drop grandfathered status in 2013: 7%
- Don’t Know: 9%

Health Care Reform Responses

Changes to Annual Benefit Limits in 2013

- Mental health and substance abuse services: 9%
- Rehabilitative services and devices: 9%
- Preventive and wellness services: 7%
- Prescription drugs: 2%
- Maternity and newborn care: 1%
- No changes made to annual benefit limits in 2013: 32%
- N/A (Do not have any annual benefit limits): 50%

Employee has choice of whether or not to participate in an Exchange – some Employees will be eligible for cost of coverage and/or premium subsidies

Employer has choice of whether or not to offer employer-sponsored coverage

Employers will be subject to penalties depending upon whether or not coverage is offered and whether or not Employees go into the Exchanges
Plans valued at $10,200 for individual coverage or $27,500 for family coverage will be subject to an excise tax of 40% on the value of the plan that exceeds these thresholds.

The tax will be levied on insurers and self-insured employers, not directly on employees.

The threshold amounts will be increased for inflation beginning in 2020.
Offer Coverage

If your plan is considered unaffordable, and at least one Employee is receiving a tax credit or subsidy and is participating in an Exchange, you pay a fee of the lesser of $3,000 for each Employee receiving a tax credit or subsidy or $2,000 for each full-time Employee, excluding the first 30 Employees.

Your plan will be considered unaffordable if the Employee premium exceeds 9.5% of the Employee’s household income.

Do Not Offer Health Coverage

Fee of $2,000 per full-time Employee, excluding the first 30 Employees, if:

at least one full-time Employee enrolls in coverage in an Exchange and receives a premium tax credit or cost-sharing subsidy.
Exchange Plans

<table>
<thead>
<tr>
<th>Exchange Plan</th>
<th>Actuarial Value</th>
<th>Annual Deductible</th>
<th>Patient Coinsurance</th>
<th>Out-of-Pocket Limit*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bronze 1</td>
<td>60% of costs</td>
<td>Single - $4,375</td>
<td>20%</td>
<td>Single - $6,350</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Family - $8,750</td>
<td></td>
<td>Family - $12,700</td>
</tr>
<tr>
<td>Bronze 2</td>
<td>60% of costs</td>
<td>Single - $3,475</td>
<td>40%</td>
<td>Single - $6,350</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Family - $6,950</td>
<td></td>
<td>Family - $12,700</td>
</tr>
<tr>
<td>Silver 1</td>
<td>70% of costs</td>
<td>Single - $2,050</td>
<td>20%</td>
<td>Single - $6,350</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Family - $4,100</td>
<td></td>
<td>Family - $12,700</td>
</tr>
<tr>
<td>Silver 2</td>
<td>70% of costs</td>
<td>Single - $650</td>
<td>40%</td>
<td>Single - $6,350</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Family - $1,300</td>
<td></td>
<td>Family - $12,700</td>
</tr>
</tbody>
</table>

* Estimated 2014 out-of-pocket limit for health savings account-qualified health plans
Exchange plan designs do not take into account potential cost-of-coverage subsidies.
## Federal Poverty Level (FPL) and Annual Premium

<table>
<thead>
<tr>
<th>% of FPL</th>
<th>Household Income</th>
<th>Annual Premium</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Single</td>
<td>Family of 4</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>$690</td>
<td>$1,405</td>
</tr>
<tr>
<td>150%</td>
<td>$16,755</td>
<td>$34,575</td>
<td></td>
<td></td>
</tr>
<tr>
<td>200%</td>
<td>$22,340</td>
<td>$46,100</td>
<td>$1,450</td>
<td>$2,952</td>
</tr>
<tr>
<td>300%</td>
<td>$33,510</td>
<td>$69,150</td>
<td>$3,279</td>
<td>$6,676</td>
</tr>
<tr>
<td>400%</td>
<td>$44,680</td>
<td>$92,200</td>
<td>$4,372</td>
<td>$8,901</td>
</tr>
<tr>
<td>&gt;400%</td>
<td>Over $44,680</td>
<td>Over $92,200</td>
<td>$6,798</td>
<td>$16,858</td>
</tr>
</tbody>
</table>

### Silver Plan in Exchange

**Age 50**

Health Care Reform 2014 – Will Employees Go Into The Exchange?
Tax credits and cost-sharing subsidies will be available to eligible individuals. **Premium subsidies will be available to families with incomes up to 400% of the federal poverty level** to purchase insurance through the Exchanges. **Cost-sharing subsidies will be available to those with incomes up to 400% of the poverty level.**

<table>
<thead>
<tr>
<th>FAMILY SIZE</th>
<th>2012 FEDERAL POVERTY LEVEL</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>HOUSEHOLD INCOME</td>
</tr>
<tr>
<td></td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td>150%</td>
</tr>
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<td></td>
<td>200%</td>
</tr>
<tr>
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<td>300%</td>
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<td>1</td>
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<td>$ 16,755</td>
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<td>$ 22,695</td>
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<td></td>
<td>$ 30,260</td>
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<td></td>
<td>$ 45,390</td>
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<td>$ 60,520</td>
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<td>$ 19,090</td>
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<td>$ 28,635</td>
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<td>$ 77,780</td>
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<tr>
<td></td>
<td>$ 116,670</td>
</tr>
<tr>
<td></td>
<td>$ 155,560</td>
</tr>
</tbody>
</table>
Employee Groups Expected to Find Health Exchanges as a Viable Option

- Retirees: 51%
- COBRA plan participants: 38%
- Current part-time employees: 35%
- Current full-time employees: 16%
- Spouses or dependents: 14%
- None: 26%

Health Care Reform 2014 – Do Not Offer Coverage

Do Not Offer Health Coverage

Fee of $2,000 per full-time Employee, excluding the first 30 Employees, if: at least one full-time Employee enrolls in coverage in an Exchange and receives a premium tax credit or cost-sharing subsidy.

- Potential for significant savings to employer
- Employees will have to buy coverage on the Exchange with or without a subsidy
- Expectation from Employees will be that compensation and/or other benefits will be increased
- Compensation and benefit comparisons will become more important than ever in job decisions
- Competitive stance for attracting and retaining Employees will be key in decision not to offer coverage – Who goes first in your industry or geographic area?