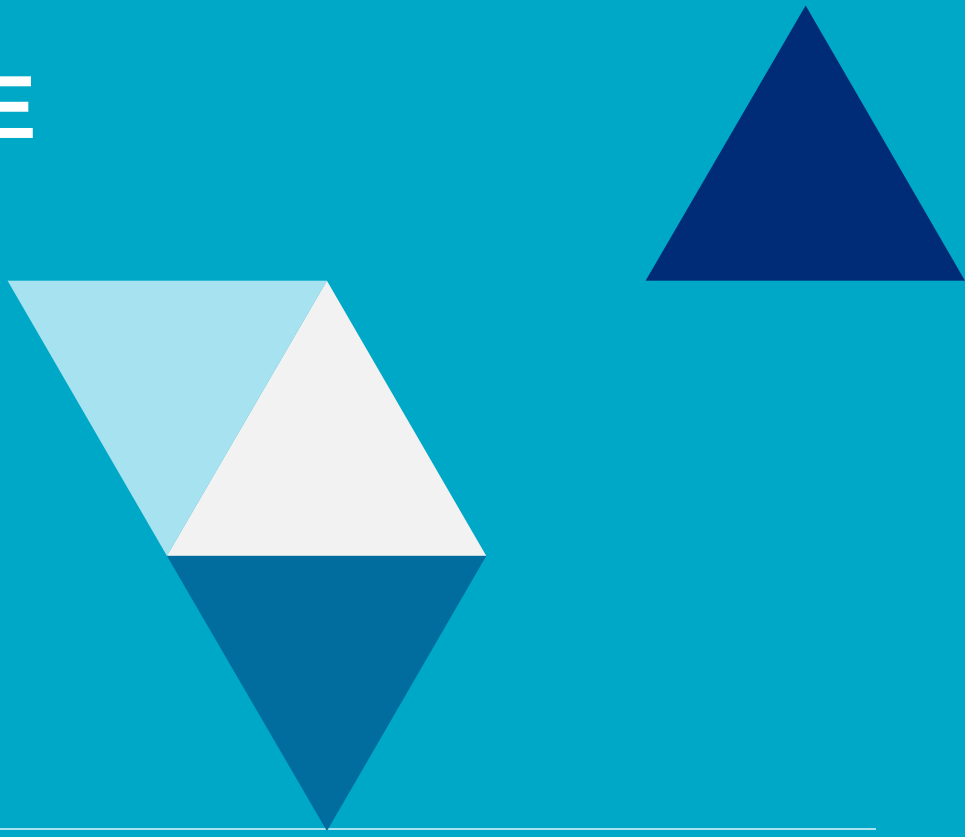
HEALTH WEALTH CAREER

MERCER'S NATIONAL SURVEY OF EMPLOYER-SPONSORED HEALTH PLANS 2015

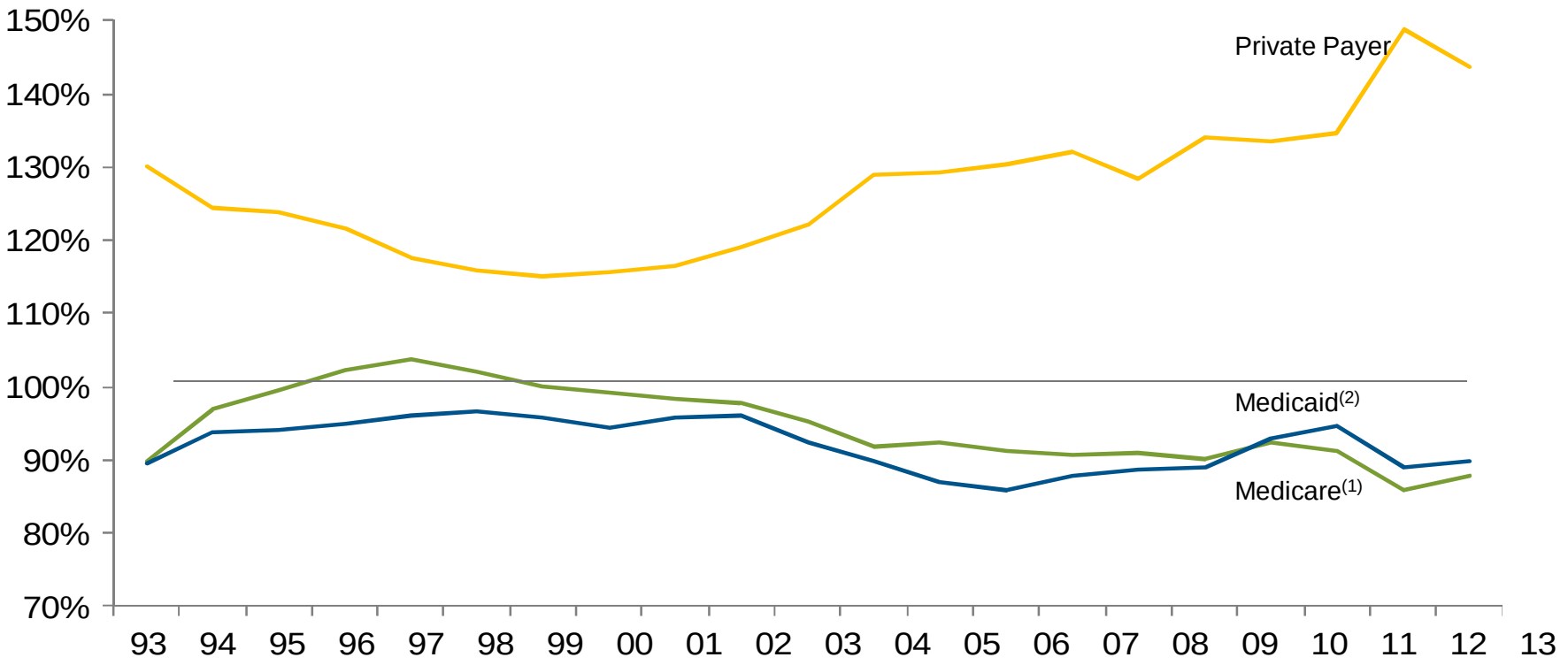
MAKE TOMORROW, TODAY MERCER

SETTING THE STAGE



AGGREGATE HOSPITAL PAYMENT-TO-COST RATIOS FOR PRIVATE PAYERS, MEDICARE AND MEDICAID, 1993 – 2013

- Avalere Health / AHA Annual Survey Data, Community Hospitals



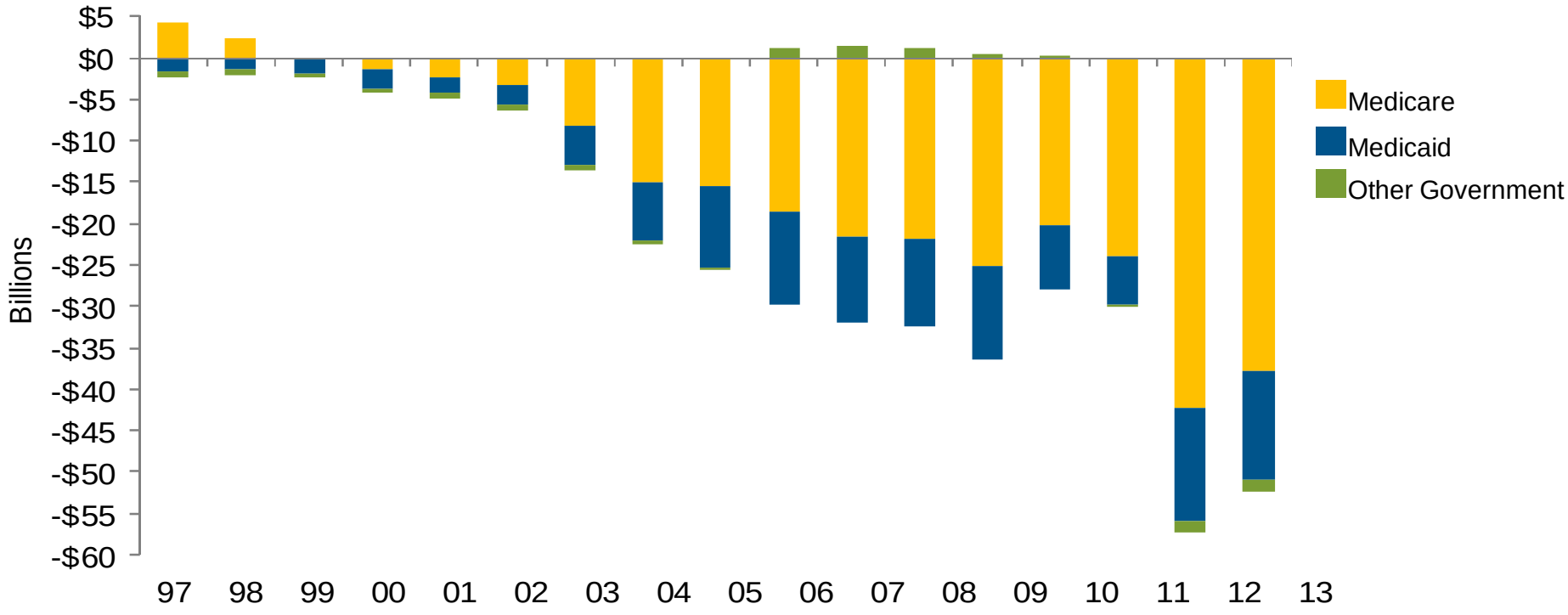
Source: Avalere Health analysis of American Hospital Association Annual Survey data, 2013, for community hospitals.

(1) Includes Medicare Disproportionate Share payments.

(2) Includes Medicaid Disproportionate Share payments.

HOSPITAL PAYMENT SHORTFALL RELATIVE TO COSTS FOR MEDICARE, MEDICAID AND OTHER GOVERNMENT, 1997 – 2013(1)

- Avalere Health / AHA Annual Survey Data, Community Hospitals

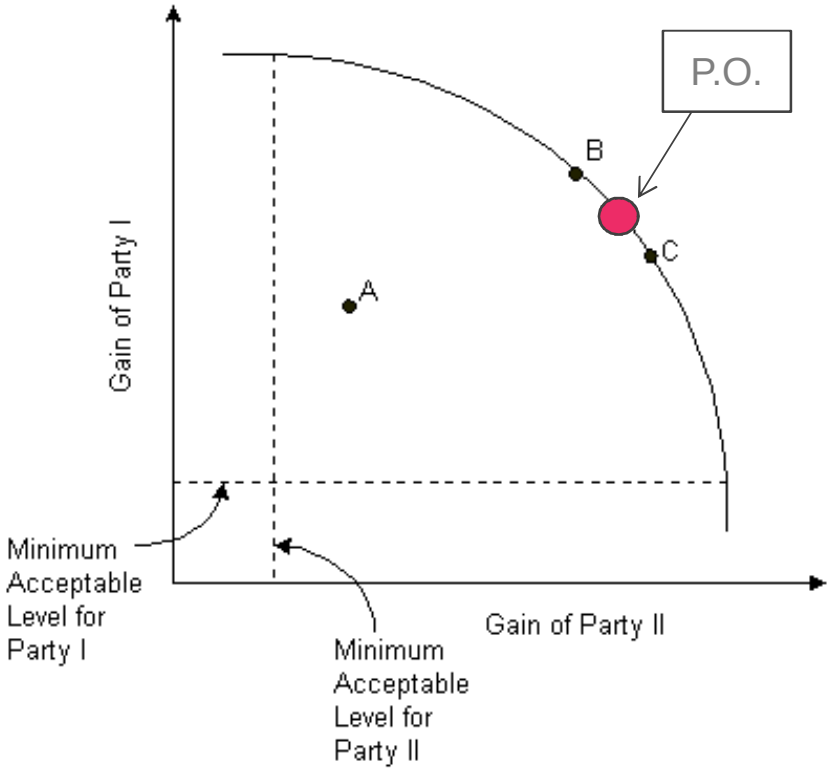


Source: Avalere Health analysis of American Hospital Association Annual Survey data, 2013, for community hospitals.

(1) Costs reflect a cap of 1.0 on the cost-to-charge ratio.

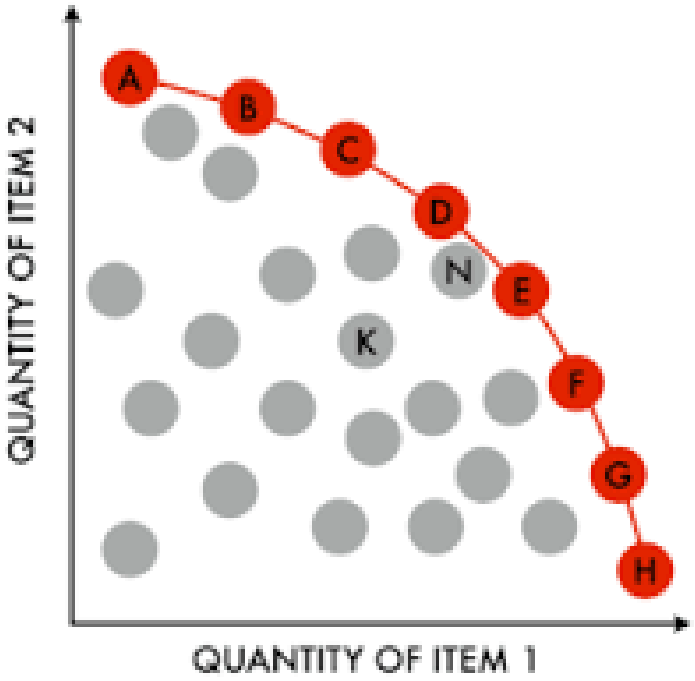
WILL COMPETITION SAVE US?

- Definition of a competitive market:
  - No other allocation of services that will make all the market participants better off
    - The “Pareto Optimum” is achieved
- What’s required?
  - Supply and demand are balanced
  - Cost and value are balanced
  - Returns are stable (no “excess rents”)
- What about medical care?



UNIQUE CHARACTERISTICS OF MEDICAL CARE

- Demand for services is inconsistent and often unpredictable
- Seller of services is expected to perform with the buyer's best interest at heart
- Quality of the product purchased is unknown
- Supply of product is restricted
  - Time, place, qualifications, experience, licensing, etc.
- Pricing of product is highly variable (and can be contingent upon seller's ability to pay)



WHAT DO PLAN SPONSORS DO? (WHAT DO THE SURVEY RESULTS SHOW?)

- Share the risk of providing medical care
  - Increase deductibles, copays, etc.
  - Move toward consumerism
- Reduce the risk of providing medical care
  - Improve the health status of the population covered
- Improve the quality of the services provided
  - Employ value-based care and improved service models when available
- Expand the availability of service, reduce information "imbalance" between provider and patient
  - Employ new modalities of treatment
  - Enhance participant-facing resources
- Relate price to outcome when possible

National Survey results

ABOUT MERCER'S NATIONAL SURVEY OF EMPLOYER-SPONSORED HEALTH PLANS

Oldest
Marking 30 years of measuring health plan trends

Largest
2,486 employers participated in 2015

Most comprehensive
Extensive questionnaire covers a full range of health benefit issues and strategies

Statistically valid
Based on a probability sample of private and public employers for reliable results

Includes employers of all sizes, all industries, all regions
Results project to all US employers with 10 or more employees

Employer size groups in presentation
Small: 10-499 employees/Large: 500+ employees/Jumbo: 20,000+ employees

THE YEAR'S TOP STORIES

1. **Cost growth moderate, at 3.8% in 2015 with 4.3% projected for 2016**
   But while large employers held increase to 2.9%, small employers saw cost rise 5.9%

2. **One in four covered employees is now in a CDHP**
   Consumerism tools are helping employees make the best plan choice.

3. **Analysis: 25 strategies that helped employers achieve lower cost and trend in 2015**
   Successful practices spanned program design, care delivery, workforce health

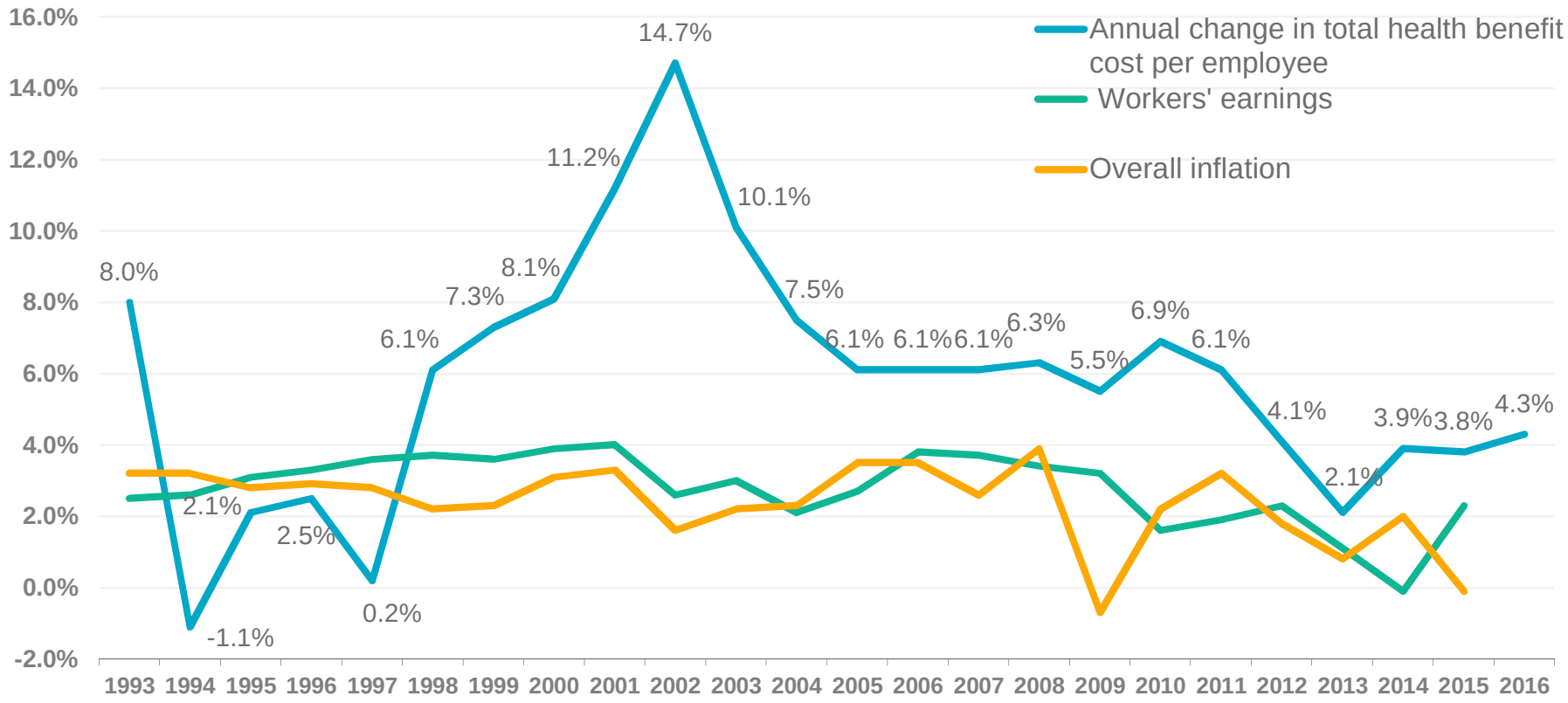
4. **Consumer empowerment is building, supported by new programs and technology**
   Telemedicine, cost transparency tools and mobile devices are all on the rise.

5. **New clinical models—ACOs and medical homes—lead the evolution to value-based care**
   Centers of Excellence and narrow networks are first steps for some employers

6. **Private exchanges will be used by 6% of large employers for 2017 open enrollment, with rapid growth expected to continue through 2020**
   Employers seek to add choice, ease administration, manage cost, and more easily transition to CDHPs

COST ROSE A MODERATE 3.8% IN 2015, WITH A SIMILAR INCREASE OF 4.3% PREDICTED FOR 2016

Change in total health benefit cost per employee compared to CPI, workers' earnings

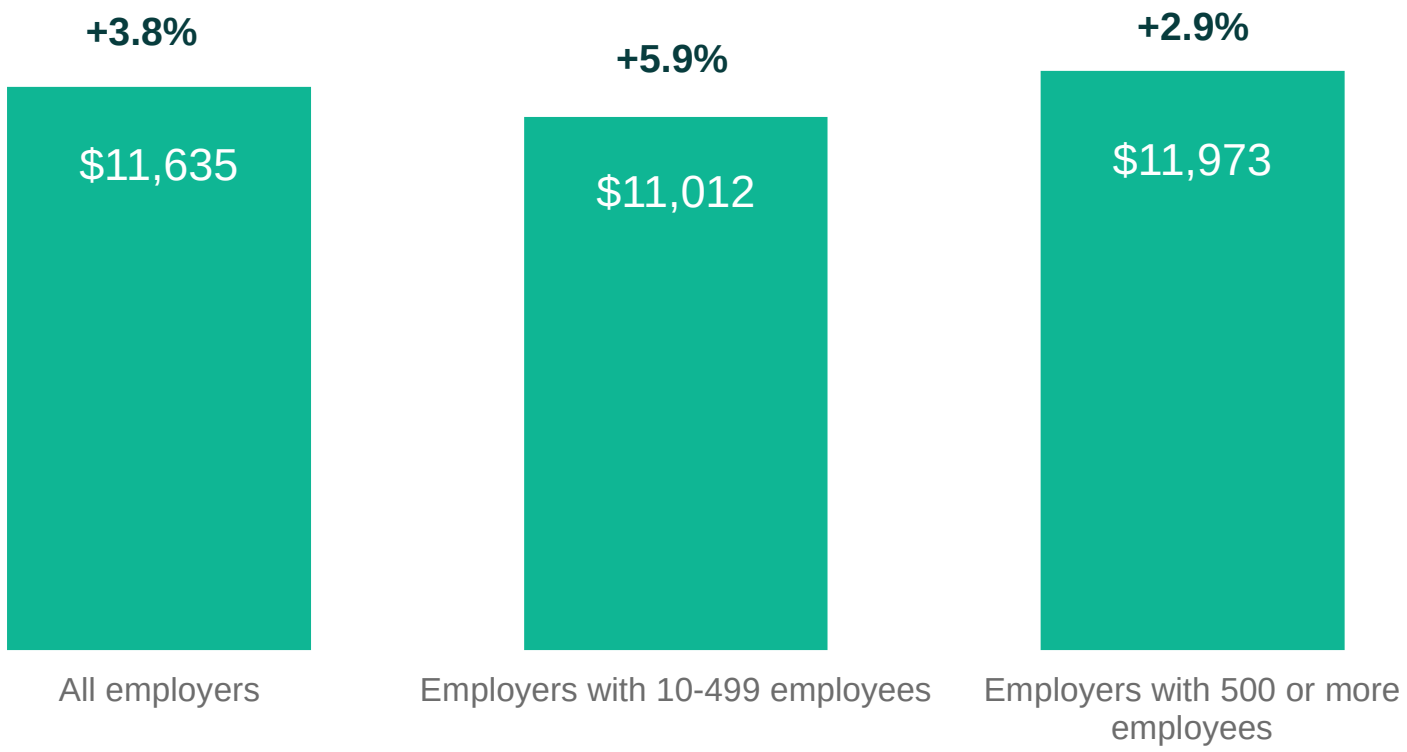


* Projected

Source: Mercer's National Survey of Employer-Sponsored Health Plans; Bureau of Labor Statistics, Consumer Price Index, U.S. City Average of Annual Inflation (April to April) 1993-2015; Bureau of Labor Statistics, Seasonally Adjusted Data from the Current Employment Statistics Survey (April to April) 1993-2015.

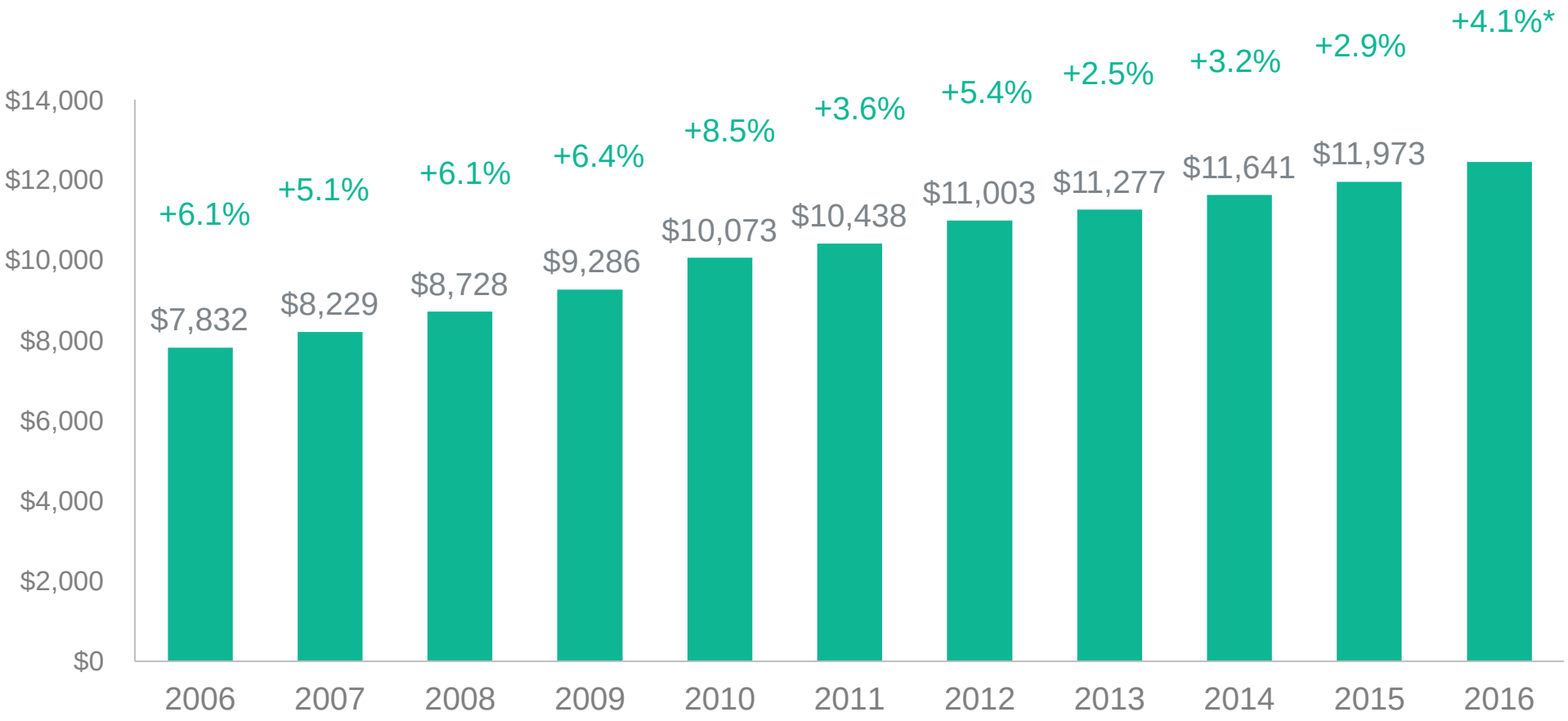
SHARPER INCREASE BUT LOWER PER-EMPLOYEE COST FOR SMALL EMPLOYERS

Average total health benefit cost per employee in 2015



Total health benefit cost up 2.9% in 2015, but employers predict bigger increase for 2016

Large employers

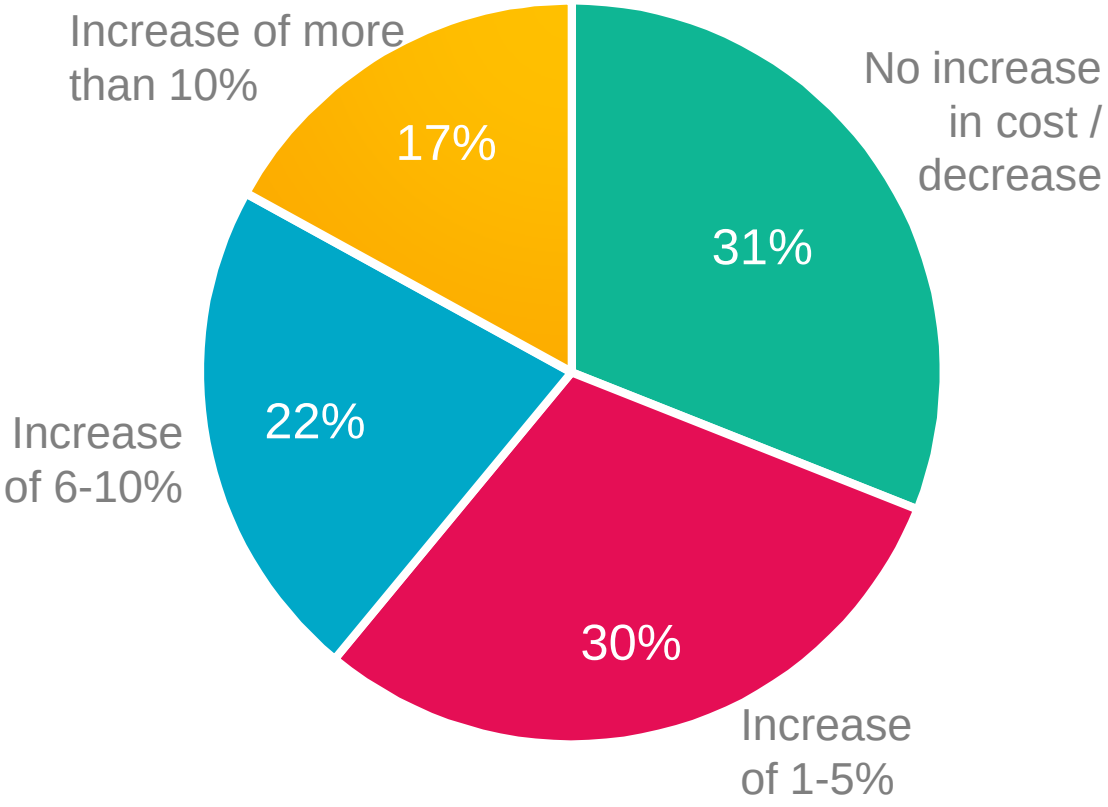


**Average increase projected for 2016 after changes; increase of 5.9% predicted before changes*

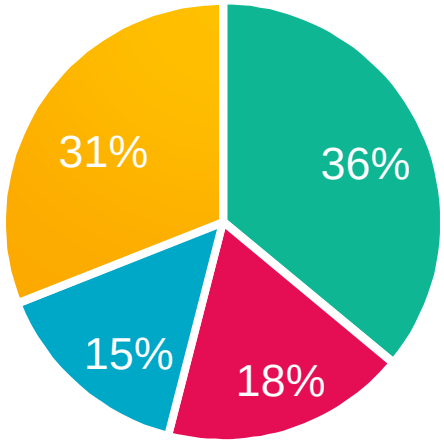
BEHIND THE AVERAGE: COST INCREASES VARIED WIDELY BY EMPLOYER IN 2015

Based on employers providing cost for 2014 and 2015

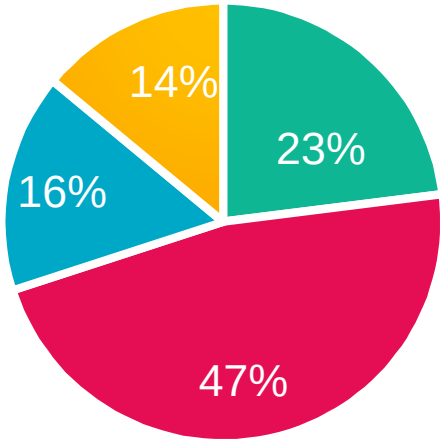
Employers with 500+ employees



Employers with10-499 employees

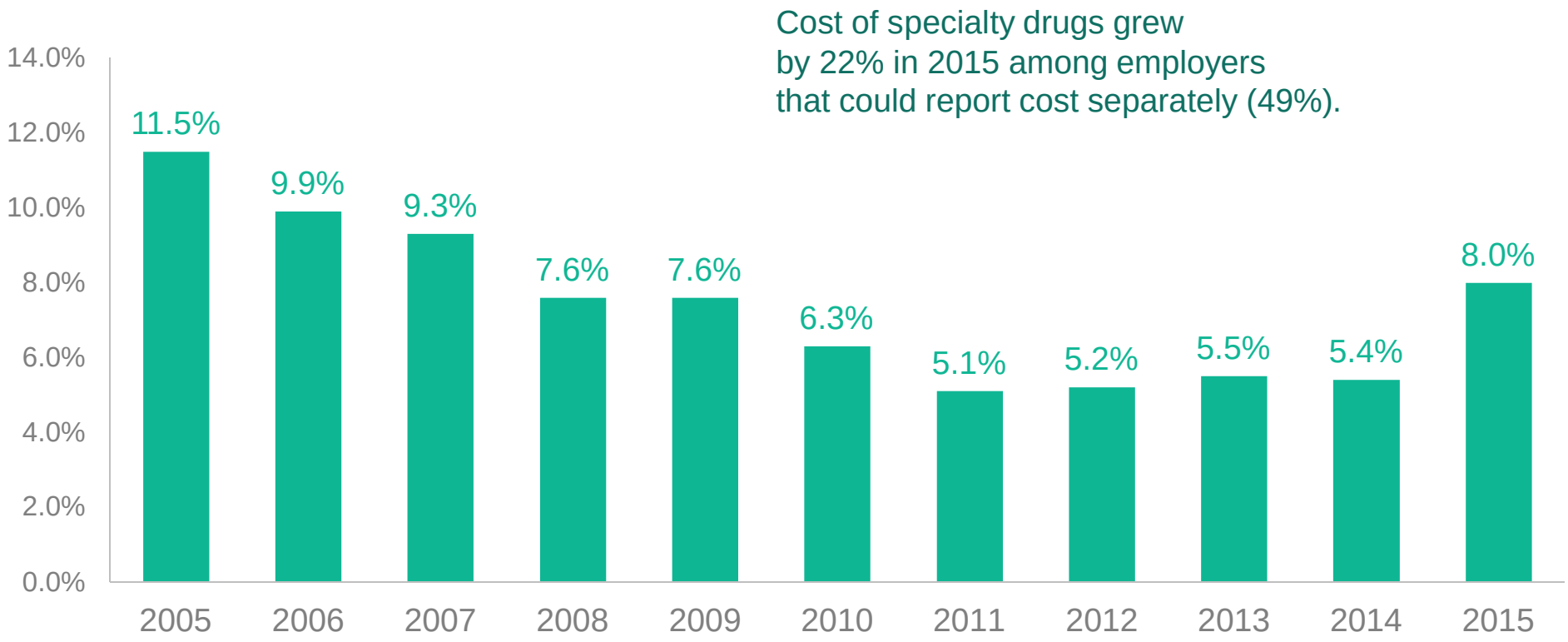


Employers with 20,000+ employees



ONE KEY COST DRIVER IN 2015: A JUMP IN PRESCRIPTION DRUG BENEFIT COST

Cost change for prescription drug benefits in primary medical plan for large employers



ACA IMPACT: WHEN THE DUST SETTLED FROM "PLAY OR PAY", ENROLLMENT LEVELS WERE LARGELY UNCHANGED

Large employers

- Only **37%** of large employers had to take action to comply with the ACA requirement to offer coverage to all employees working 30+ hours per week – most were in compliance prior to the ACA requirement.
- Of those taking action, only about **one in five** experienced an increase in enrollment as a result (or 8% of all large employers).
- Of those in compliance prior to ACA, **10%** made eligibility requirements tougher:
  - **5%** eliminated coverage for PTEs
  - **4%** increased hours required for coverage

Threshold for offering coverage to "substantially all" employees rose to 95% as of January 2016 – employers need to consider implications

ACA IMPACT: EMPLOYERS TOOK STEPS TO REDUCE EXCISE TAX EXPOSURE

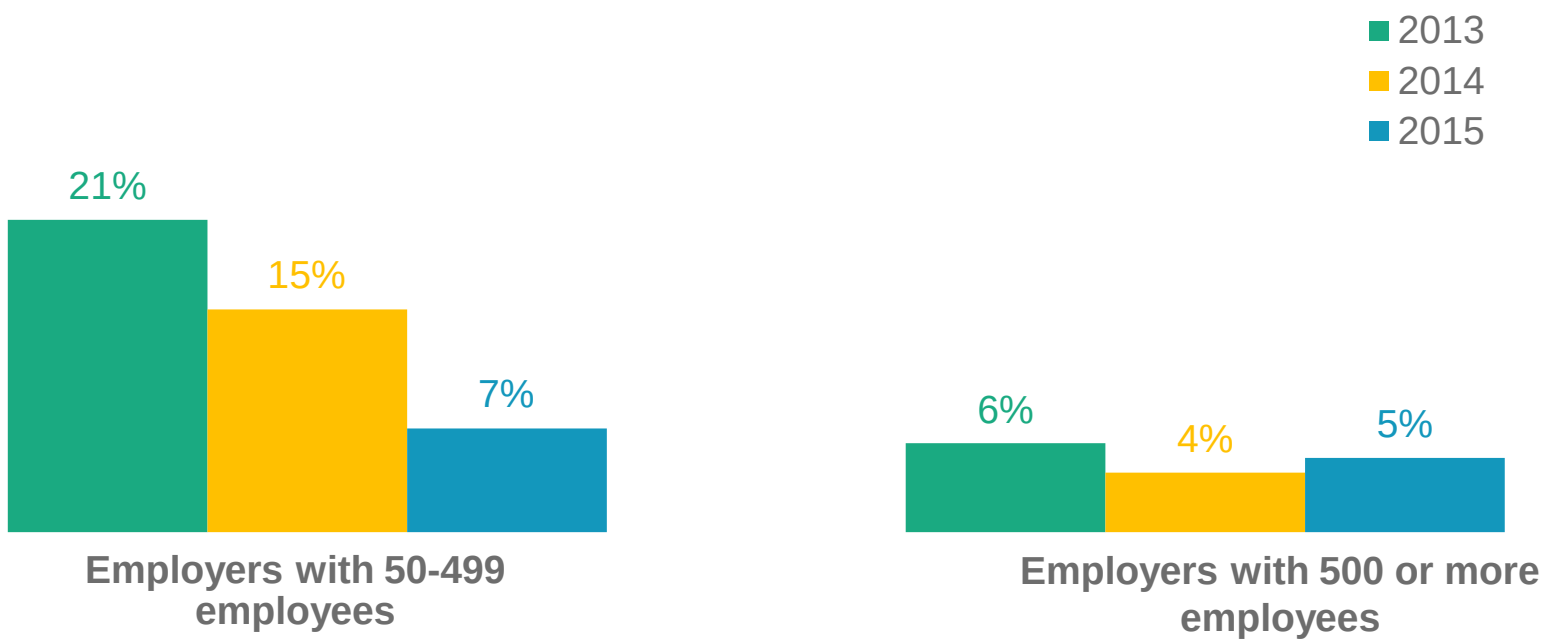
Large employers

- Consumer-directed health plans: **39%** added a plan or took steps to build enrollment in existing plan
- Dropping a high-cost plan: **11%**
- Plan design changes to shift cost to employees (reducing plan value): **19%**
- Eliminating health care FSAs: **3%**

The delay in the excise tax may slow the pace of change, but employers will continue to take action to manage long-term cost growth

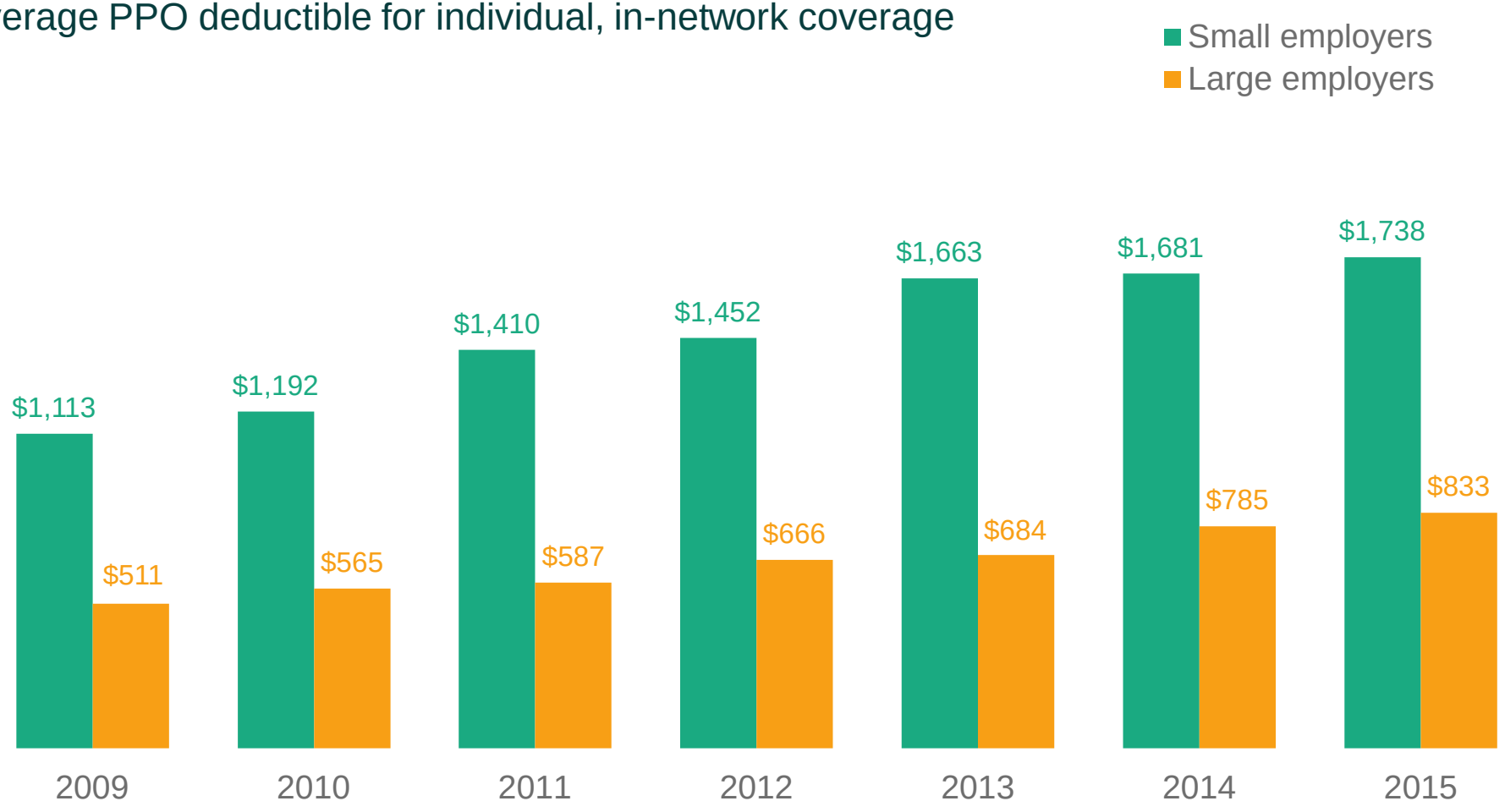
GIVEN HOW STRONGLY EMPLOYEES VALUE HEALTH BENEFITS, EVEN SMALL EMPLOYERS PLAN TO STAY IN THE GAME

Percent of employers that say they are “very likely” or “likely” to terminate plans within the next five years



COST-SHIFTING HAS CONTINUED IN THE HEALTH REFORM ERA, CHALLENGING EMPLOYERS TO HELP EMPLOYEES MANAGE GROWING FINANCIAL RISK

Average PPO deductible for individual, in-network coverage



WHAT'S WORKING TO HOLD DOWN COST?

Respondents' costs were analyzed based on their use of more than 25 cost-management best practices

Plan design and delivery infrastructure

- Contribution for family coverage in primary plan is 20%+ of premium
- PPO in-network deductible is $500+
- Offer CDHP
- HSA sponsor makes a contribution to employees' accounts
- Voluntary benefits integrated with core
- Mandatory generics or other Rx strategies
- Steer members to specialty pharmacy for specialty drugs
- Reference-based pricing
- Data warehousing
- Collective purchasing of medical or Rx benefits
- Transparency tool provided by specialty vendor and/or used by 10% of members
- Use private health benefits exchange

Employee well-being

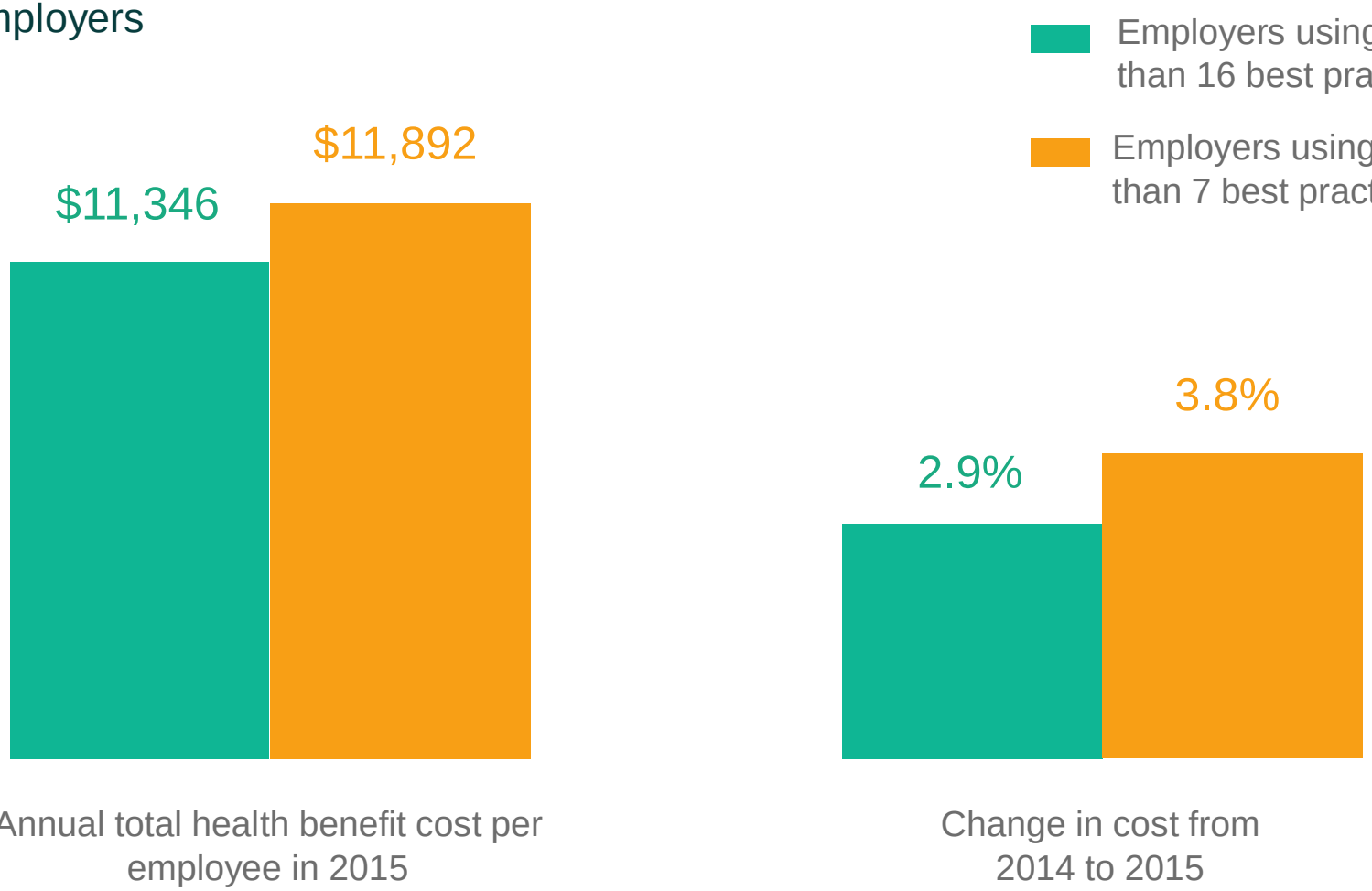
- Offer optional (paid) well-being programs through plan or vendor
- Provide opportunity to participate in personal/group health challenges
- Offer technology-based well-being resources (apps, devices, web-based)
- Worksite biometric screening
- Encourage physical activity at work (gym, walking trails, standing desks, etc.)
- Use incentives for well-being programs
- Spouses and/or children may participate in programs
- Smoker surcharge
- Offer EAP

Care delivery

- High-performance networks
- Surgical centers of excellence
- On-site clinic
- Telemedicine
- Value-based design
- Medical homes
- Accountable care organizations

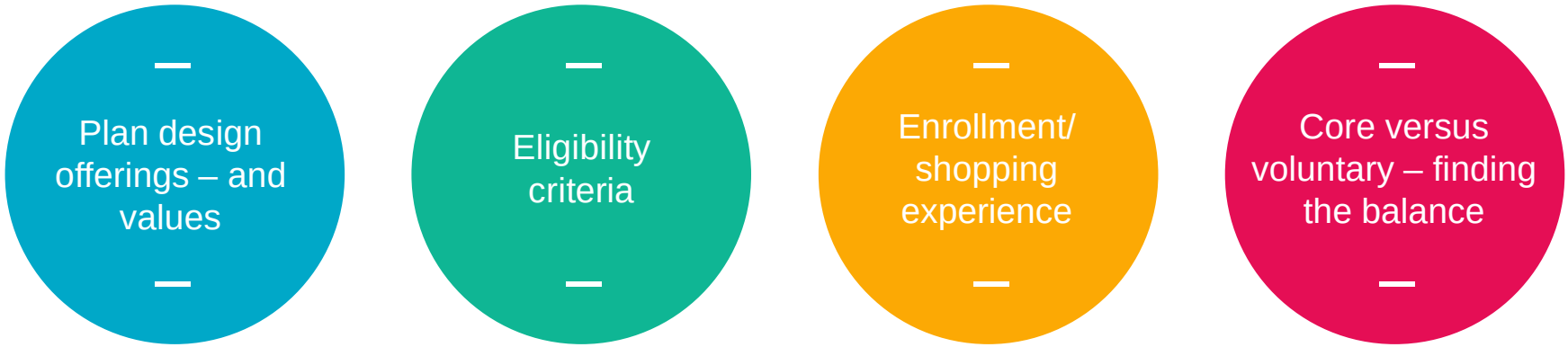
COMPARISON OF EMPLOYERS USING THE MOST VS. THE FEWEST BEST PRACTICES AGAIN FINDS DIFFERENCES IN COST AND COST GROWTH

Large employers



*Analysis based on unweighted cost data from respondents providing cost for both 2014 and 2015.

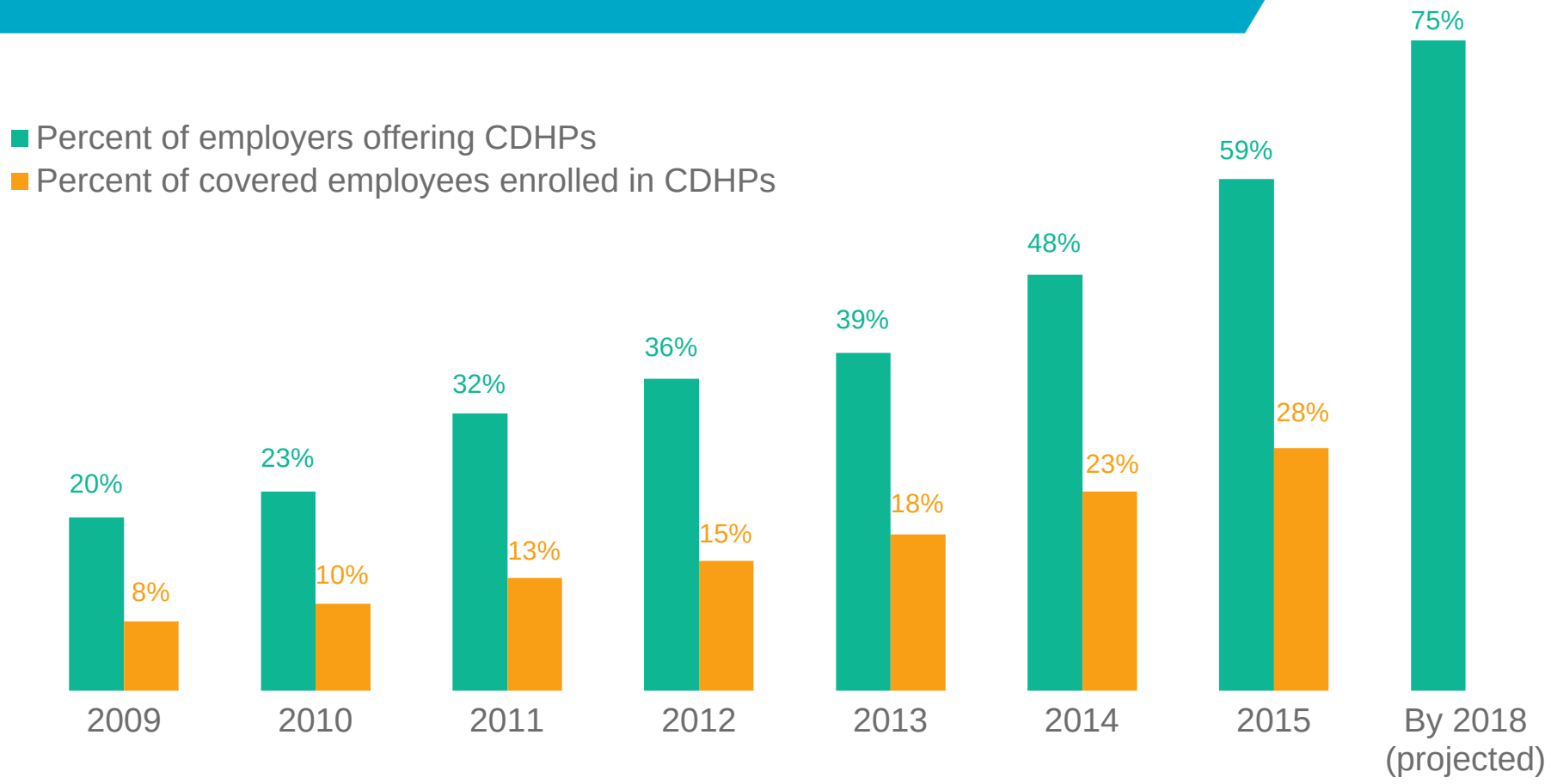
PROGRAM DESIGN: WHO IS OFFERED WHAT BENEFITS, AND HOW THEY PAY FOR THEM



OVER A FOURTH OF ALL COVERED EMPLOYEES ARE ENROLLED IN A CONSUMER-DIRECTED HEALTH PLAN

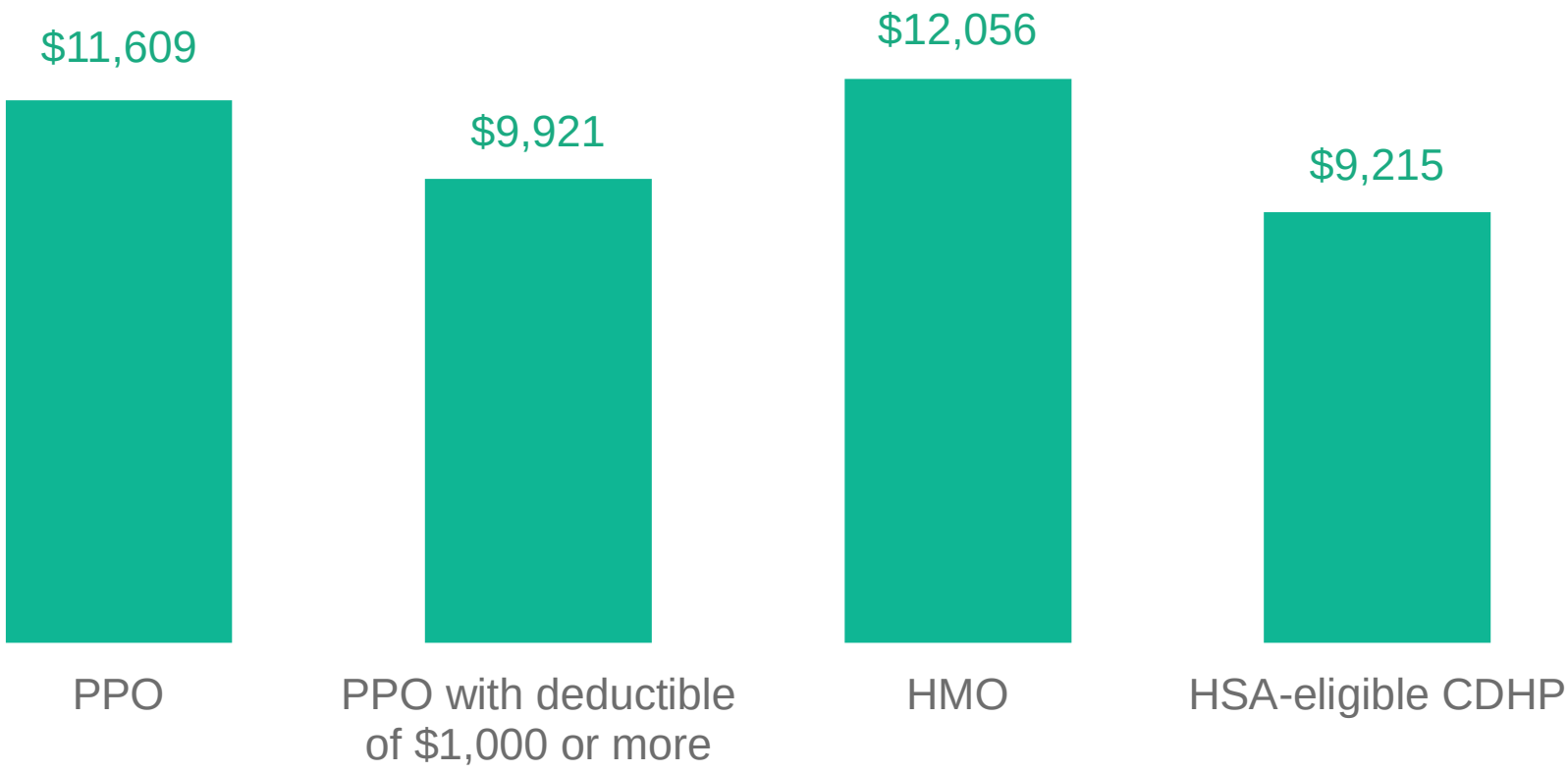
Large employers

By 2018, 75% of large employers expect to offer a CDHP

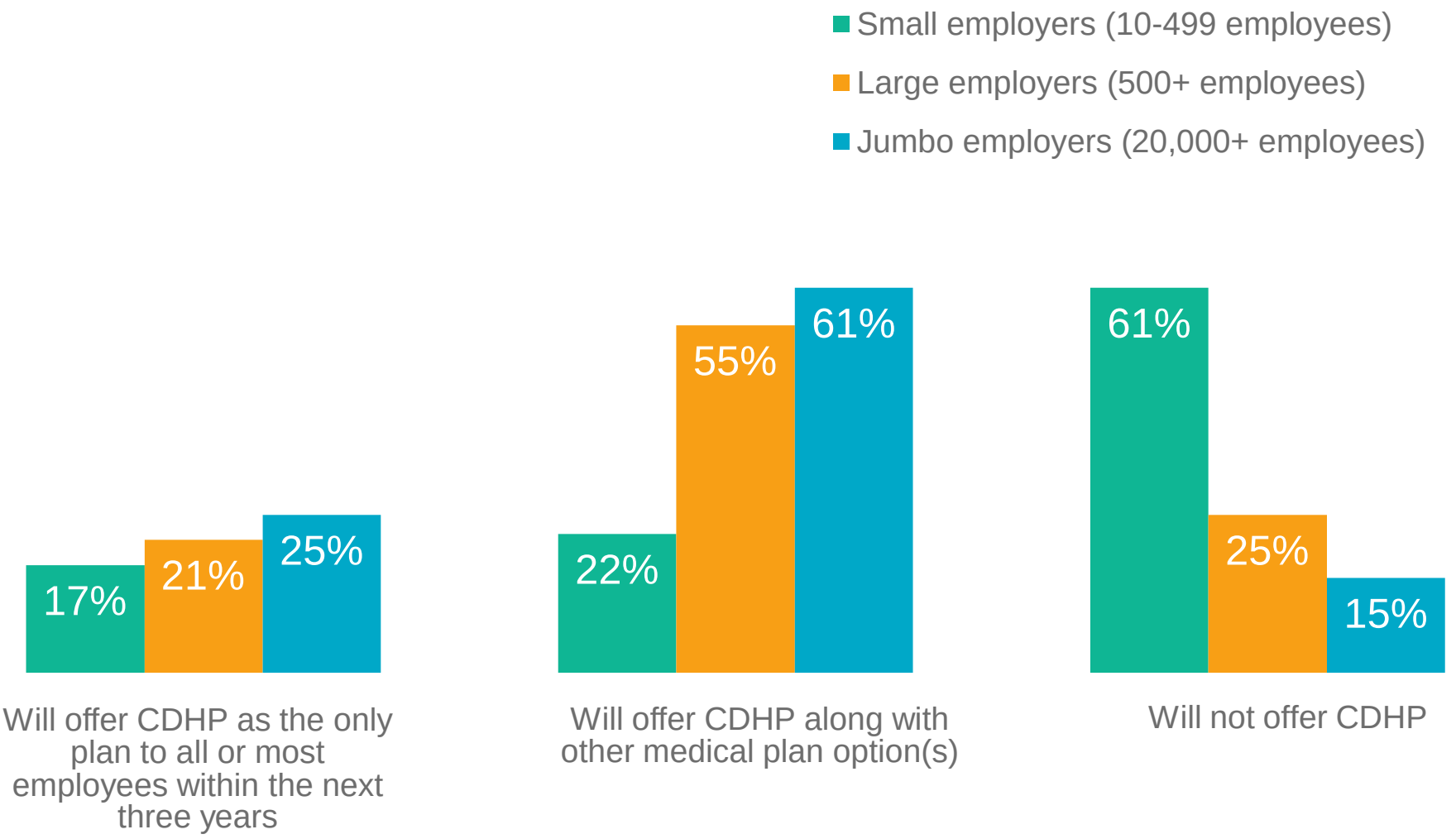


EMPLOYERS SAVE WITH HSA-BASED CDHPs: AVERAGE COST WAS MORE THAN 20% LOWER THAN FOR EITHER PPOs OR HMOs IN 2015

Medical plan cost per employee (includes employer contributions to HSA accounts) among large employers

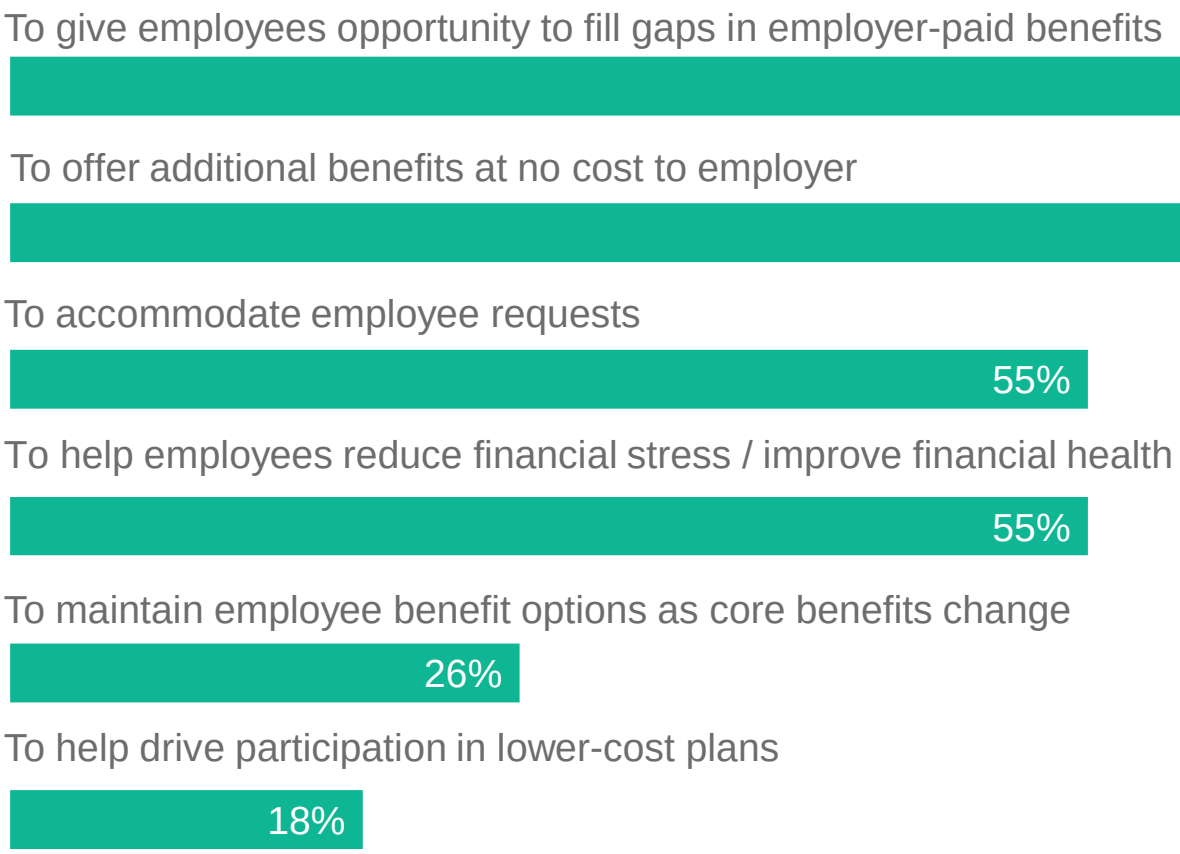


MAJORITY OF LARGE EMPLOYERS EXPECT TO OFFER A CDHP BY 2018 – BUT MOST SEE IT AS AN OPTION, RATHER THAN A FULL REPLACEMENT



EMPLOYERS USING VOLUNTARY BENEFITS TO FILL GAPS IN CORE BENEFITS

Objectives for program, based on large employers offering VBs



76% of employers with voluntary benefits say their objectives have been met

EXPANDING EMPLOYEES' VIEW OF THE WHOLE BENEFIT PACKAGE

Meeting diverse needs without driving up employer costs

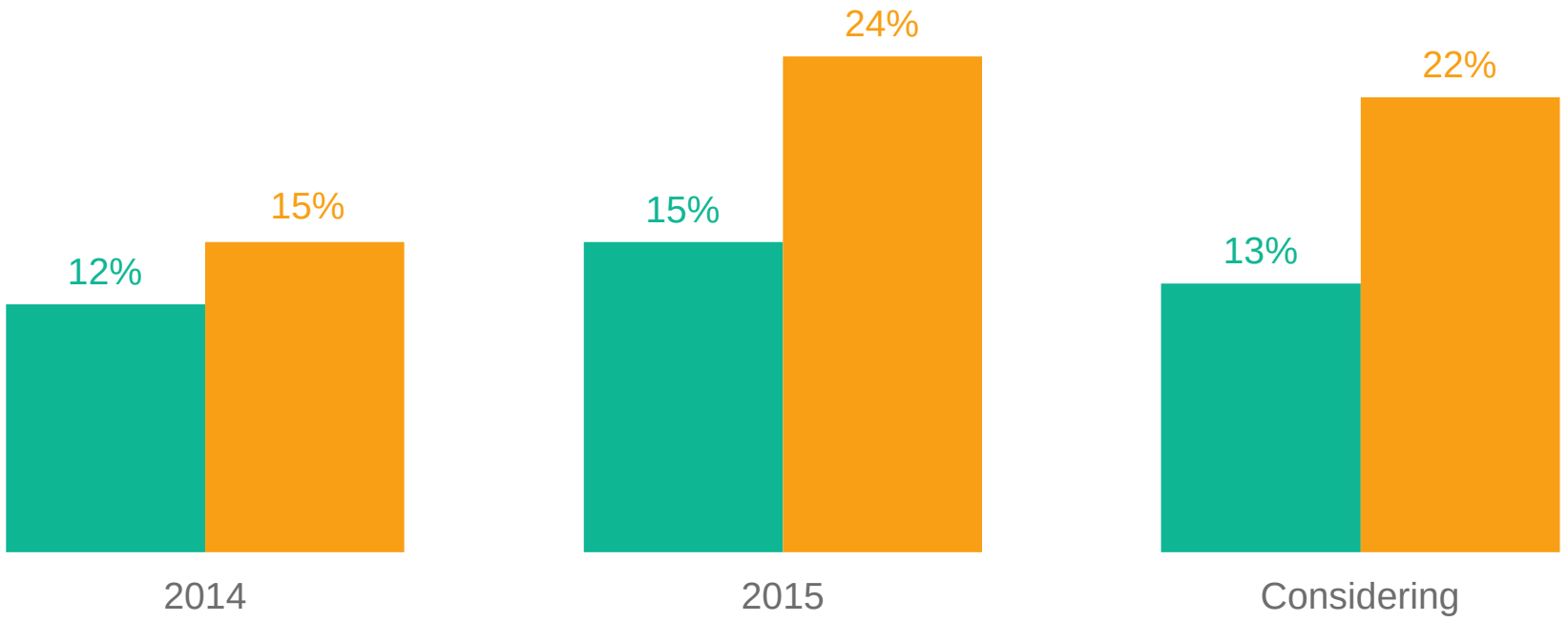
VOLUNTARY BENEFITS (percent of large employers offering the benefit)	
Individual disability	61%
Accident	59%
Cancer / critical illness	45%
Whole / universal life	43%
Legal benefit	30%
Discount purchase program	26%
Long-term care	25%
Hospital indemnity	21%
Auto / Homeowners	20%
Investment advisory	19%
Telemedicine	18%
ID theft	17%
Pet insurance	10%

COST TRANSPARENCY TOOLS

Percentage of employers that contract with a specialty vendor outside the health plan to provide transparency tool

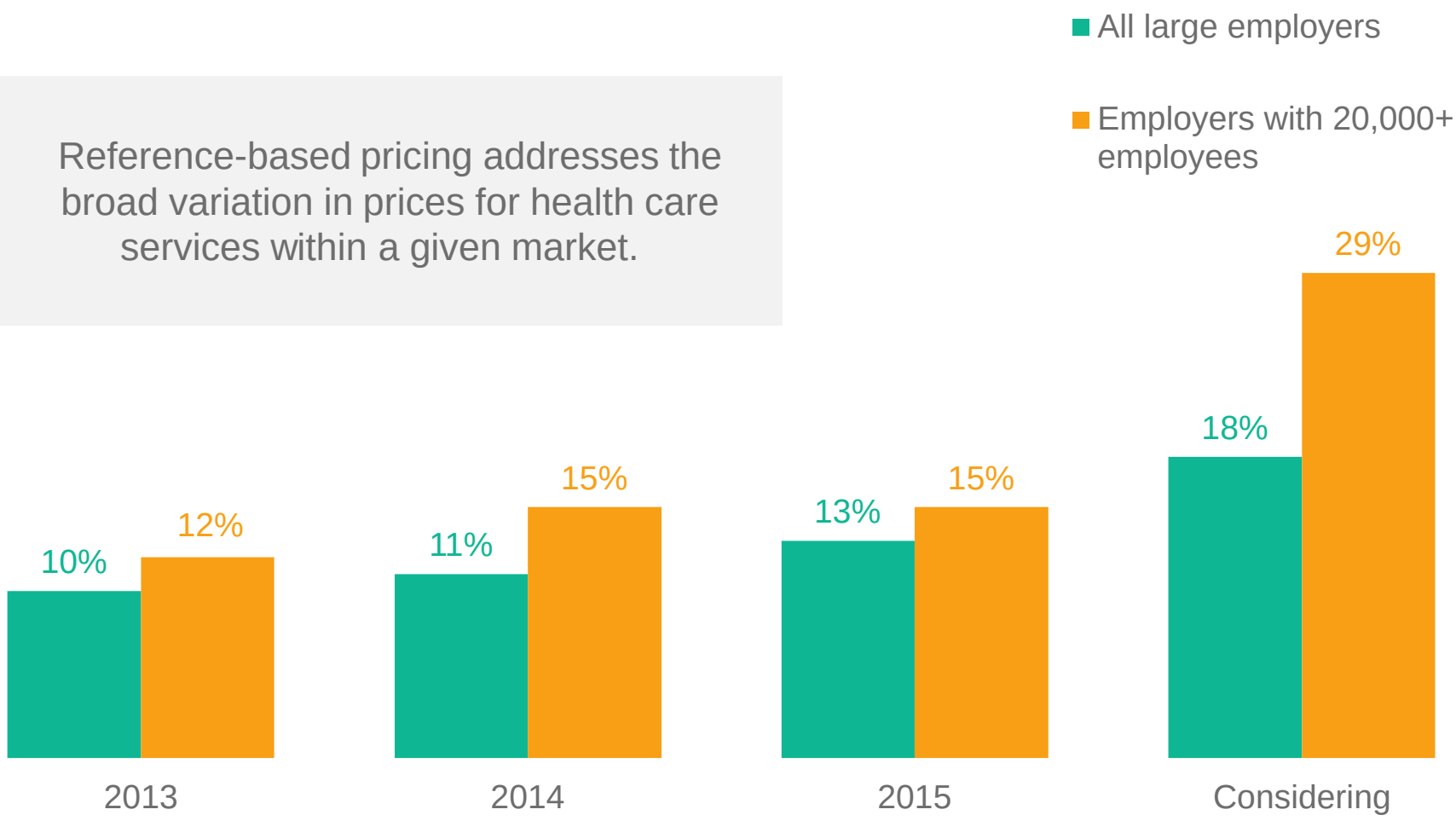
Among large employers who provide transparency tools:

- 13% provide incentives to encourage employees to use them.
- 27% track utilization. Of those, about 1 in 5 report utilization of 20% or more, but nearly half report utilization of less than 5%.

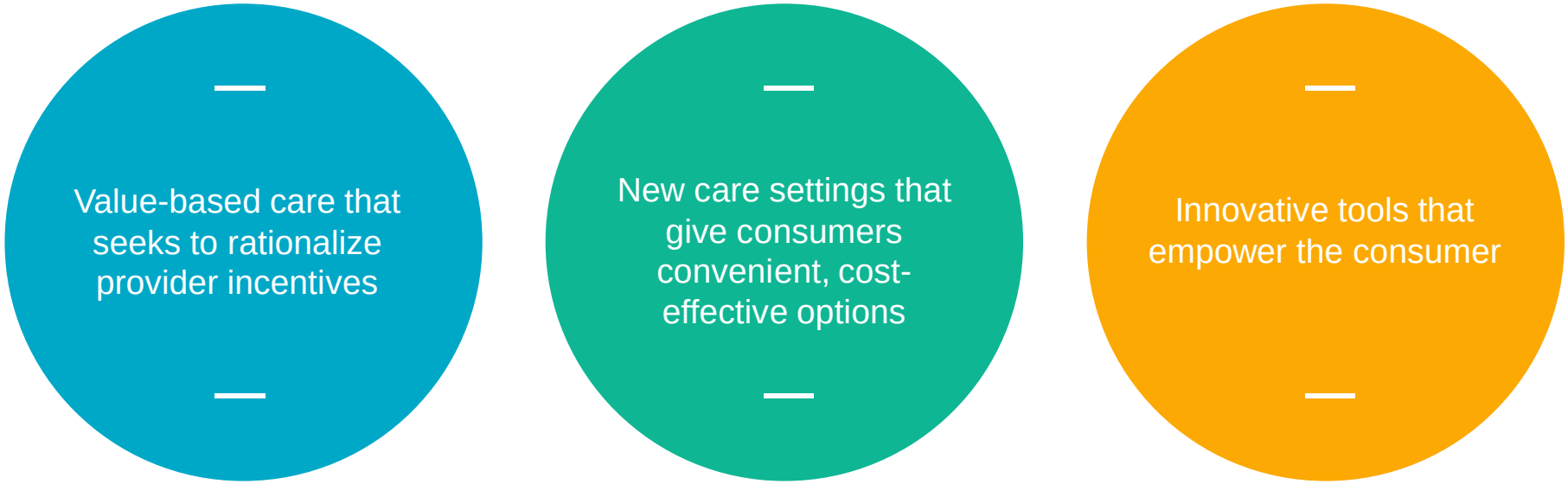


STRONG INTEREST IN REFERENCE-BASED PRICING AMONG THE LARGEST EMPLOYERS

Reference-based pricing addresses the broad variation in prices for health care services within a given market.



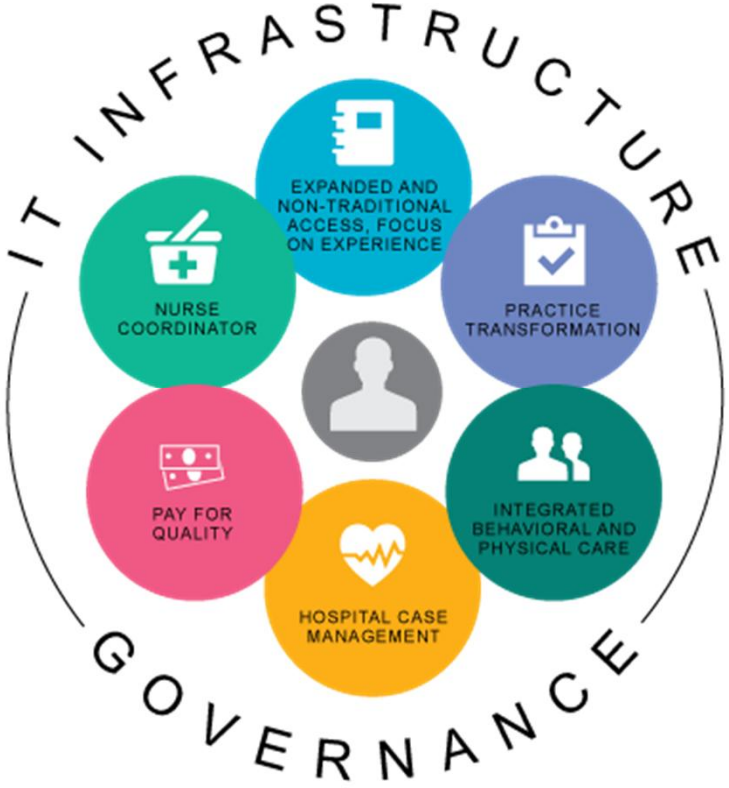
CARE DELIVERY: HOW AND WHERE A MEMBER ACCESSES CARE



SUCCESSFUL VALUE-BASED CARE REQUIRES A MULTI-FACETED APPROACH

- Mercer's point-of-view is that VBC has the potential to drive cost, quality and patient experience improvements if, and only if, appropriately structured and deployed.

- There are several fundamental components of successful VBC models – all pieces are critical to success.

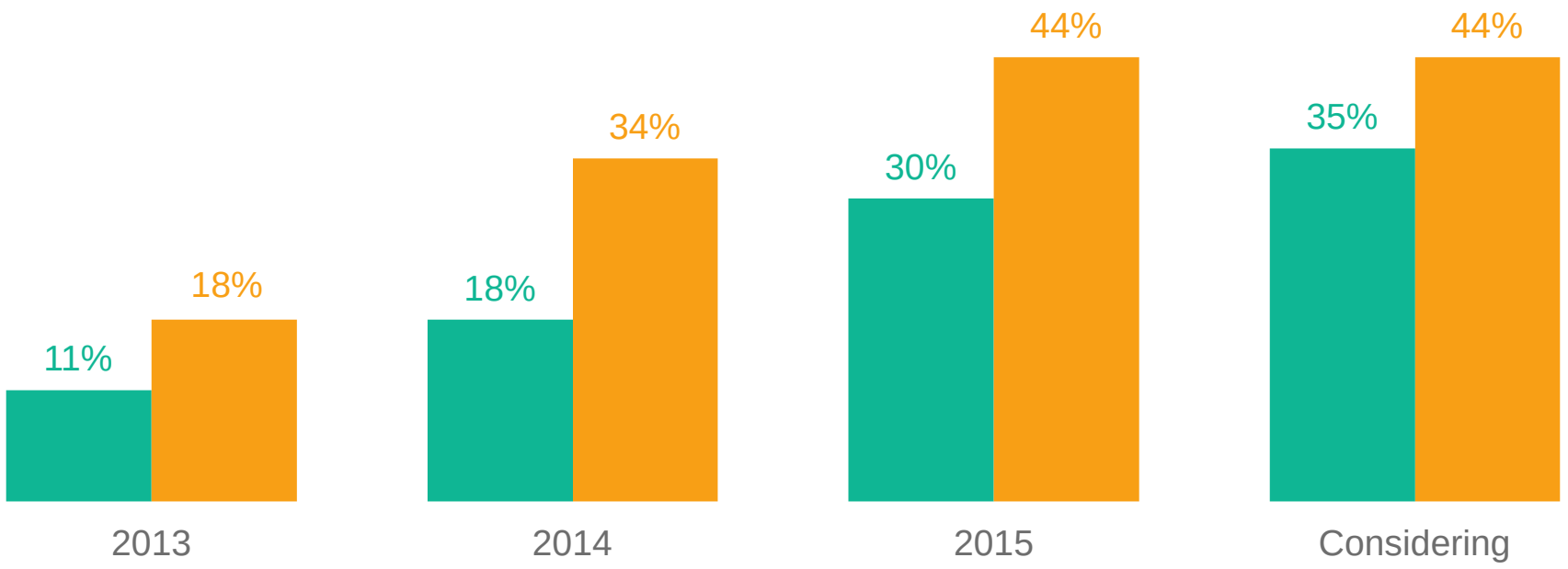


Successful VBC delivery systems focus on several key elements to transform their organizations from the ground up

TELEMEDICINE IS THE FASTEST-GROWING TREND IN CARE DELIVERY

Among large employers offering telemedicine:

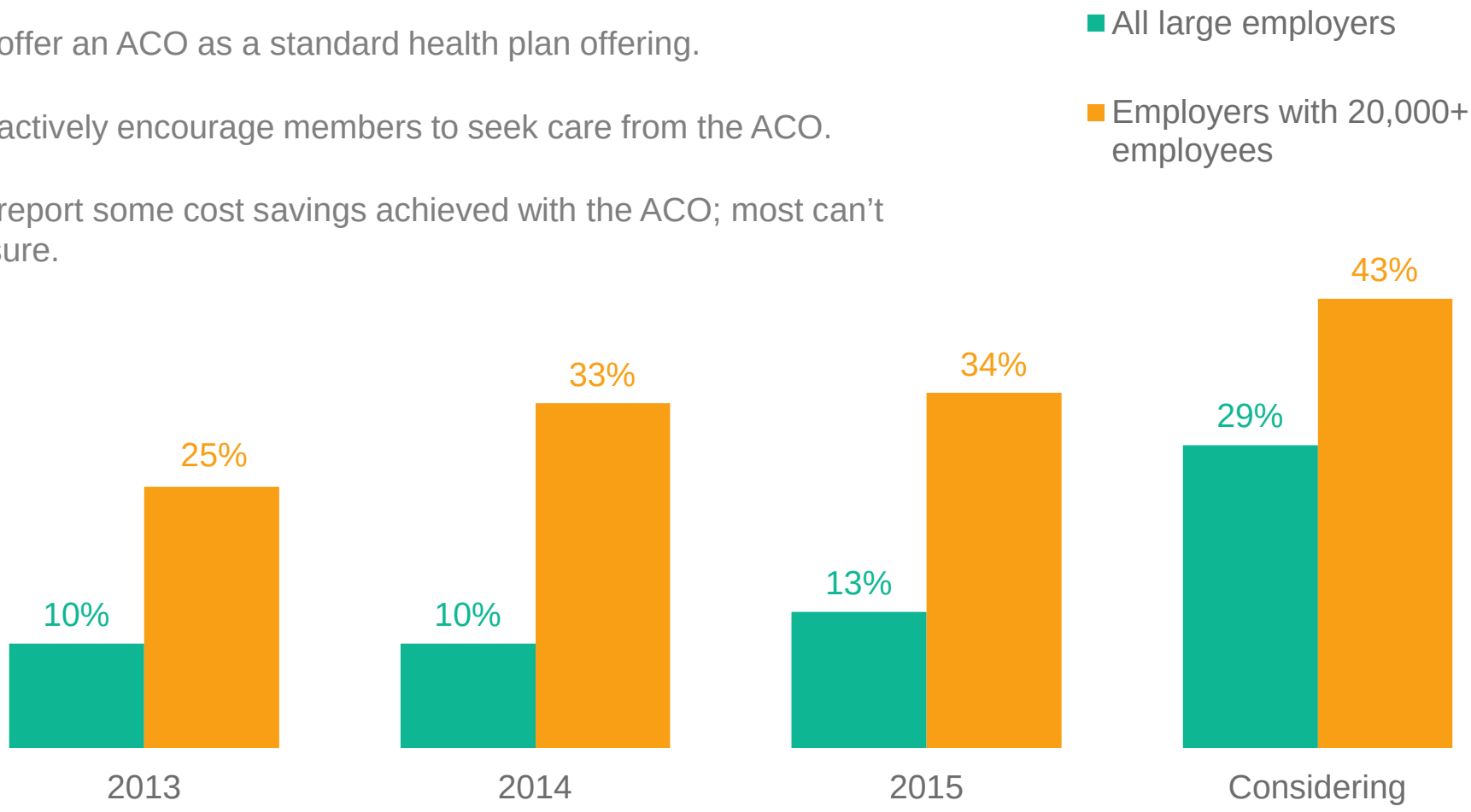
- 26% reported a utilization rate of 5% or higher in 2014.
- 47% agree that the telemedicine program has met their objectives.
- 85% say that the most important reason for offering telemedicine is to provide employees with a more affordable, convenient source of care.



USE OF ACCOUNTABLE CARE ORGANIZATIONS (ACOs) IS RISING, BUT COST IMPACT NOT CLEAR TO MOST

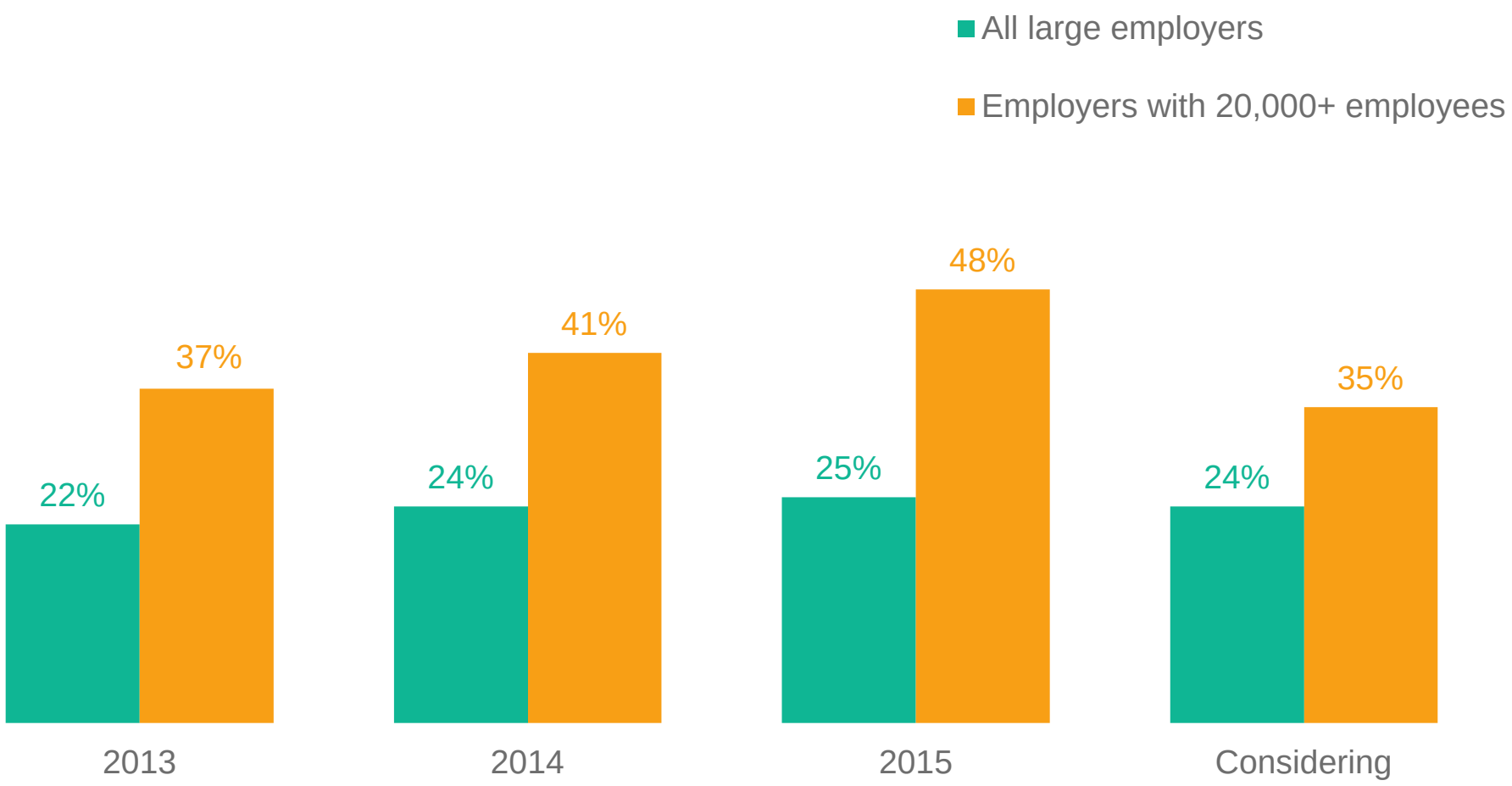
Among employers with 5,000+ employees offering ACOs*:

- 80% offer an ACO as a standard health plan offering.
- 28% actively encourage members to seek care from the ACO.
- 16% report some cost savings achieved with the ACO; most can't measure.



*Preliminary results from supplemental survey of employers with 5,000 or more employees

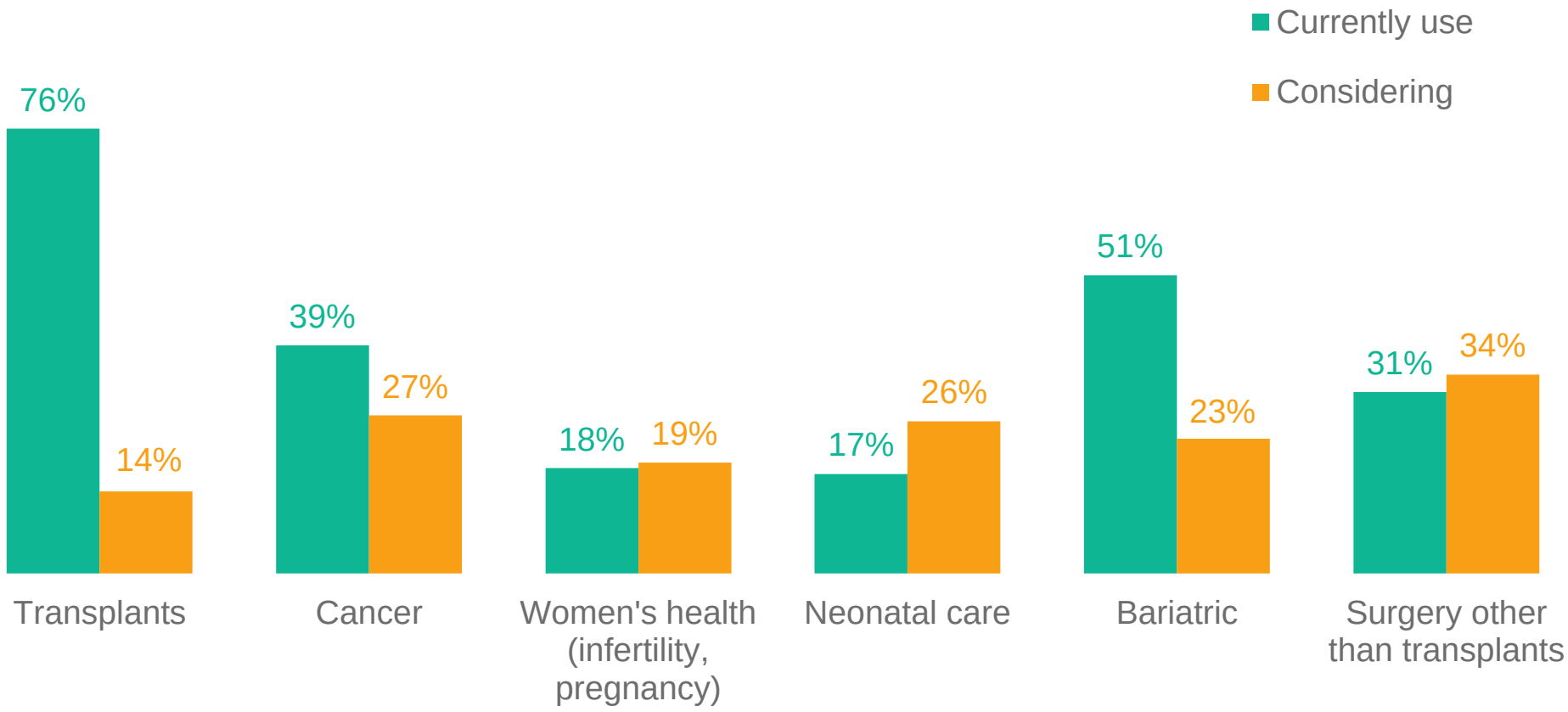
GROWTH IN USE OF "CENTERS OF EXCELLENCE" AMONG LARGEST EMPLOYERS



TYPES OF COEs CURRENTLY USED OR BEING CONSIDERED

Among employers with 5,000+ employees offering COEs*:

- 79% say they are likely to expand COE use in the future

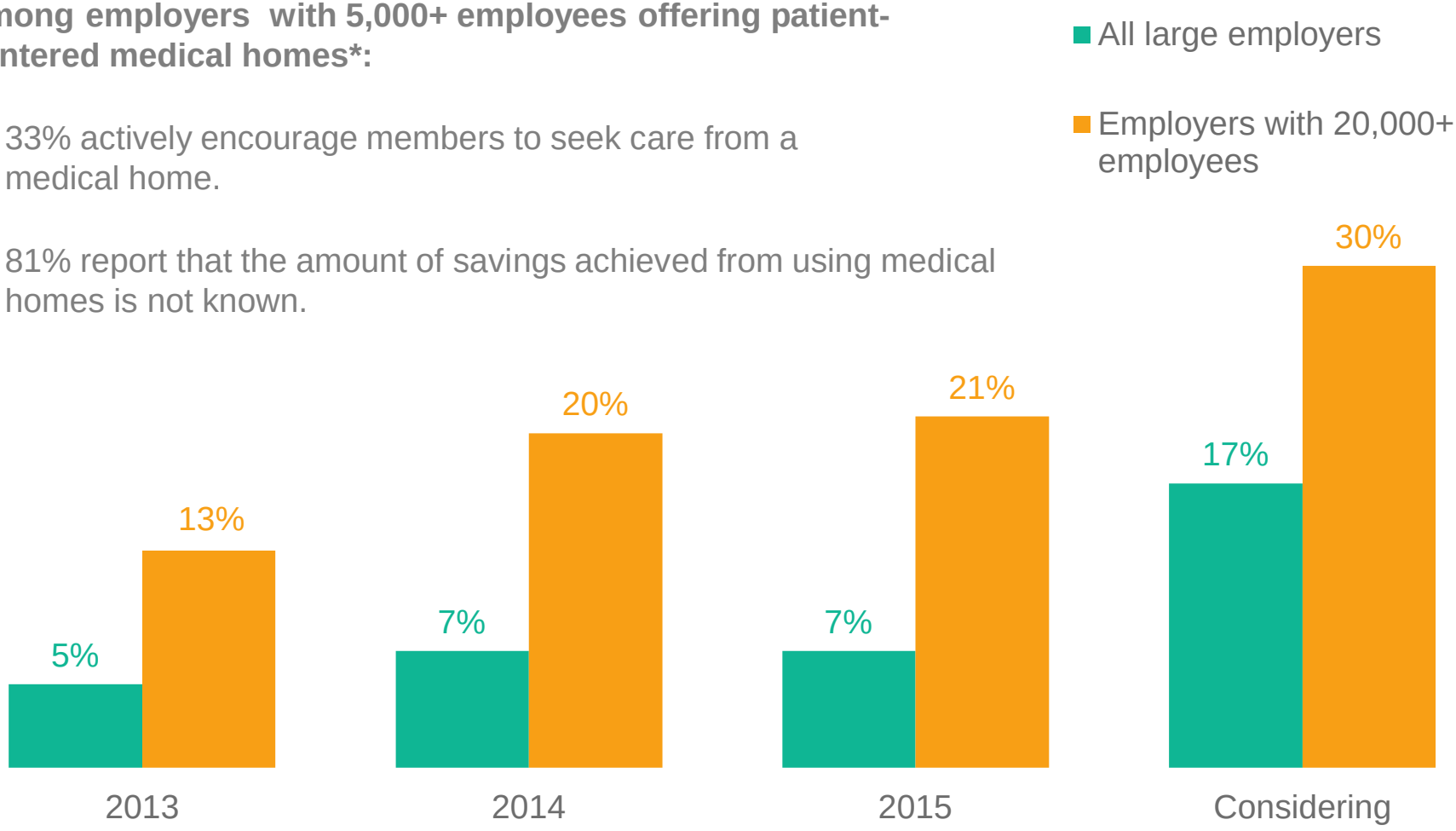


*Preliminary results from supplemental survey of employers with 5,000 or more employees

MEDICAL HOMES GROWING MORE SLOWLY, BUT THE LARGEST EMPLOYERS SHOW STRONG INTEREST

Among employers with 5,000+ employees offering patient-centered medical homes*:

- 33% actively encourage members to seek care from a medical home.
- 81% report that the amount of savings achieved from using medical homes is not known.



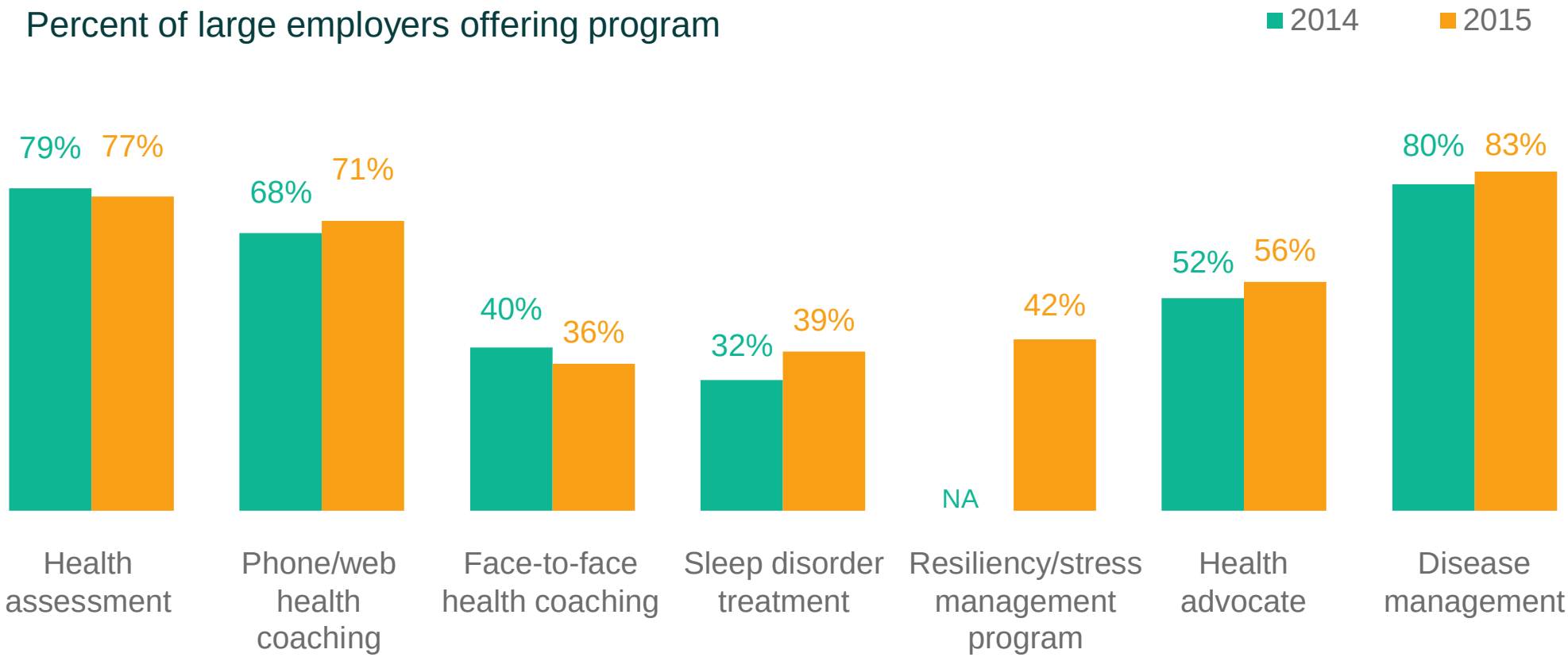
*Preliminary results from supplemental survey of employers with 5,000 or more employees

WORKFORCE HEALTH: HOW AN EMPLOYER INFLUENCES BEHAVIOR, HEALTH AND WELL-BEING

- Three pillars of well-being: physical, emotional, financial
- Physical environment can make the healthy choice the easy choice
- Activity trackers, mobile apps bring health consciousness into daily life
- Culture of health and social connections key to building intrinsic motivation
- Employers starting to measure well-being VOI as well as ROI.

HEALTH ADVOCACY IS INCREASINGLY RECOGNIZED AS A CRITICAL RESOURCE IN A COMPLEX HEALTH CARE SYSTEM

Percent of large employers offering program



Addressing the continuum of health needs

INNOVATIVE TECHNOLOGIES AND ACTIVITIES FOR A MORE ENGAGING MEMBER EXPERIENCE

ACTIVITIES

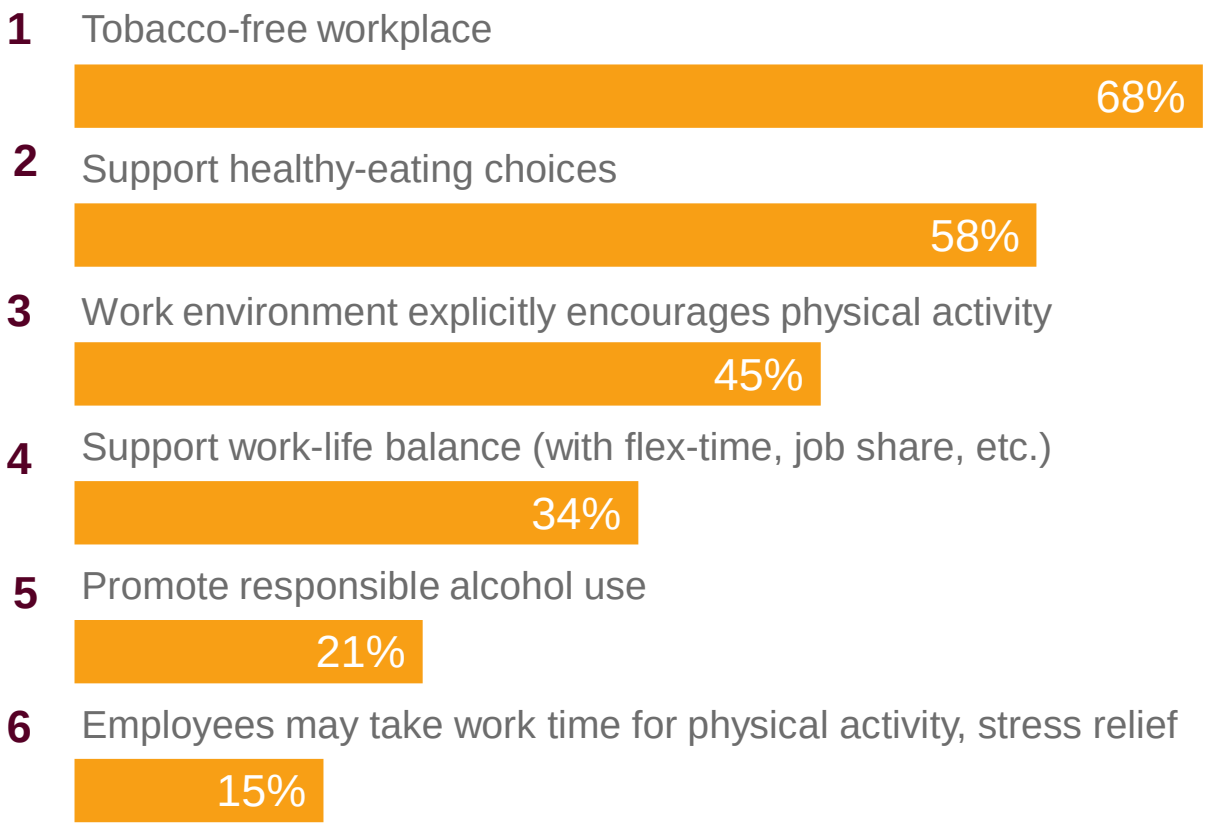
	All large employers	Employers with 20,000+ employees
Worksite biometric screening event	56%	71%
Business unit/location group challenges	45%	57%
Onsite exercise or yoga classes or weight loss programs (such as Weight Watchers)	43%	76%
Personal challenges	40%	55%
Peer-to-peer support	19%	33%

TECHNOLOGY-BASED RESOURCES

	All large employers	Employers with 20,000+ employees
Mobile apps	30%	44%
Wearables / apps to monitor activity	24%	38%
Devices to transmit health measures to providers	4%	11%
Onsite kiosks	7%	12%
Other web-based resources/tools	40%	63%

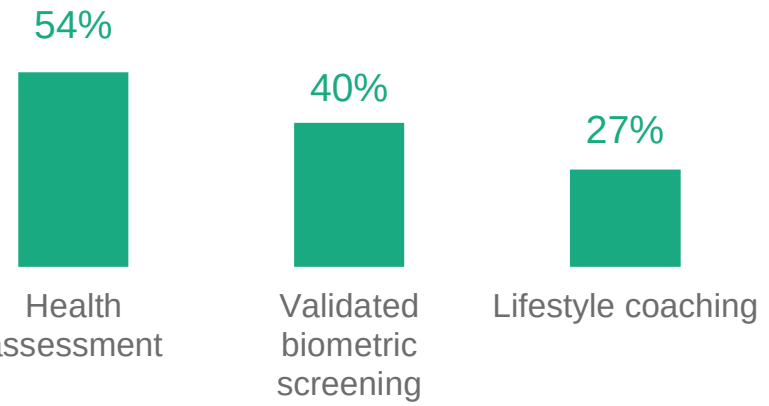
BUILDING A CULTURE OF HEALTH: SIX POLICIES THAT PROMOTE EMPLOYEE WELL-BEING

Large employers



EMPLOYERS USE FINANCIAL INCENTIVES TO IMPROVE PARTICIPATION RATES IN KEY PROGRAMS

Large employers

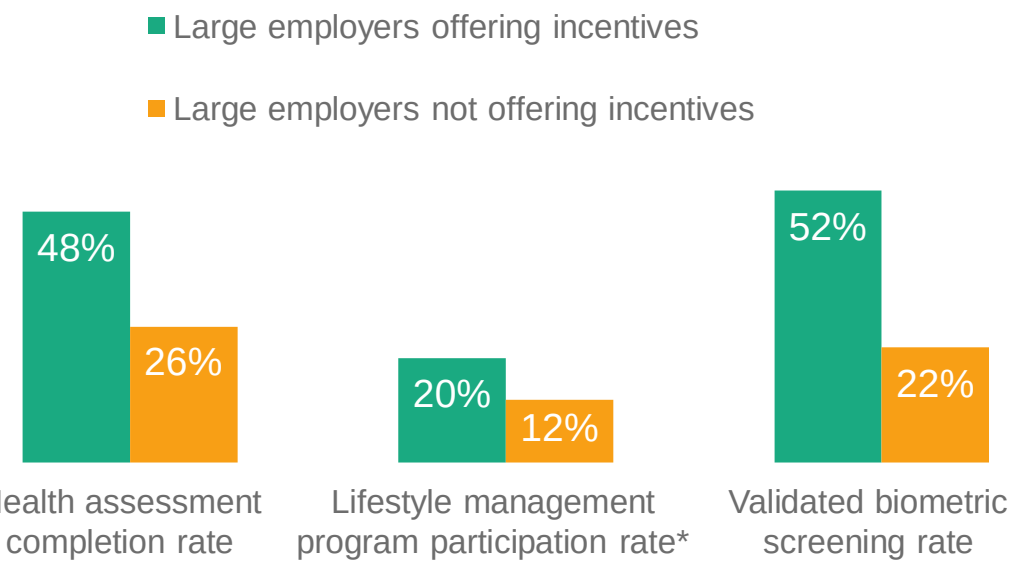


Offer incentives (among employers with programs)

Including spouses builds engagement:

- 62% of employers make key elements of program available to spouses (up from 56% in 2014)
- Half of those make spouses eligible for incentives

Large employers using incentives report higher participation rates.

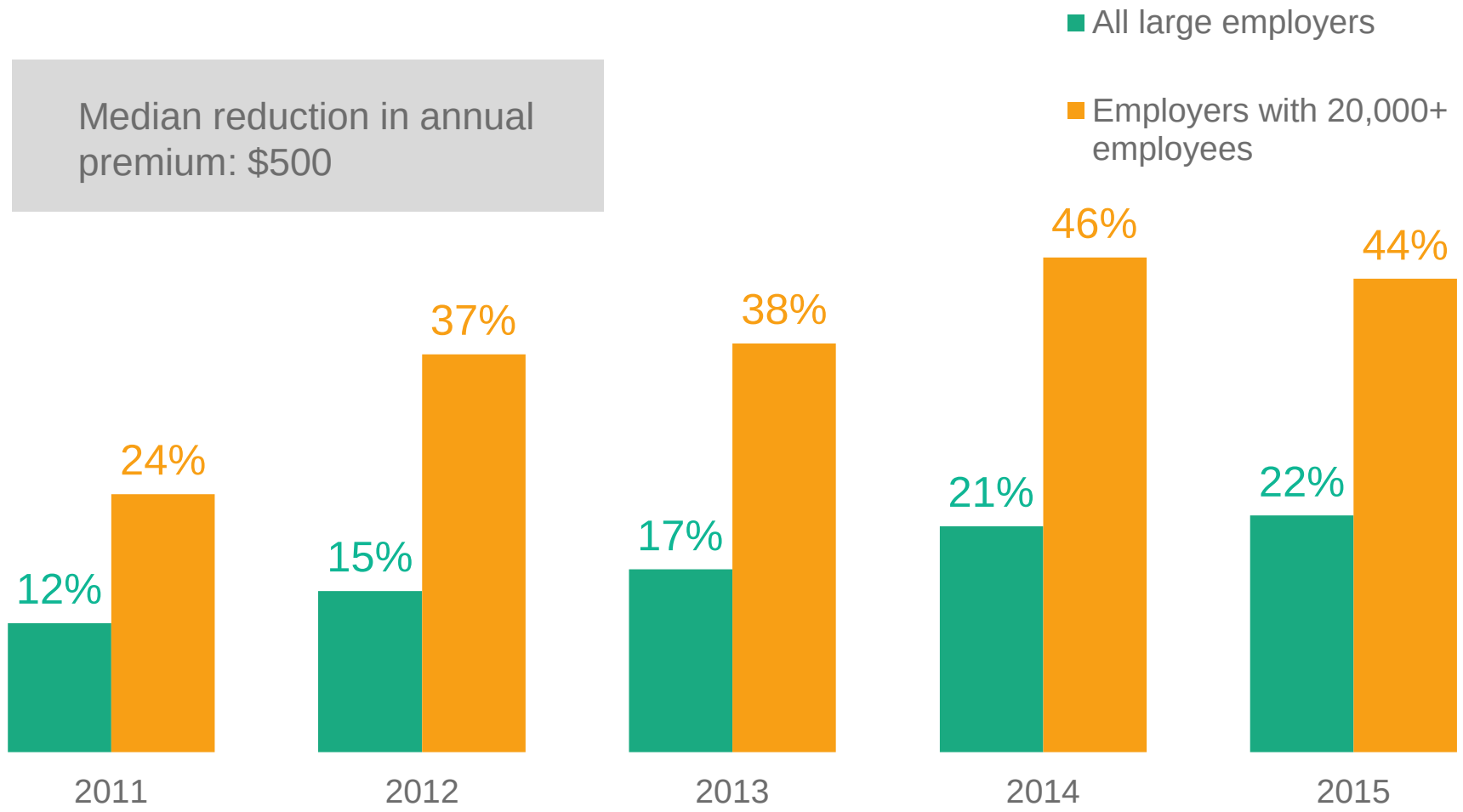


*Average % of identified persons actively engaged in program

SOME EMPLOYERS MAY BE COOLING ON TOBACCO-USE INCENTIVES IN WAKE OF LEGAL CHALLENGES

Offer lower premium contributions to non-tobacco users

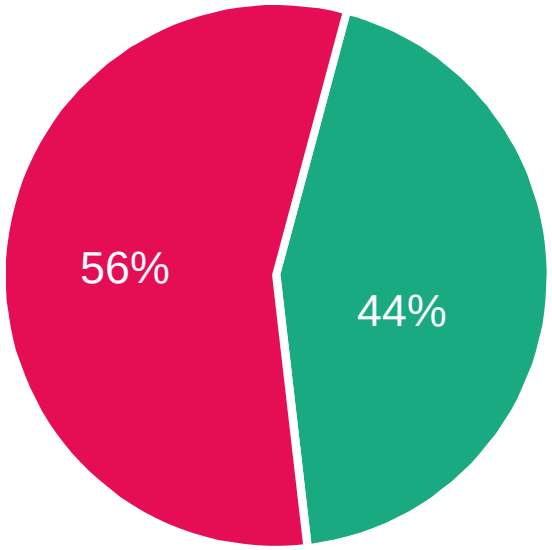
Median reduction in annual premium: $500



CONSIDERING "VALUE OF INVESTMENT" (VOI) AS WELL AS ROI MEANS DEVELOPING NEW METRICS

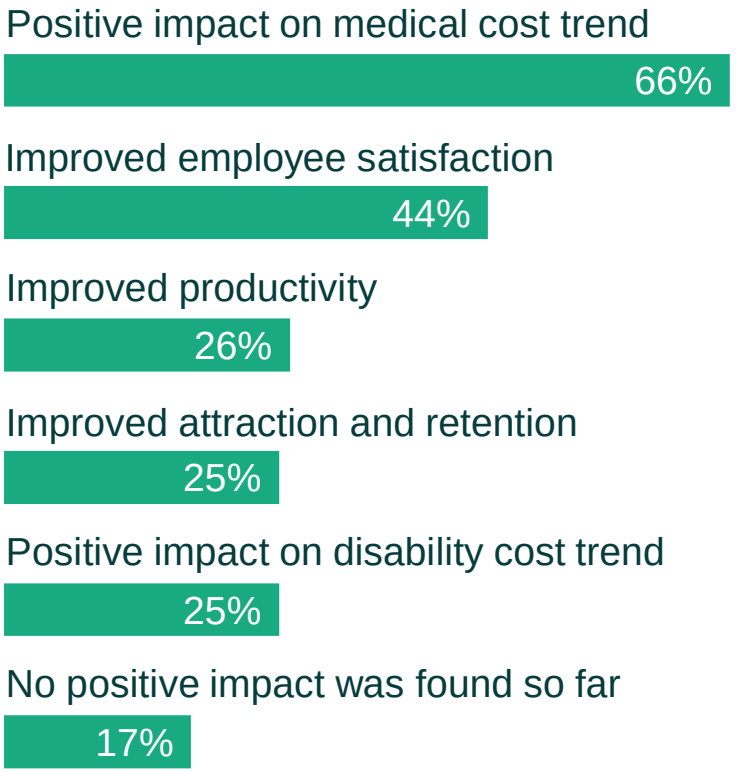
Employers with 20,000 or more employees

Over two-fifths have attempted to measure program impact…

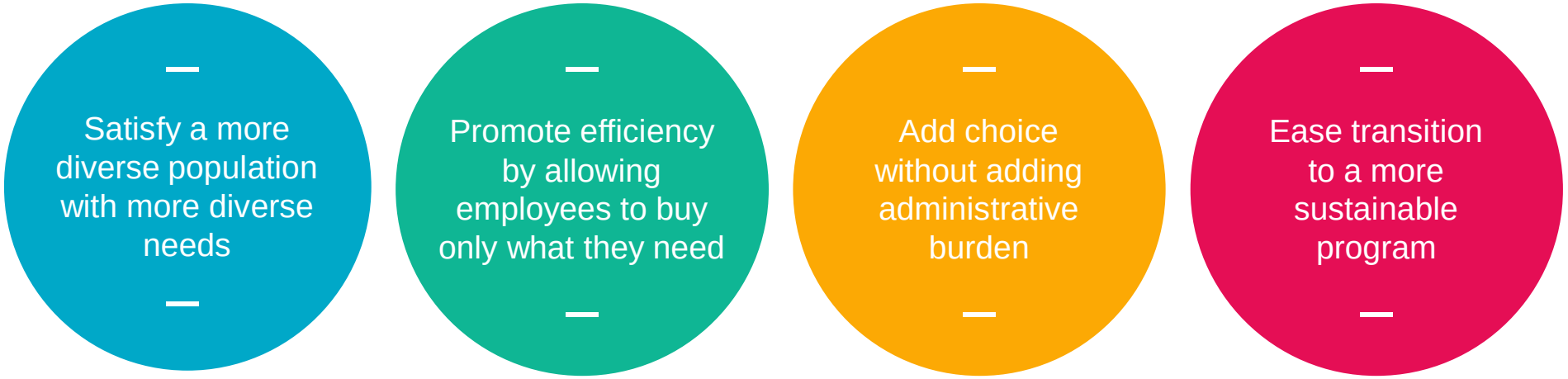


Have measured VOI

…with the majority of these reporting improvement in medical plan trend and/or other areas

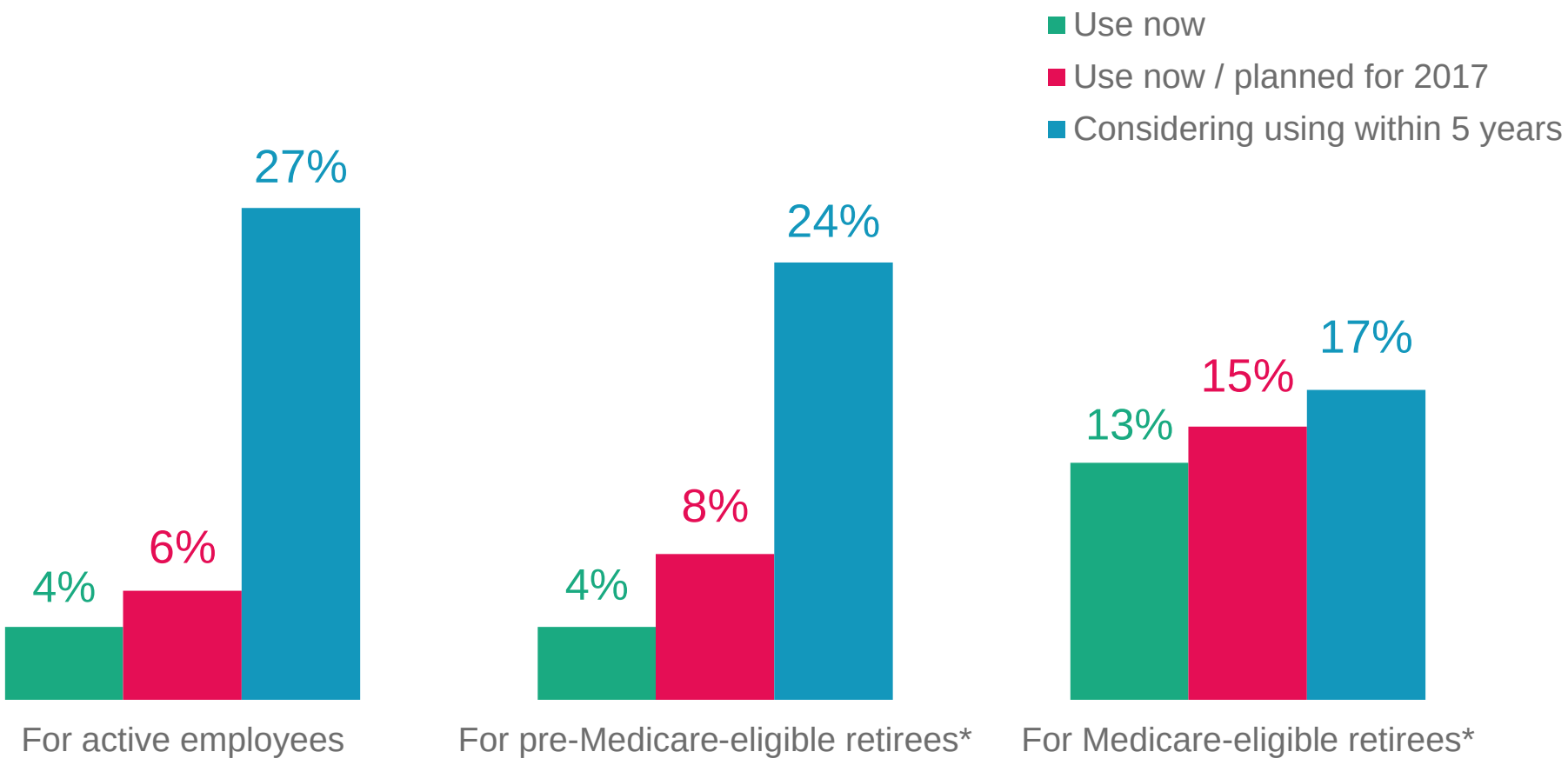


BRINGING IT ALL TOGETHER: PRIVATE BENEFIT EXCHANGE EMPOWERS CONSUMER, ADDING VALUE BY ADDING CHOICE



PRIVATE HEALTH BENEFIT EXCHANGES GAIN A FOOTHOLD AS INTEREST CONTINUES TO BUILD

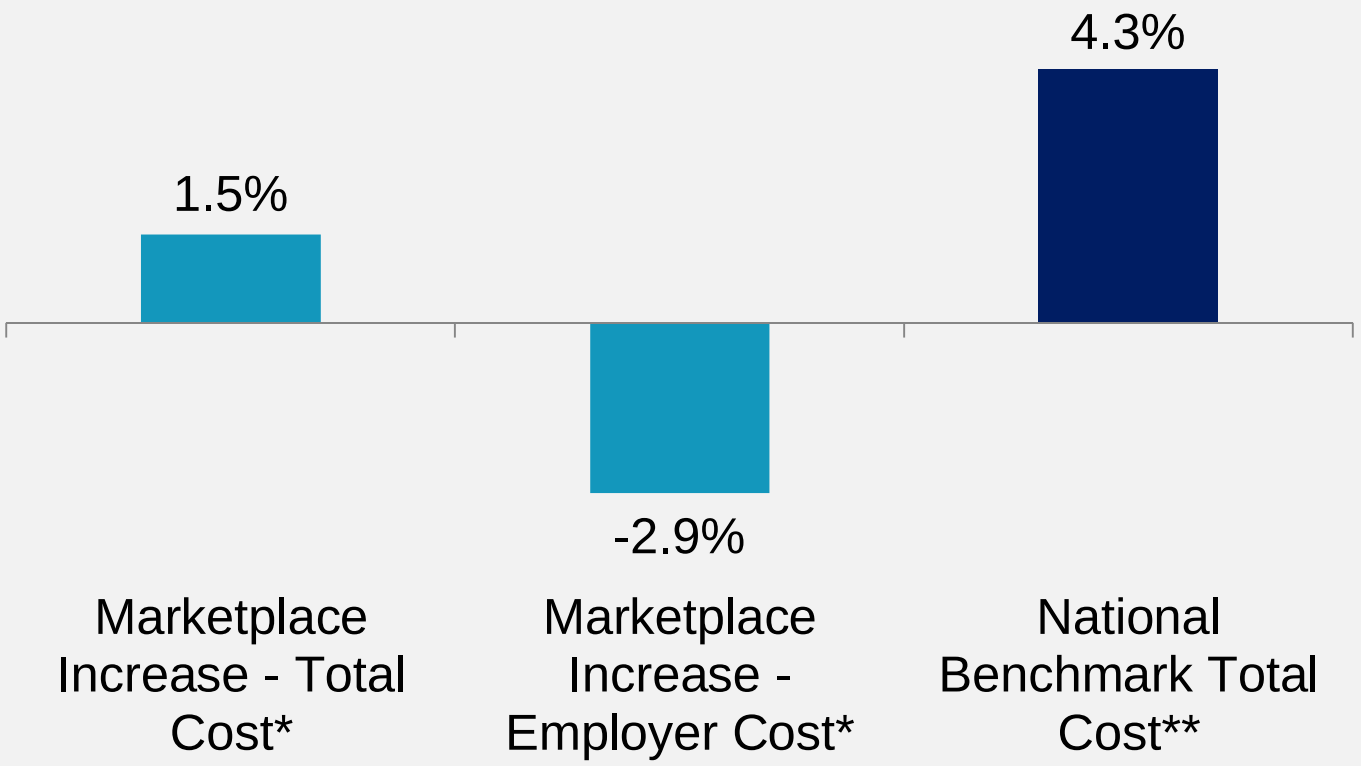
Large employers



* Among current retiree medical plan sponsors

SAVINGS OPPORTUNITIES… UP TO 15%

YEAR 2 MEDICAL COST RESULTS ARE VERY FAVORABLE
Mercer Marketplace outcomes for 1/1/2015 (1/16 results pending)



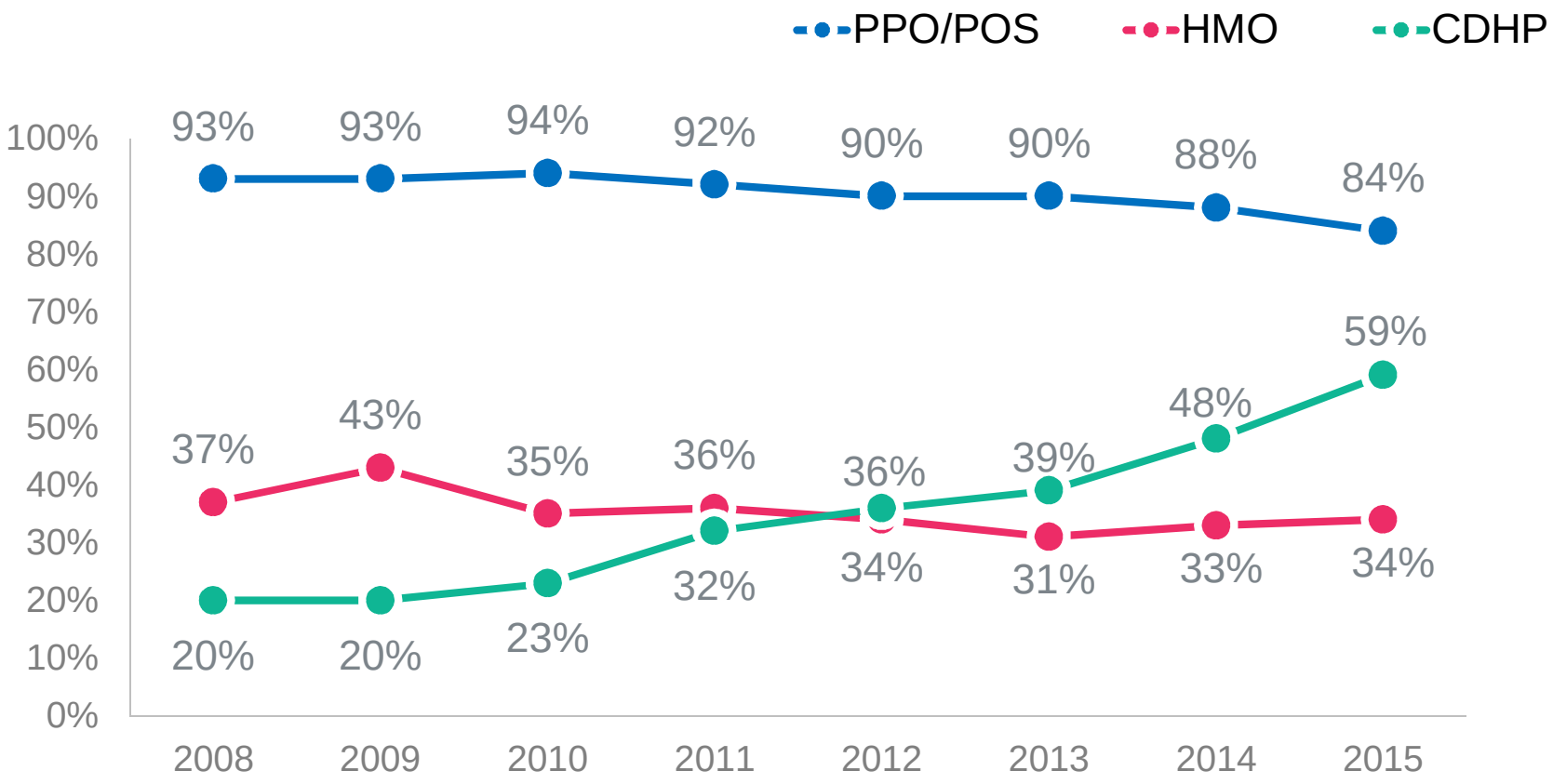
*Average increase for clients with January 2015 renewals

**Mercer 2015 Survey of Employer-Sponsored Plans: Average projected percent change in total health benefit cost per employee for 2016

THE BASICS
OFFERINGS, ELIGIBILITY AND ENROLLMENT

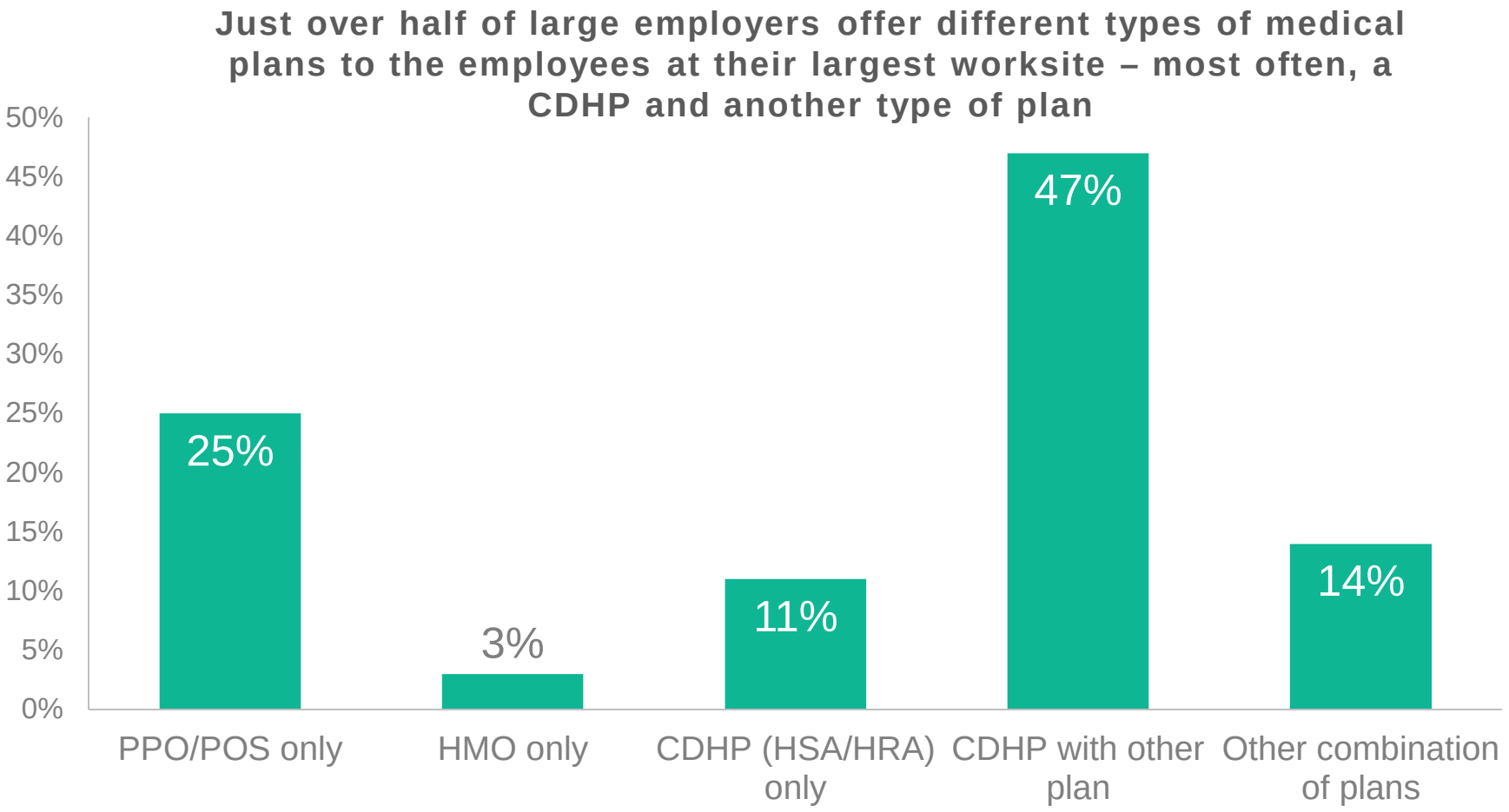
TYPE OF MEDICAL PLAN OFFERED, 2008-2015

Large employers



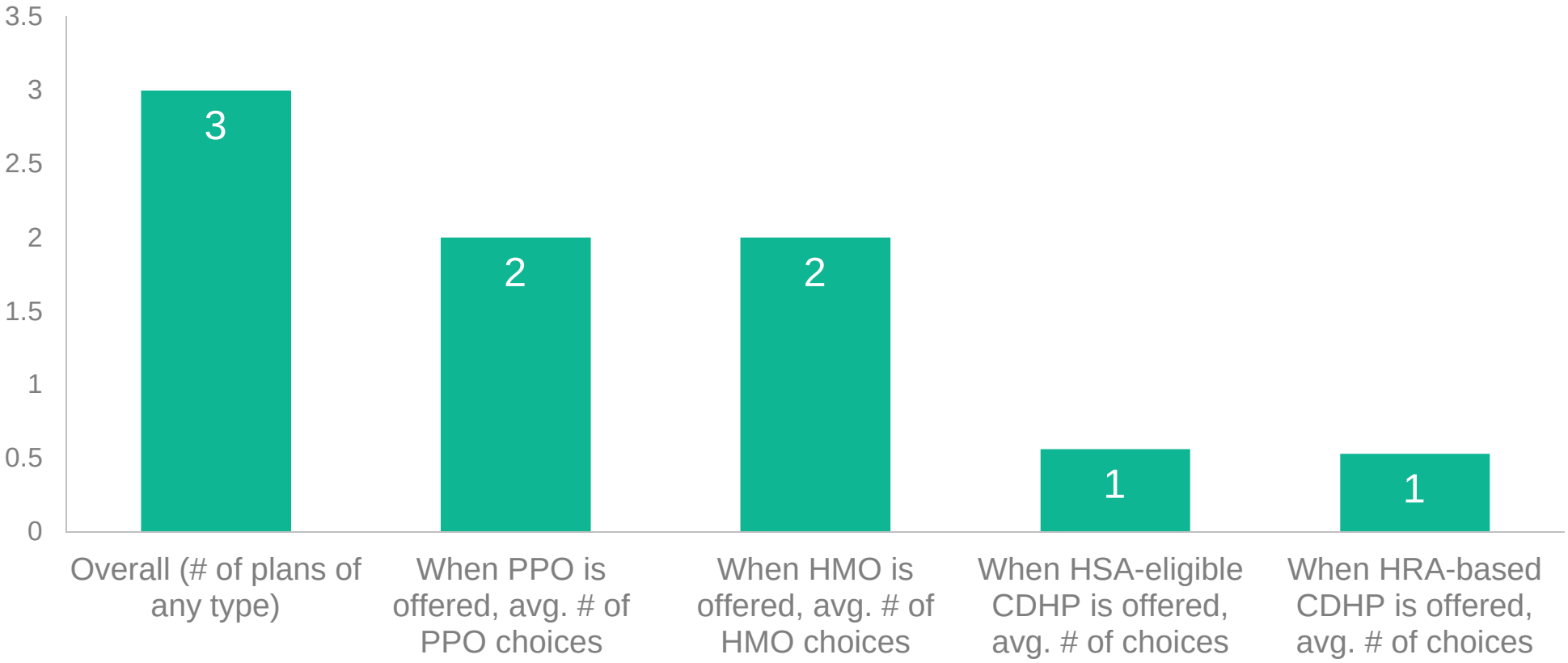
MEDICAL PLAN CHOICES AVAILABLE AT LARGEST WORKSITE

Large employers

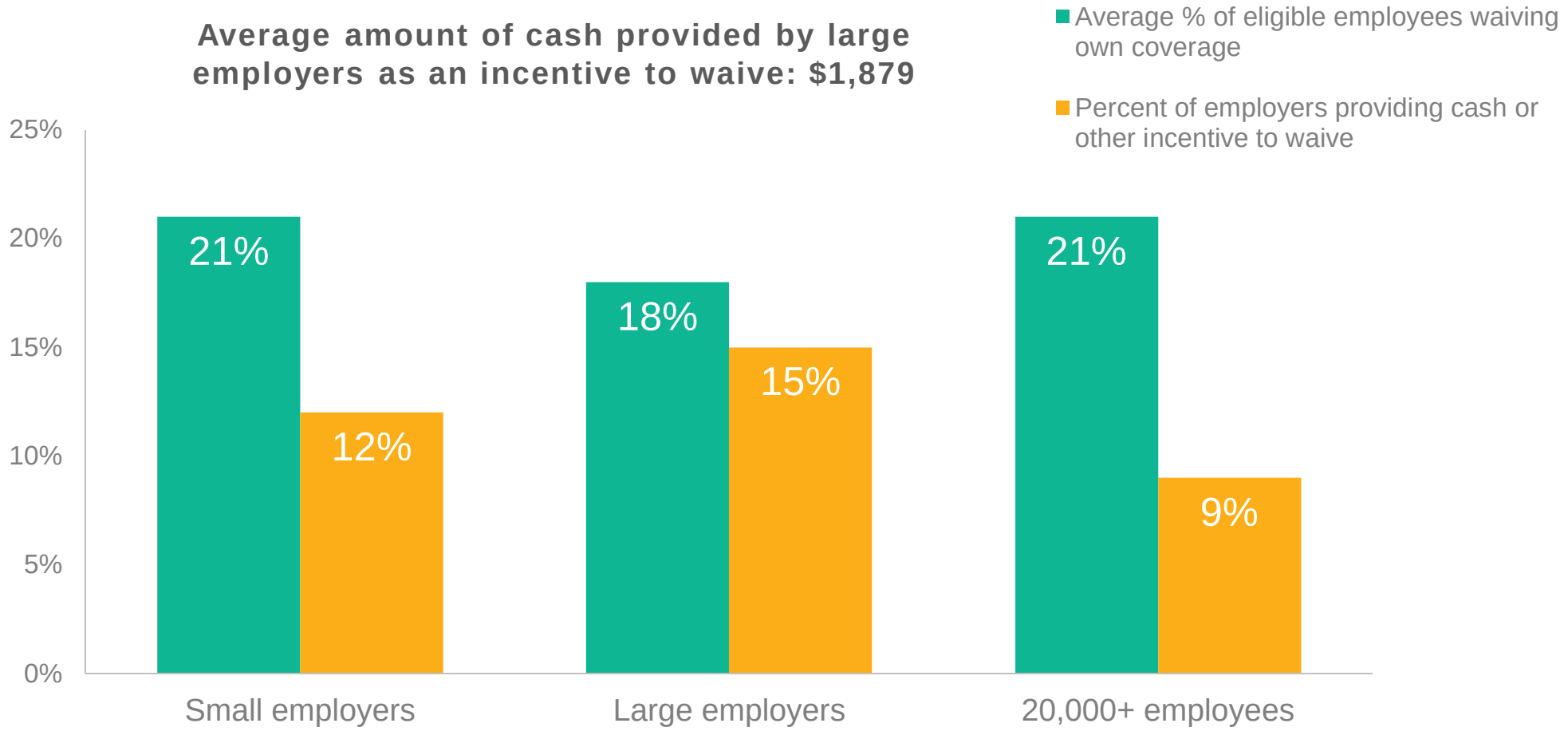


AVERAGE NUMBER OF PLANS OFFERED AT LARGEST WORKSITE

Large employers

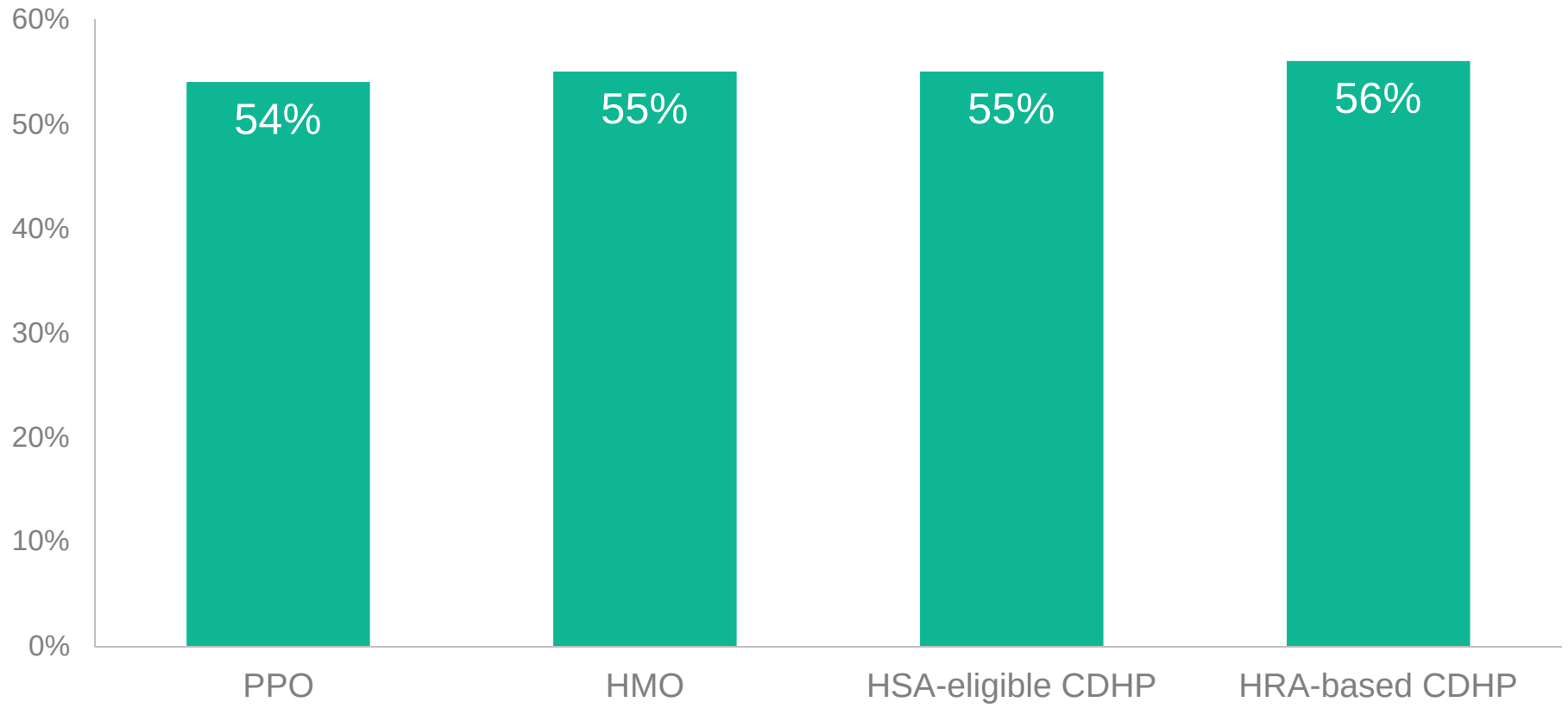


WAIVING COVERAGE, BY EMPLOYER SIZE



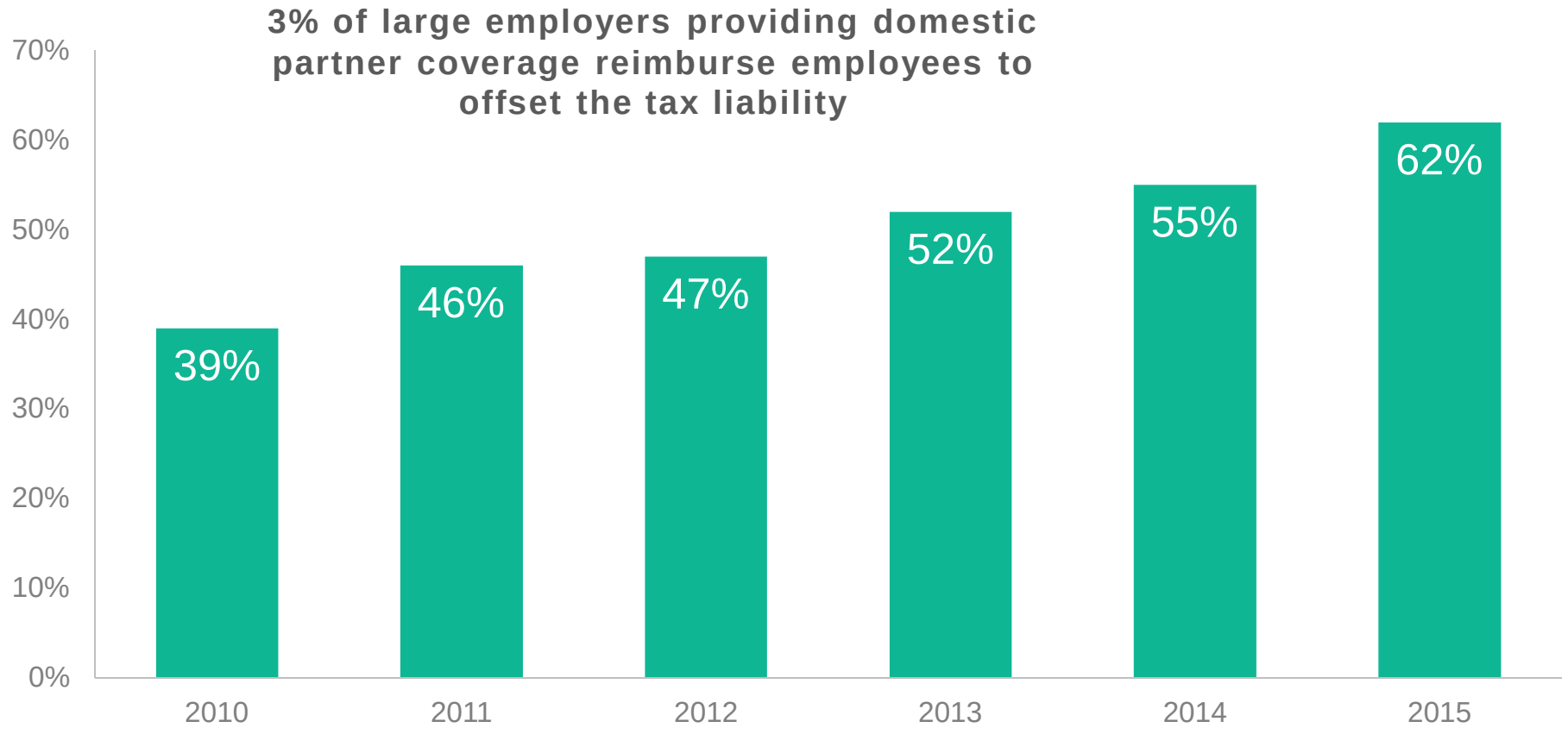
DEPENDENT COVERAGE ELECTION, BY MEDICAL PLAN TYPE

Average % of covered employees electing dependent coverage, among large employers

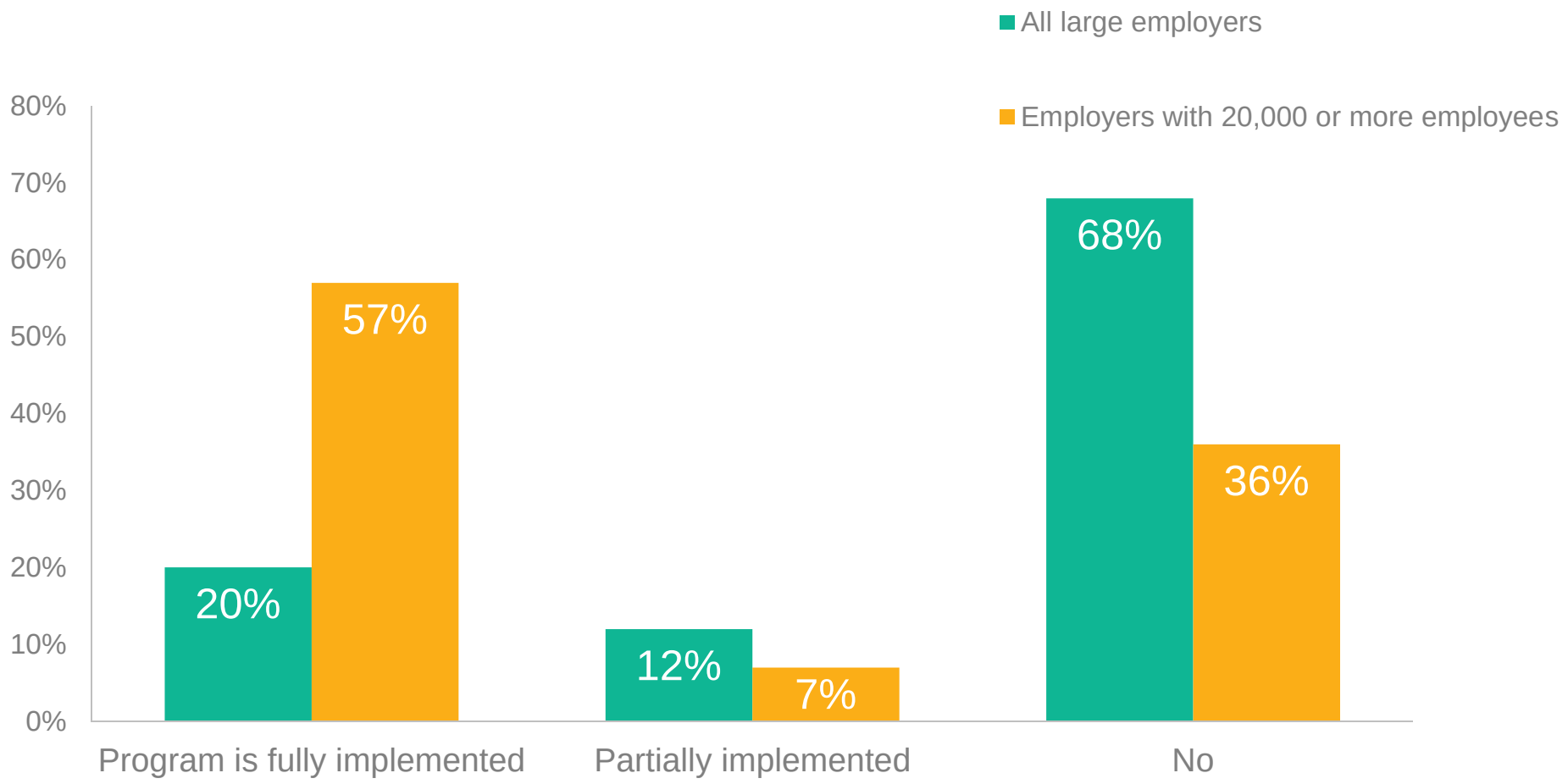


SAME-SEX DOMESTIC PARTNER COVERAGE HAS BECOME INCREASINGLY COMMON

Large employers

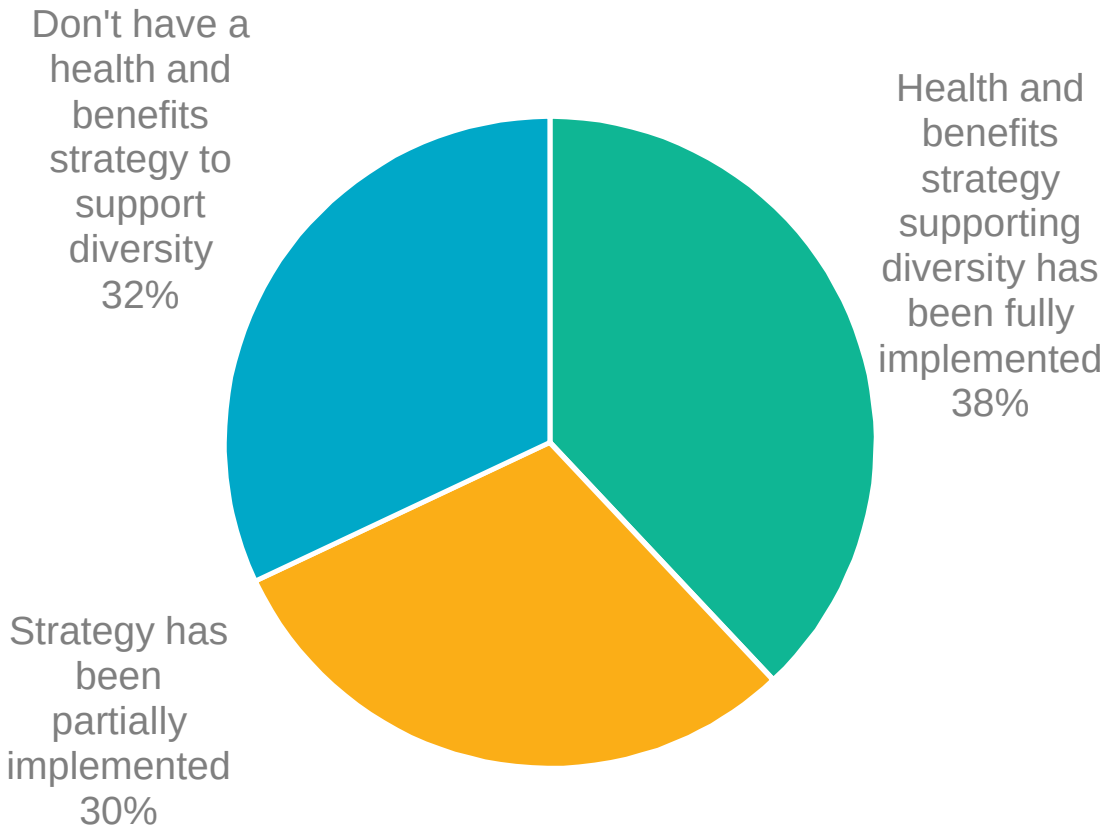


HAVE IMPLEMENTED A STRUCTURED DIVERSITY AND INCLUSION POLICY/PROGRAM



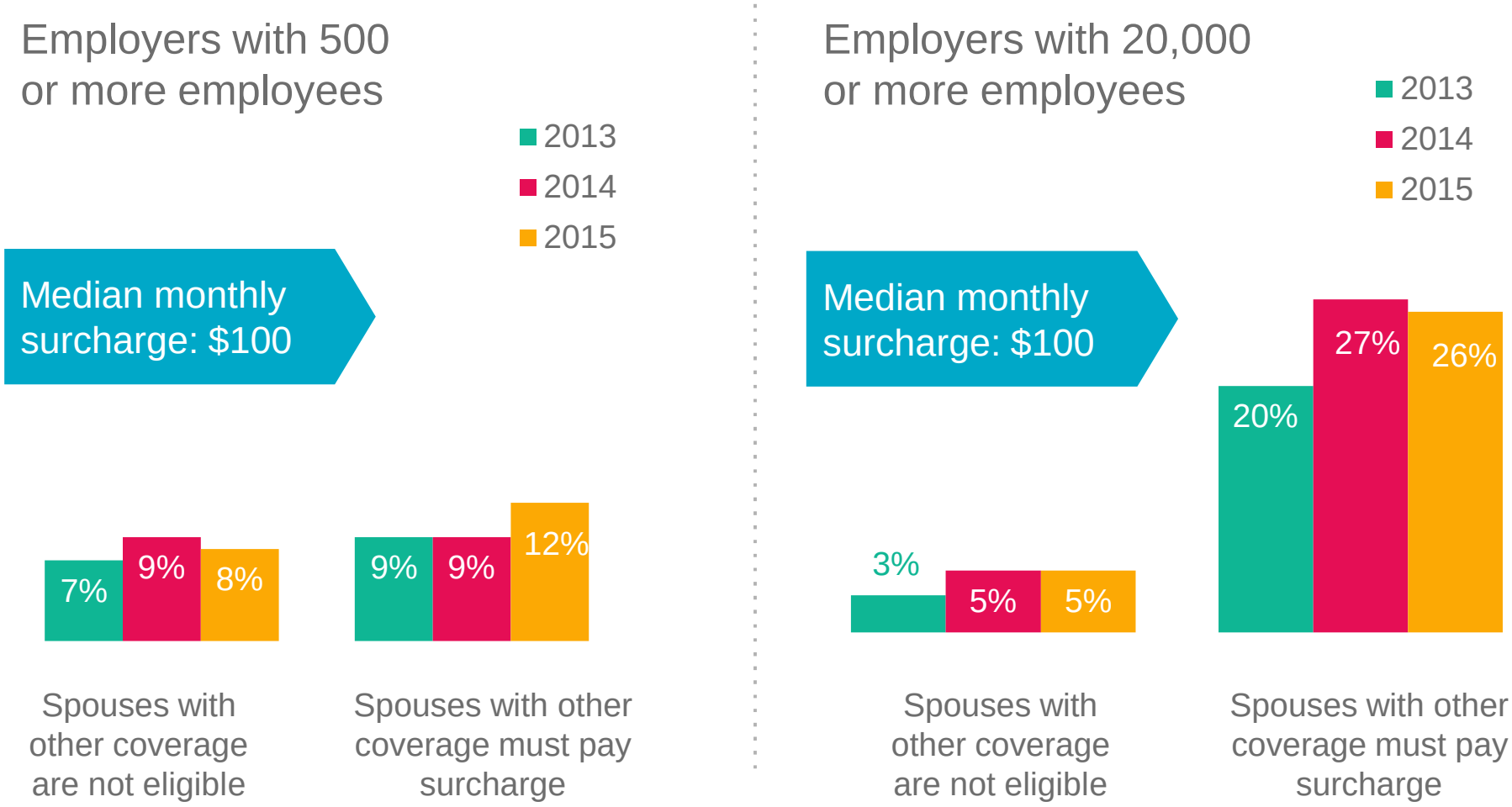
HEALTH AND BENEFITS STRATEGY SUPPORTS THE DIVERSITY POLICY BY ADDRESSING NEEDS OF LBGT, WOMEN, OR ETHNIC GROUPS

Based on large employers that have a structured diversity and inclusion program



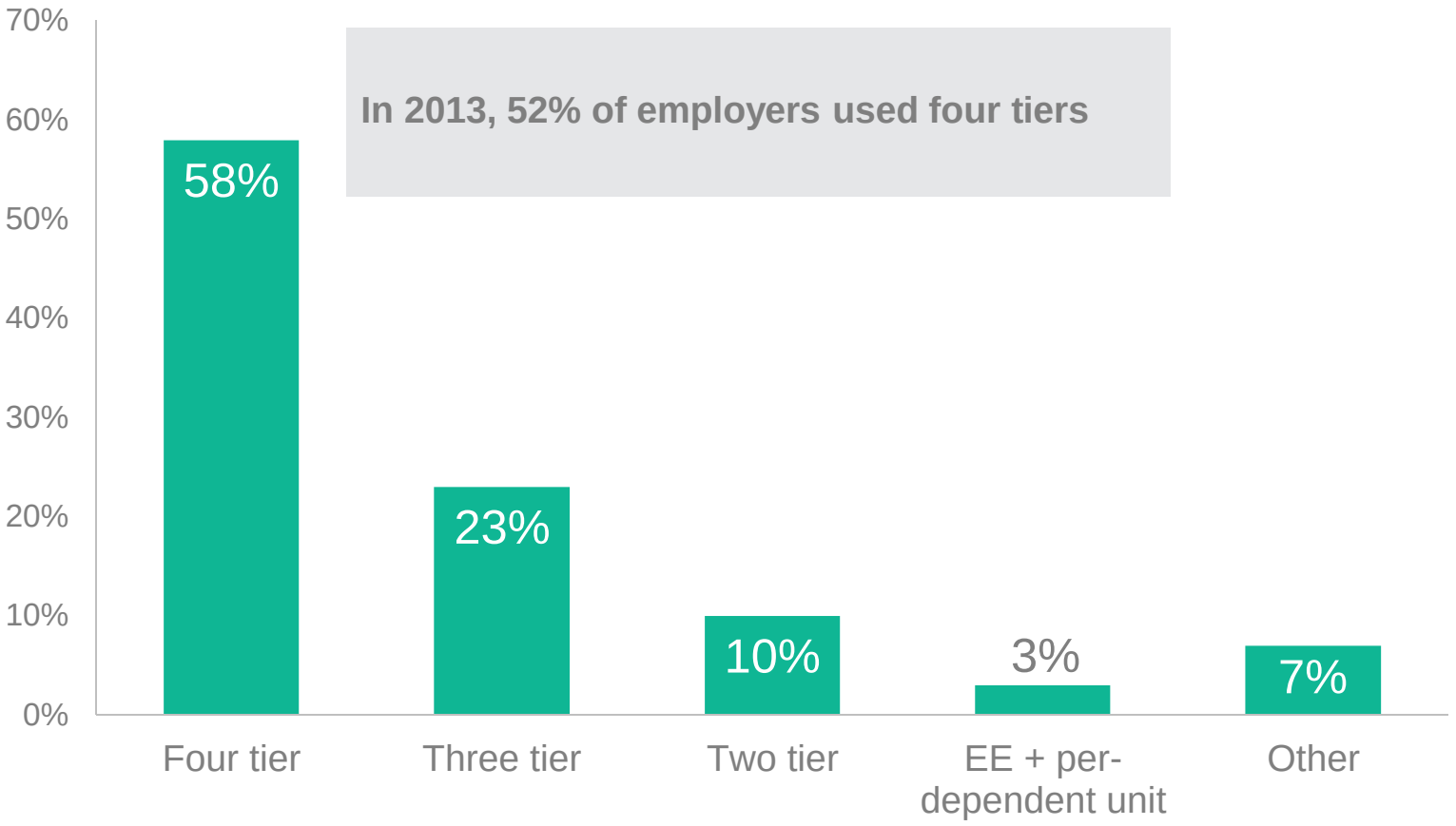
SOME GROWTH IN USE OF SPOUSAL SURCHARGES, BUT NOT IN EXCLUSIONS

Special provisions for employees' spouses with other coverage available



CONTRIBUTION STRATEGY: EMPLOYERS CONTINUE TO ADD CONTRIBUTION TIERS

Large employers



In 2013, 52% of employers used four tiers

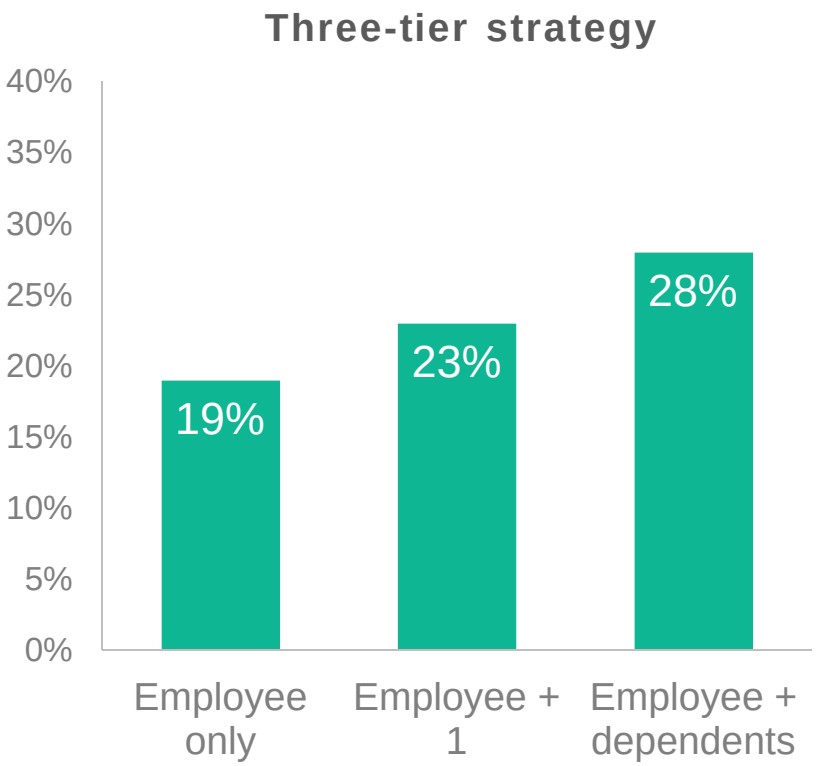
Four tier
EE only
EE + spouse
EE + children
EE + spouse + children

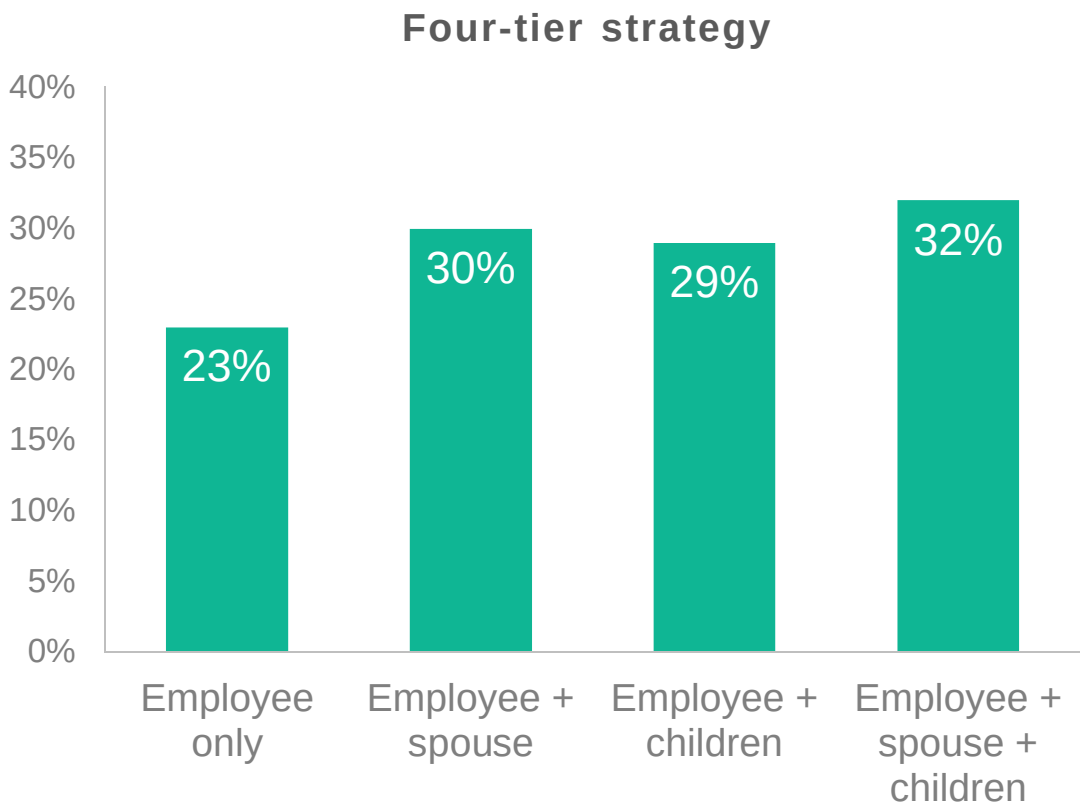
Three tier
EE only
EE + 1
EE + dependents

Two tier
EE only
EE + dependents

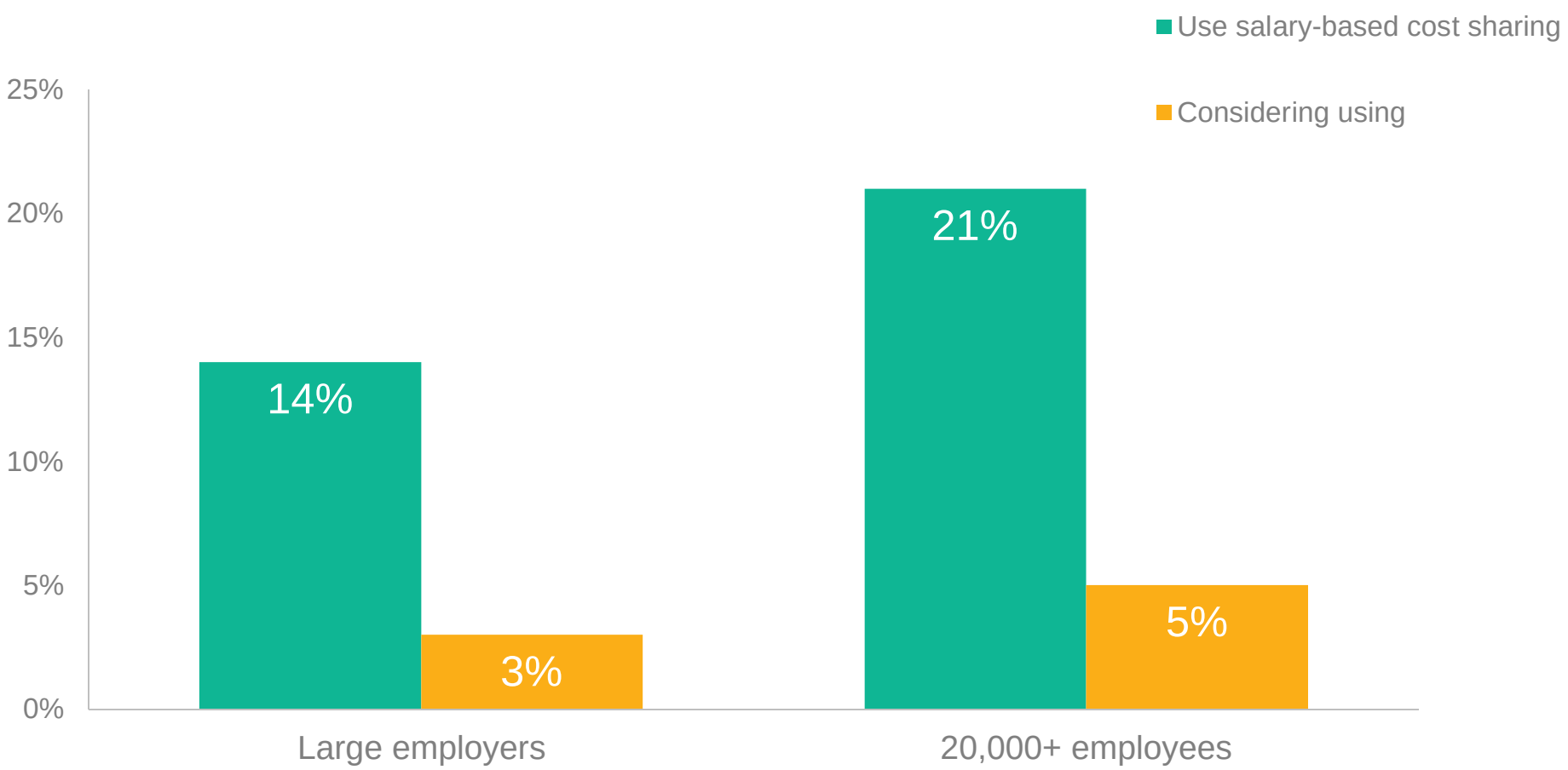
AVERAGE CONTRIBUTION AMOUNTS BY TIER

Large employers

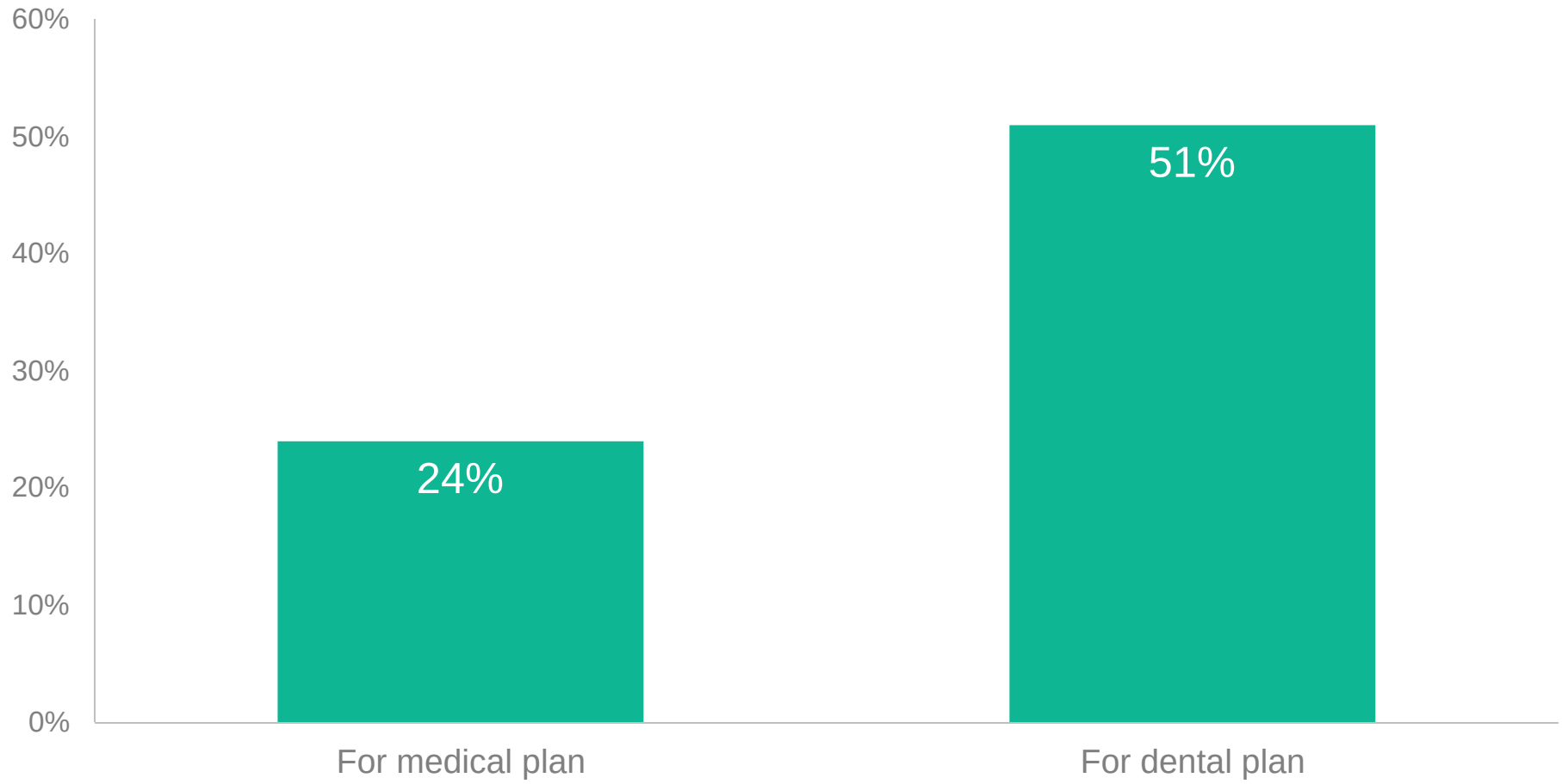




CONTRIBUTION STRATEGY: VARY CONTRIBUTION AMOUNT BASED ON SALARY

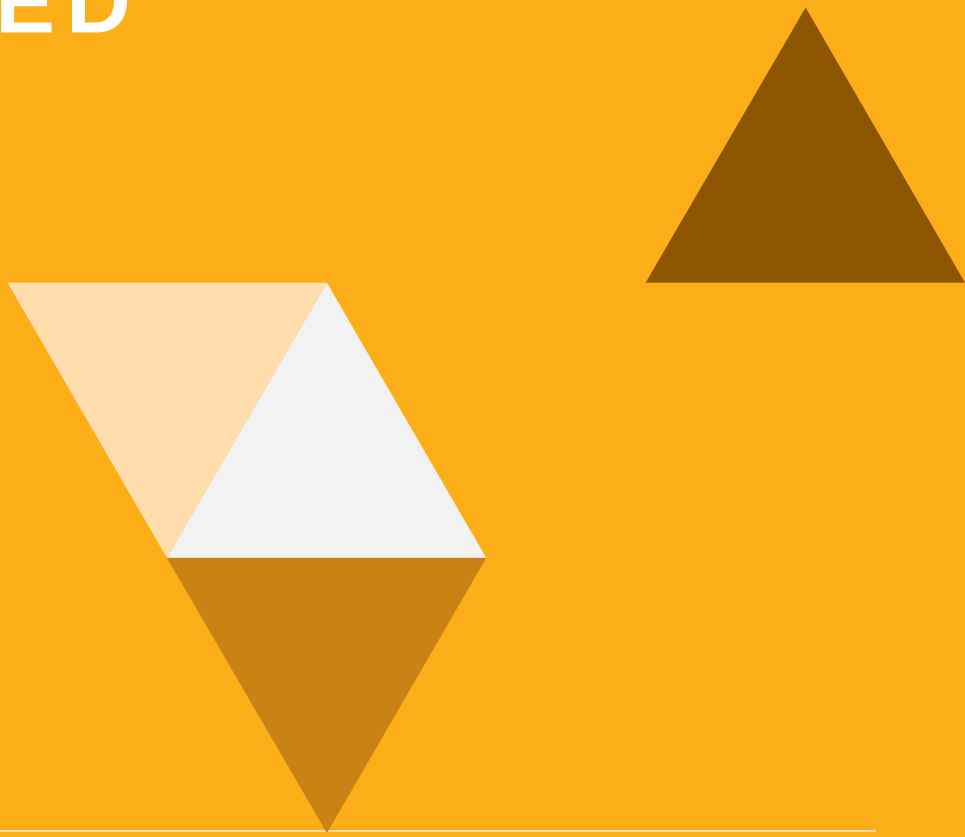


AVERAGE PERCENTAGE OF THE TOTAL PREMIUM* EMPLOYEES PAID IN 2015



*Across all plans and coverage tiers

CONSUMER-DIRECTED HEALTH PLANS



HEALTH CARE CONSUMERISM IN A NUTSHELL

- Consumerism means taking personal responsibility for maintaining or improving one's health and for choosing cost-effective, quality health care providers
- Strategies for encouraging consumerism range from providing decision-support tools and education to innovative plan design
- In the survey, CDHP means a plan that features and employer-funded account (H.R.A or H.S.A)
- Consumerism is more than a consumer-directed health plan!

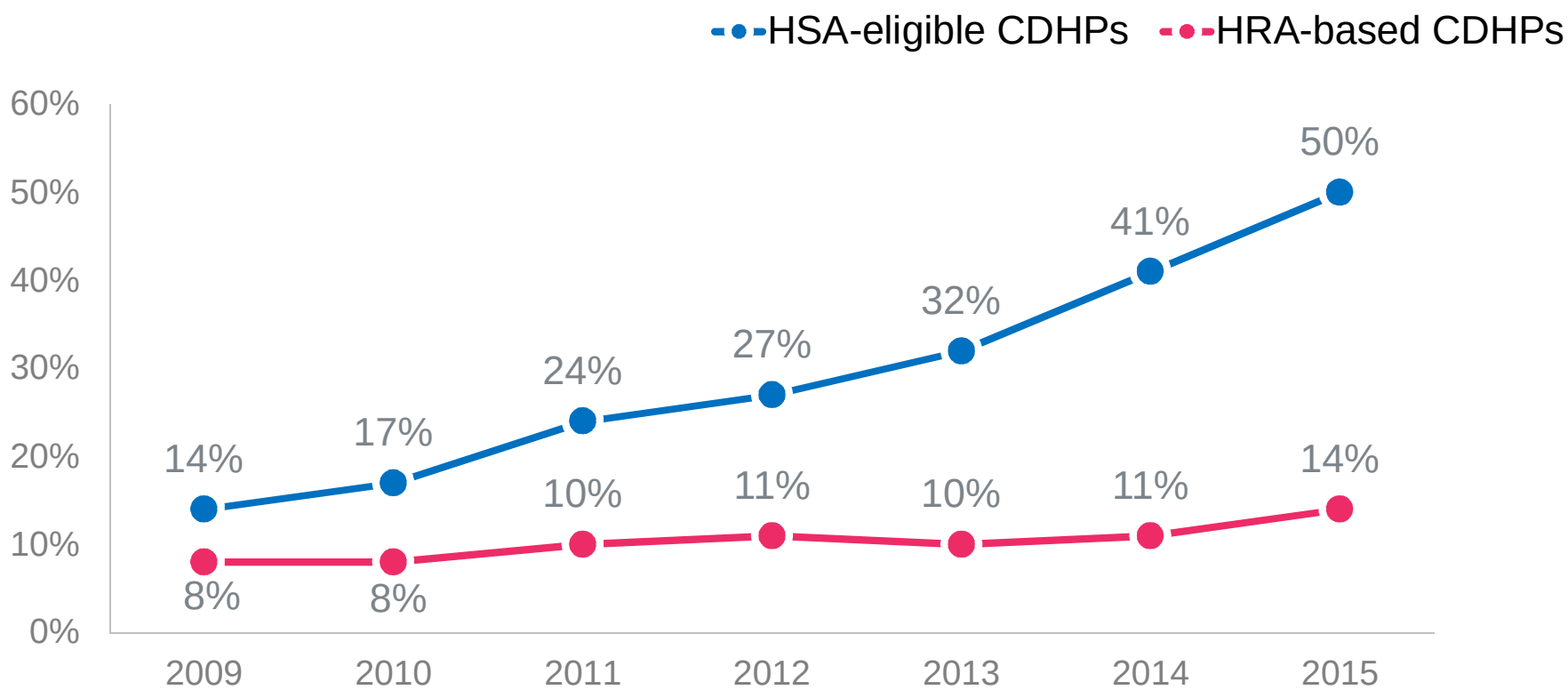
CONTINUED GROWTH IN CDHP OFFERINGS IN 2015

Percent of employers offering CDHP, by employer size

NUMBER OF EMPLOYEES	2009	2010	2011	2012	2013	2014	2015	EXPECT TO OFFER CDHP IN 2018
10-499	15%	16%	20%	22%	23%	26%	28%	39%
500-999	16%	18%	26%	35%	33%	44%	53%	71%
1,000-4,999	20%	24%	34%	33%	41%	48%	62%	77%
5,000-9,999	42%	39%	42%	46%	52%	63%	63%	84%
10,000-19,999	39%	41%	46%	53%	56%	66%	69%	82%
20,000 or more	43%	51%	48%	59%	63%	72%	73%	86%

HSA-ELIGIBLE PLANS ARE FAR MORE COMMON THAN HRA-BASED PLANS

Percent of large employers offering plan

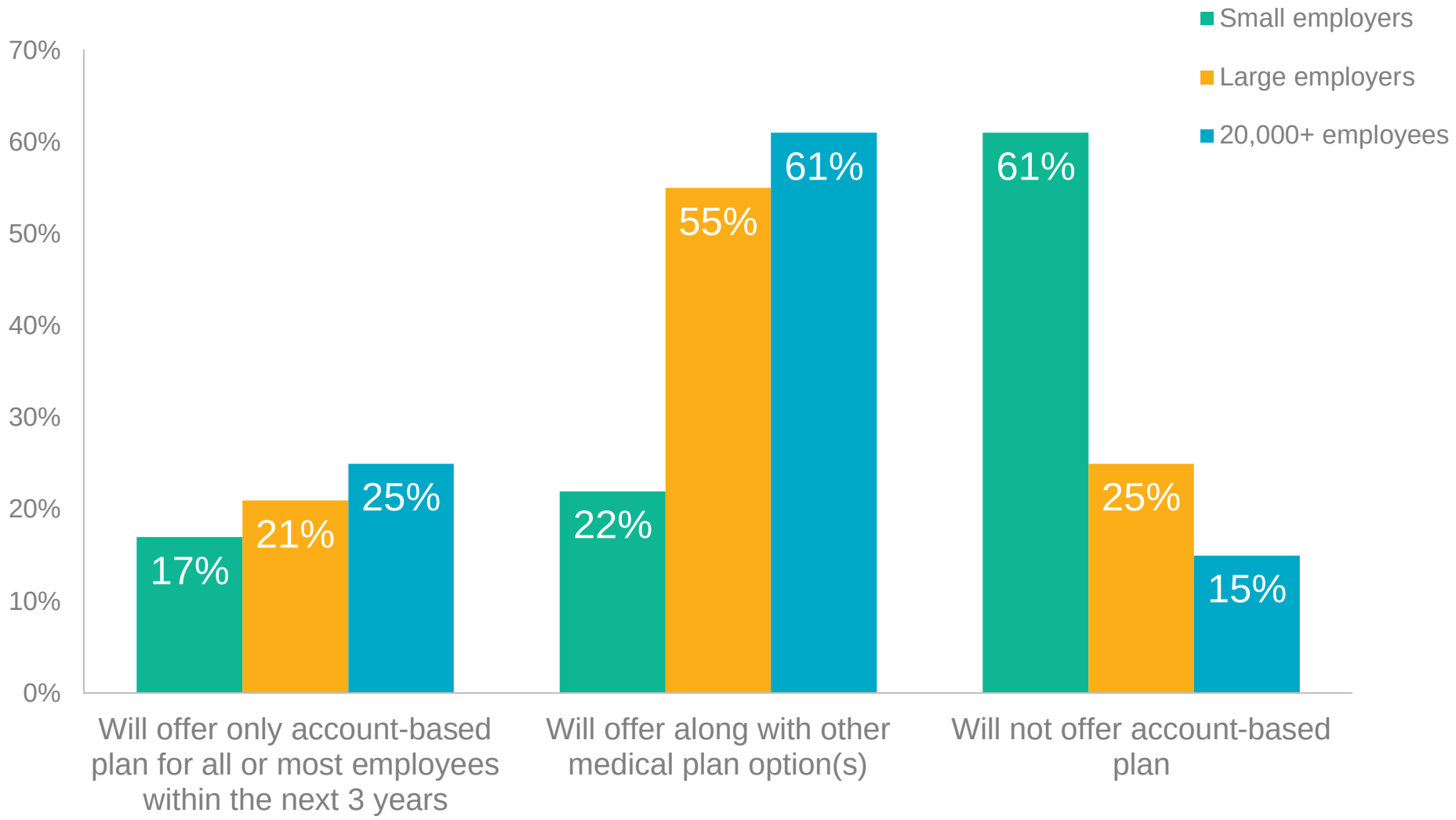


MOST CDHP SPONSORS OFFER THEIR ACCOUNT-BASED PLAN ALONGSIDE A TRADITIONAL MEDICAL PLAN CHOICE

Large employers

- 10% of HSA sponsors offer the plan as a full replacement
- 19% of HRA sponsors offer the plan as a full replacement

MAJORITY OF LARGE EMPLOYERS EXPECT TO OFFER AN ACCOUNT-BASED PLAN BY 2018, BUT ONLY ABOUT A FIFTH BELIEVE IT WILL BE THEIR ONLY PLAN



EMPLOYEE DOLLAR CONTRIBUTIONS FOR CDHP COVERAGE SIGNIFICANTLY LOWER THAN FOR PPO AND HMO COVERAGE

Large employers

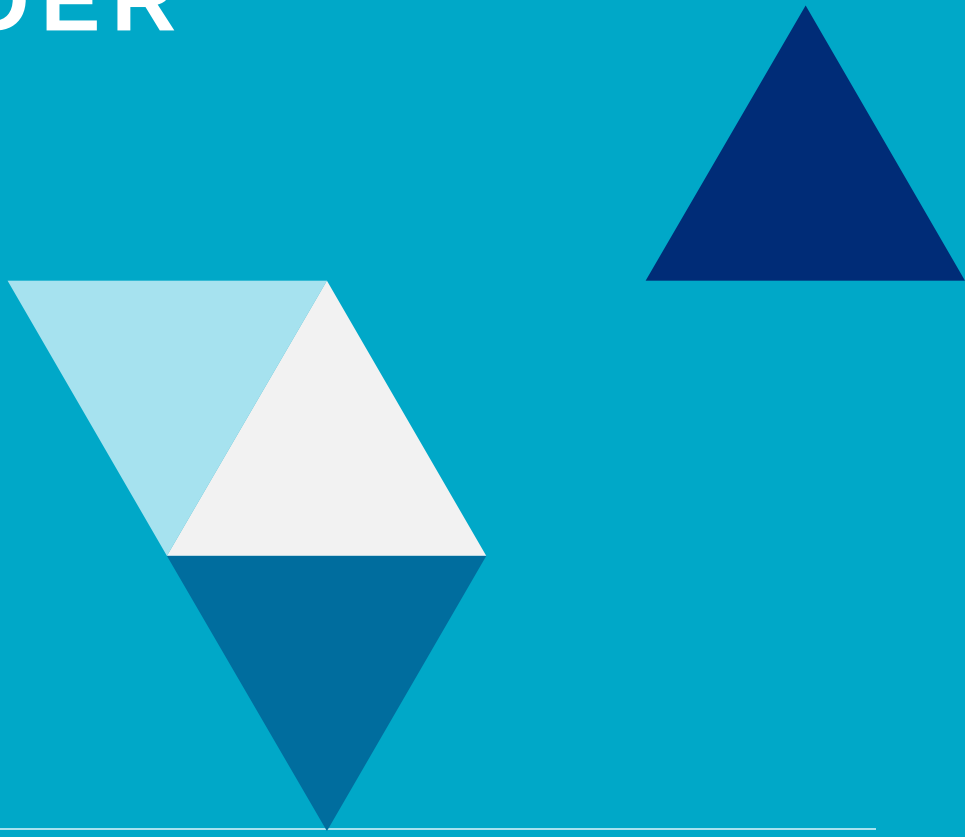
	NO CONTRIBUTION REQUIRED	AVERAGE MONTHLY DOLLAR AMOUNT	AVERAGE CONTRIBUTION AS A % OF PREMIUM
HRA-based CDHP			
Employee-only	13%	$82	19%
Family	2%	$313	25%
H.S.A-based CDHP			
Employee-only	11%	$85	20%
Family	4%	$338	27%
PPO			
Employee-only	7%	$130	24%
Family	3%	$472	32%
HMO			
Employee-only	11%	$127	23%
Family	5%	$476	32%

ACCOUNT CONTRIBUTIONS, DEDUCTIBLES AND OOP MAXIMUMS

Large sponsors

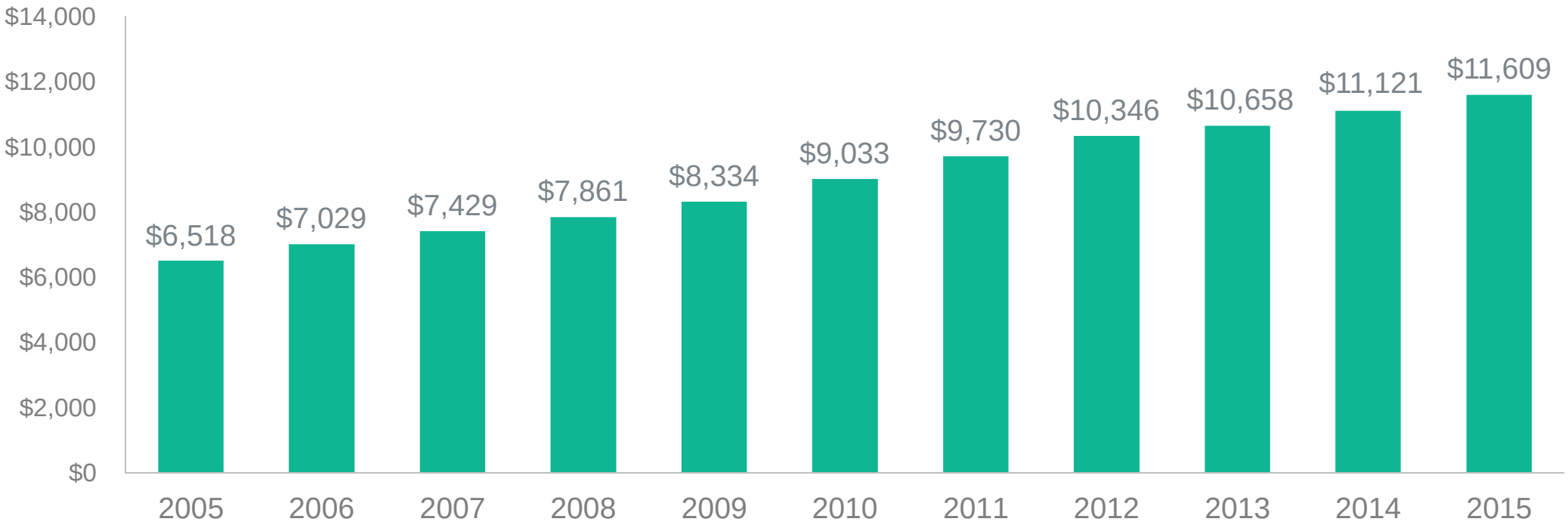
	% OF EMPLOYERS MAKING CONTRIBUTION TO ACCOUNT	EMPLOYER CONTRIBUTION AMOUNT (MEDIAN)	DEDUCTIBLE (MEDIAN)	OUT-OF-POCKET MAXIMUM (MEDIAN)
HRA in-network				
Employee-only	100%	$600	$1,500	$4,000
Family	100%	$1,250	$3,250	$8,000
H.S.A in-network				
Employee-only	72%	$500	$1,800	$3,600
Family	72%	$1000	$4,000	$7,500

PREFERRED PROVIDER ORGANIZATIONS



PPO* COST PER EMPLOYEE, 2005-2015

Large PPO sponsors



Note: Results for 2005-2010 include prescription drug costs if the drug benefit was offered through the medical plan. Beginning 2011, all prescription drug plan costs are included in the medical plan costs, even if the prescription drug benefit was carved out.

*Results for 2005-2007 include PPO plans only. Results beginning in 2008 include PPO and POS plans.

EMPLOYEE CONTRIBUTION REQUIREMENTS FOR PPO

Large PPO sponsors

	EMPLOYEE-ONLY	FAMILY
Employers requiring contribution	93%	97%
Average contribution as a % of premium	24%	32%
Average monthly contribution	$130	$472

EMPLOYEE COST-SHARING REQUIREMENTS FOR PPO

Large PPO sponsors

	IN-NETWORK	OUT-OF NETWORK
Deductible		
Require deductible	93%	96%
Individual amount (median)	$500	$1,000
Family amount (median)	$1,500	$3,000
Primary care physician's office visit		
Require copay	79%	12%
Copay amount (median)	$25	$25
Require coinsurance	26%	91%
Coinsurance amount (median)	20%	40%
Specialist's office visit		
Require higher copay for specialist visit	52%	--
Copay amount, when higher (median)	$40	--

EMPLOYEE COST-SHARING REQUIREMENTS FOR PPO, CONTINUED

Large PPO sponsors

	IN-NETWORK	OUT-OF NETWORK
Lab tests / X-rays		
Require copay	15%	4%
Require coinsurance	64%	92%
Coinsurance amount (median)	20%	40%
Out-of-pocket maximum		
Individual OOP max (median)	$3,000	$5,000
Family OOP max* (median)	$6,000	$11,000
Hospitalization		
Require per-admission copay	19%	16%
Copay amount (median)	$250	$300
Require coinsurance	83%	95%
Coinsurance amount (median)	20%	40%

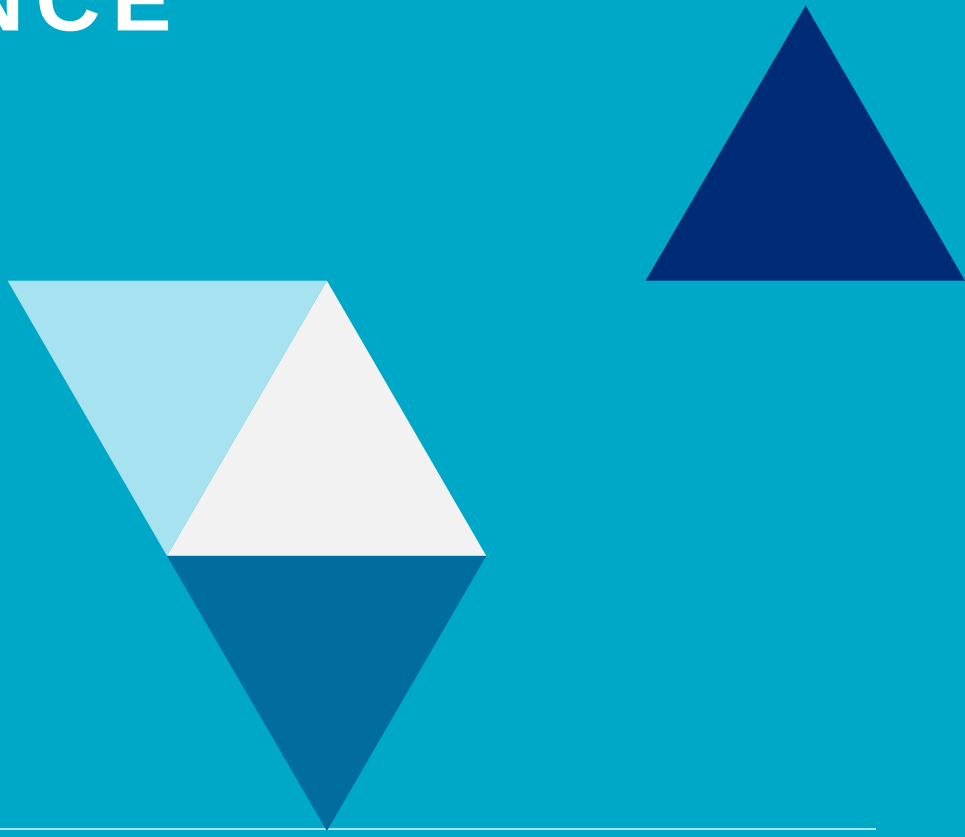
*When out-of-pocket maximum is a set amount per family

EMPLOYEE COST-SHARING REQUIREMENTS FOR PPO, CONTINUED

Large PPO sponsors

	IN-NETWORK	OUT-OF NETWORK
Emergency room visits		
Require copay	73%	--
Copay amount (median)	$150	--
Require coinsurance	44%	--
Coinsurance amount (median)	20%	--

HEALTH MAINTENANCE ORGANIZATIONS



HMO COST PER EMPLOYEE, 2005-2015

Large HMO sponsors

Note: Results for 2005-2010 include prescription drug costs if the drug benefit was offered through the medical plan. Beginning 2011, all prescription drug plan costs are included in the medical plan costs, even if the prescription drug benefit was carved out.

EMPLOYEE CONTRIBUTION REQUIREMENTS FOR HMO

Large HMO sponsors

	EMPLOYEE-ONLY	FAMILY
Employers requiring contribution	89%	95%
Average contribution as a % of premium	23%	32%
Average monthly contribution	$127	$476

EMPLOYEE COST-SHARING REQUIREMENTS FOR HMO

Large HMO sponsors

Overall deductible	
Require deductible	32%
Individual amount (median)	$500
Family amount (median)	$1,000
Primary care physician's office visit	
Require copay	94%
Copay amount (median)	$20
Require coinsurance	5%
Specialist's office visit	
Require higher copay for specialist visit	54%
Copay amount, when higher (median)	$35

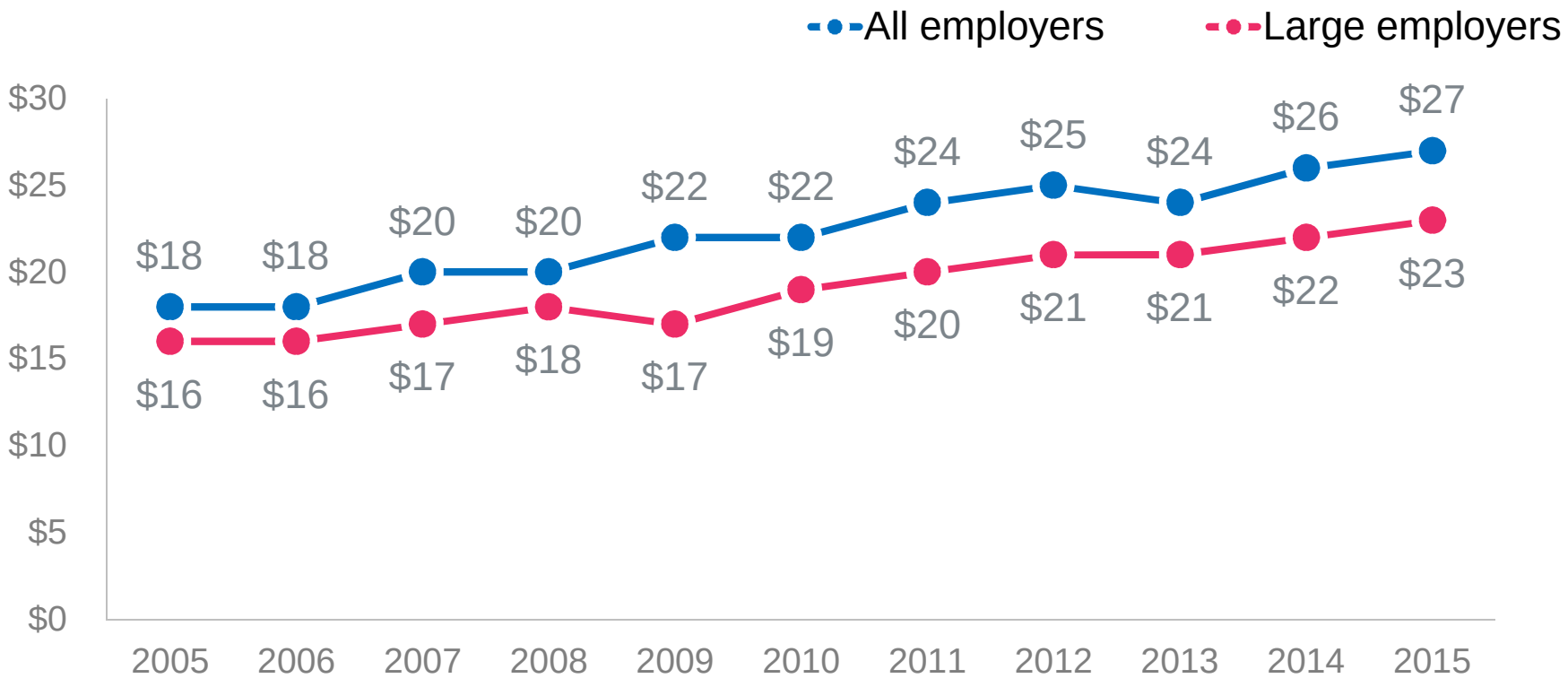
EMPLOYEE COST-SHARING REQUIREMENTS FOR HMO, CONTINUED

Large HMO sponsors

Inpatient hospital cost-sharing	
Require deductible for inpatient stays	54%
Deductible amount (median)	$250
Require coinsurance	33%
Coinsurance amount (median)	20%
Outpatient surgery cost-sharing	
Require per-procedure copay for outpatient surgery	55%
Copay amount, when higher than PCP visit (median)	$125
Require coinsurance	32%
Coinsurance amount (median)	20%
Emergency room visit	
Require copay	86%
Copay amount (median)	$100

HMO COPAY AMOUNTS

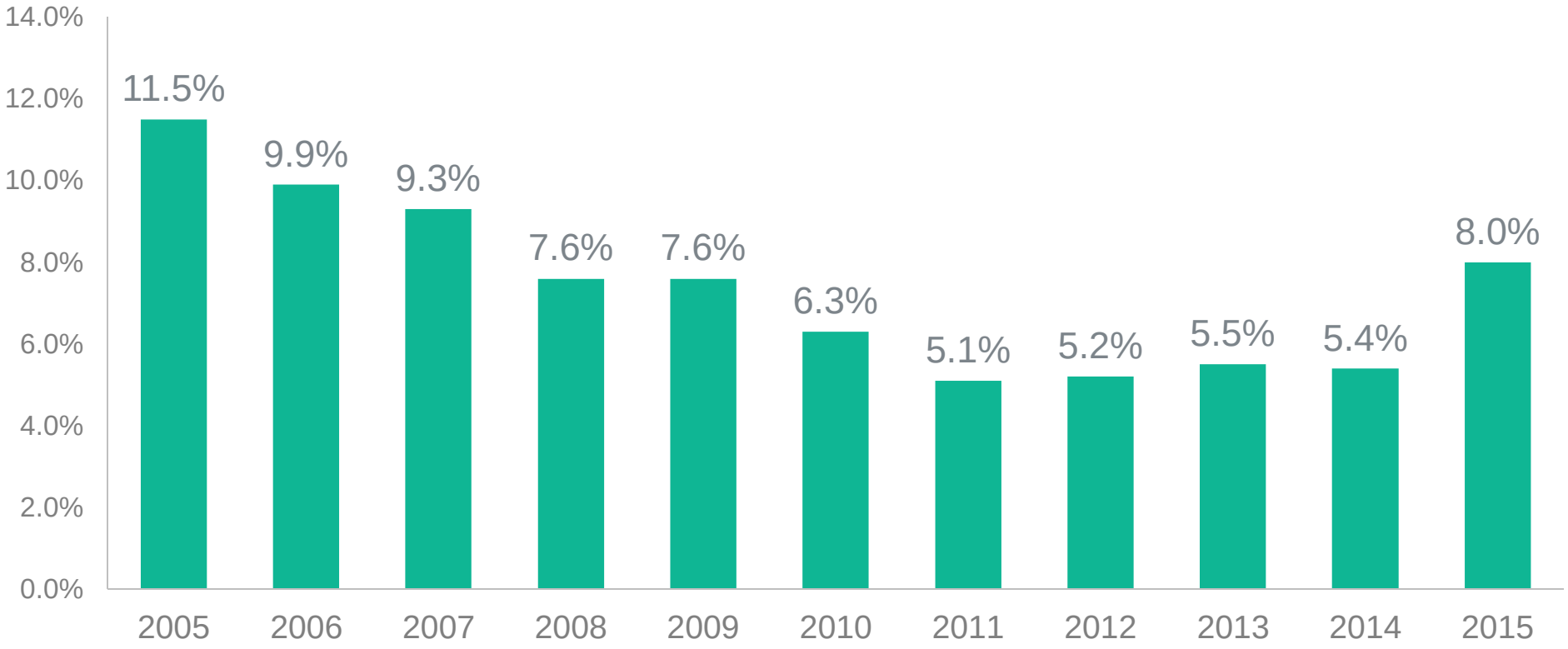
Average copay for physician visits



PRESCRIPTION DRUG BENEFITS

PRESCRIPTION DRUG BENEFIT COST GROWTH IS ACCELERATING

Cost change in prescription drug benefit offered through primary medical plan for large employers



NEARLY A QUARTER OF LARGE EMPLOYERS USE A FOURTH COST-SHARING TIER IN THEIR DRUG PLANS

Cost-sharing provisions used in large employers' primary plan

COST-SHARING STRUCTURE	RETAIL	MAIL-ORDER
Same level of cost-sharing for all drugs	7%	8%
2 levels for generic, brand drugs	10%	11%
3 levels for generic, formulary brand, non-formulary brand	57%	59%
4 or more levels	22%	19%
Other	4%	2%

AVERAGE COPAYMENT AMOUNTS IN PRESCRIPTION DRUG PLANS

In large employers' primary medical plan

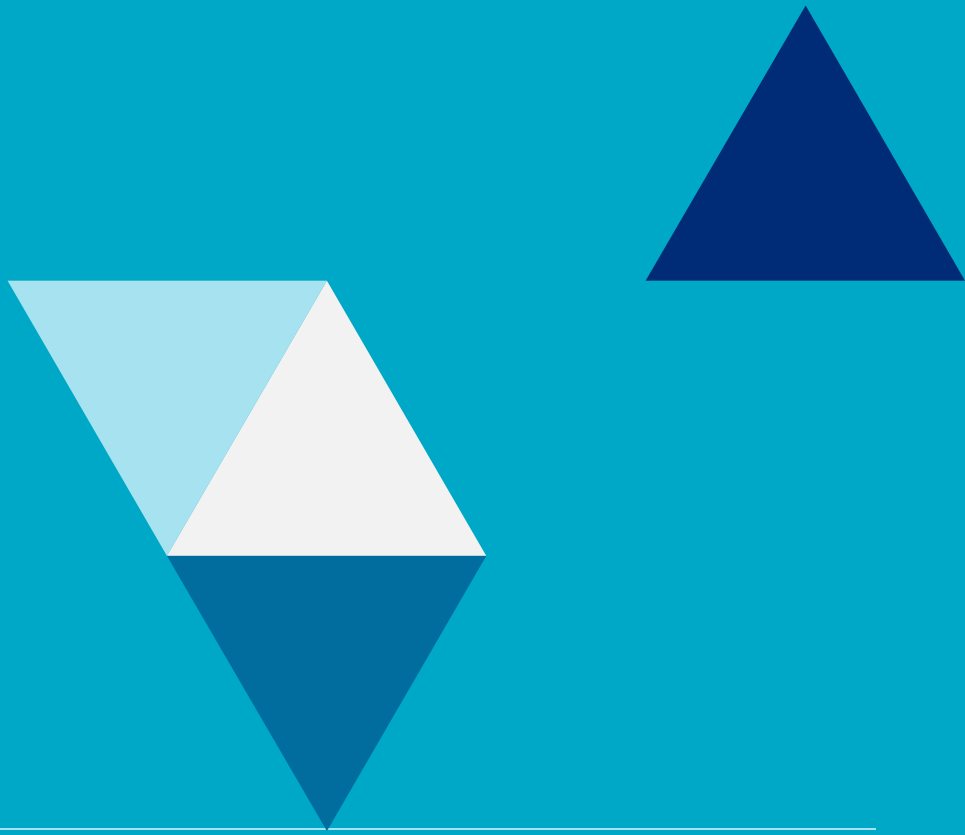
	RETAIL	MAIL-ORDER
Generic	$11	$21
Brand-name	$31	$66
Non-formulary brand	$52	$109
Specialty / biotech, when separate	$100	$169

USE OF COINSURANCE IN DRUG PLANS

Percent of large employers requiring coinsurance

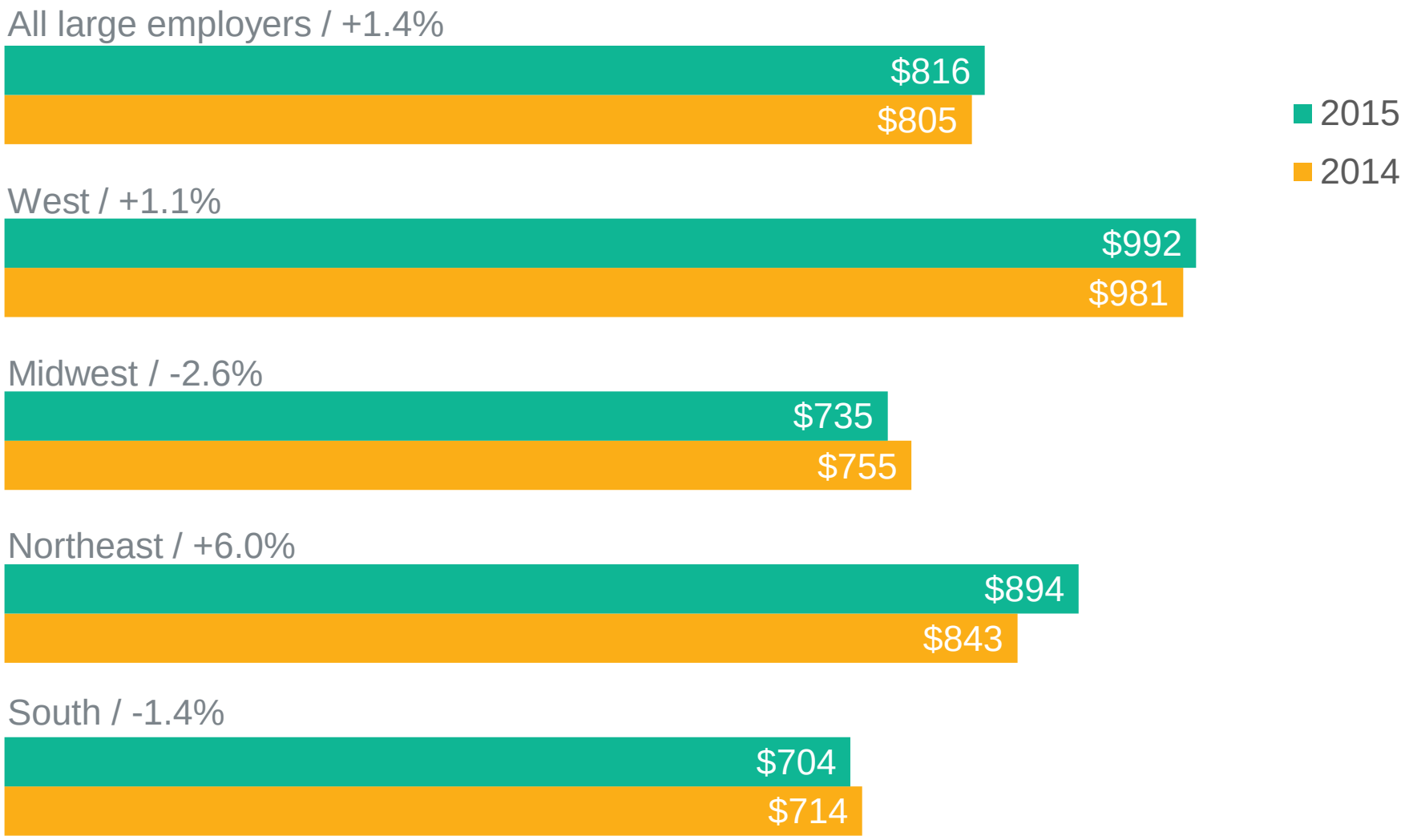
	RETAIL	MAIL-ORDER
Generic drugs	18%	17%
Formulary brand	28%	26%
Non-formulary brand	28%	26%
Specialty / biotech	10%	7%
Any drug category	38%	34%

DENTAL BENEFITS



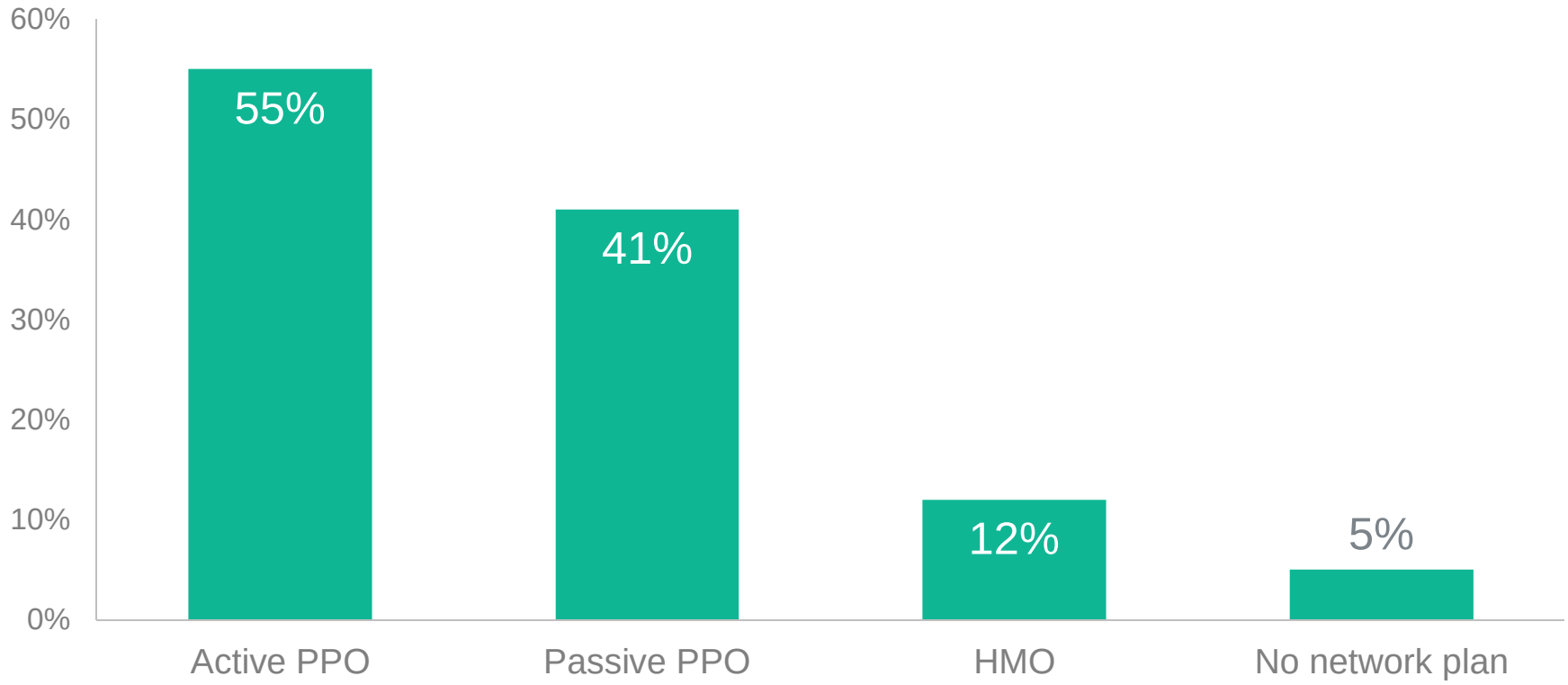
DENTAL COST PER EMPLOYEE, BY REGION

Large dental plan sponsors



OFFER A DENTAL PLAN WITH A PROVIDER NETWORK

Large dental plan sponsors



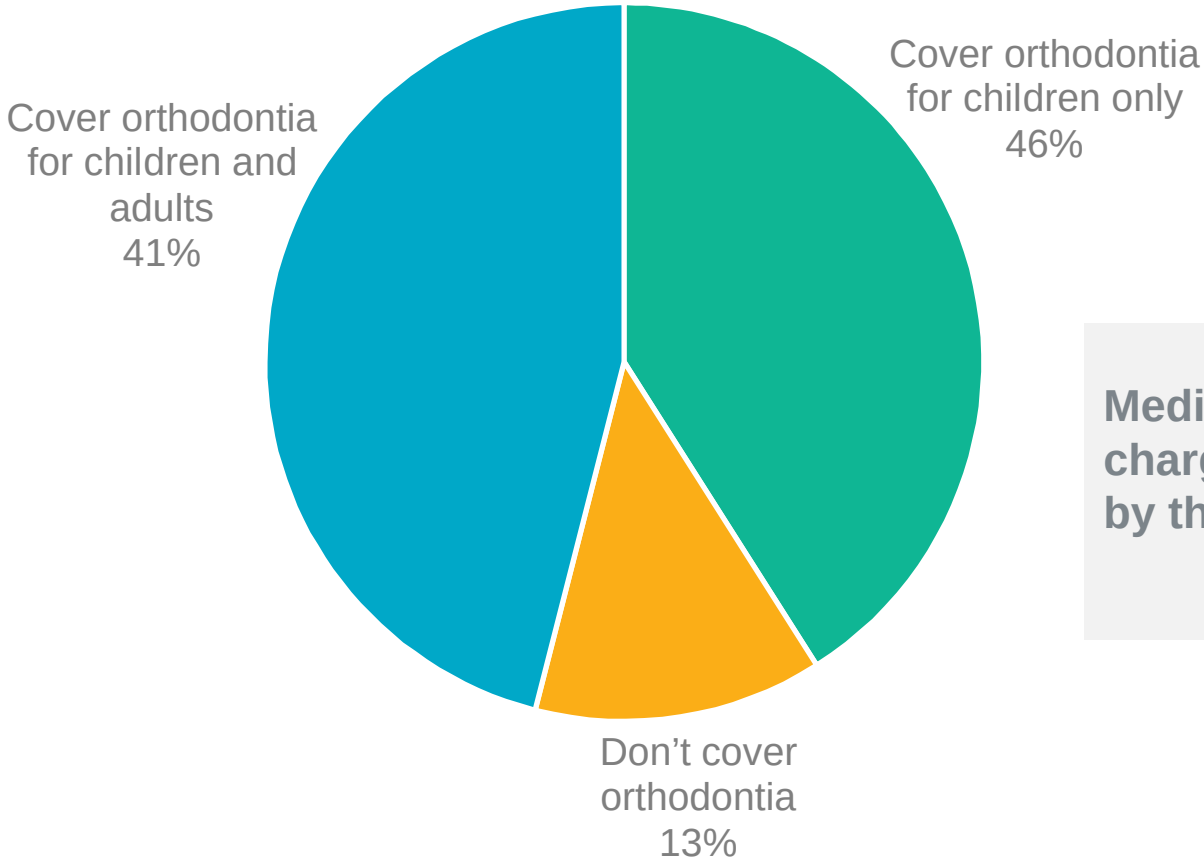
DENTAL PLAN DESIGN

Large dental plan sponsors

Benefit maximum	
Plan includes annual benefit maximum	95%
Individual maximum (median)	$1,500
Deductible (in-network)	
Require individual deductible	83%
Individual deductible amount (median)	$50
Require family deductible	81%
Family deductible amount (median)	$150
Median percentage of covered charges paid by the plan for:	
Preventive services (Type A)	100%
Basic restorative (Type B)	80%
Major restorative (Type C)	50%
Preventive care is NOT subject to the deductible	**93%**

ORTHODONTIC COVERAGE

Large dental plan sponsors



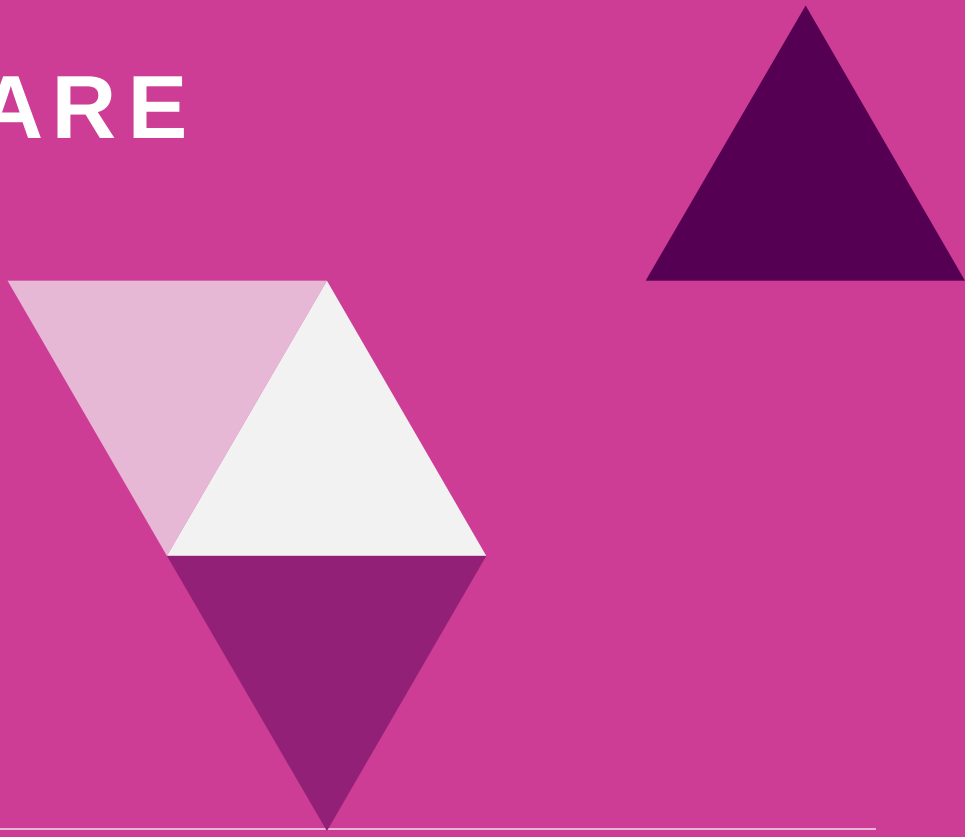
Median percentage of eligible charges covered by the plan: 50%

BENEFIT MAXIMUM FOR ORTHODONTIC SERVICES

Large dental plan sponsors that cover orthodontic services

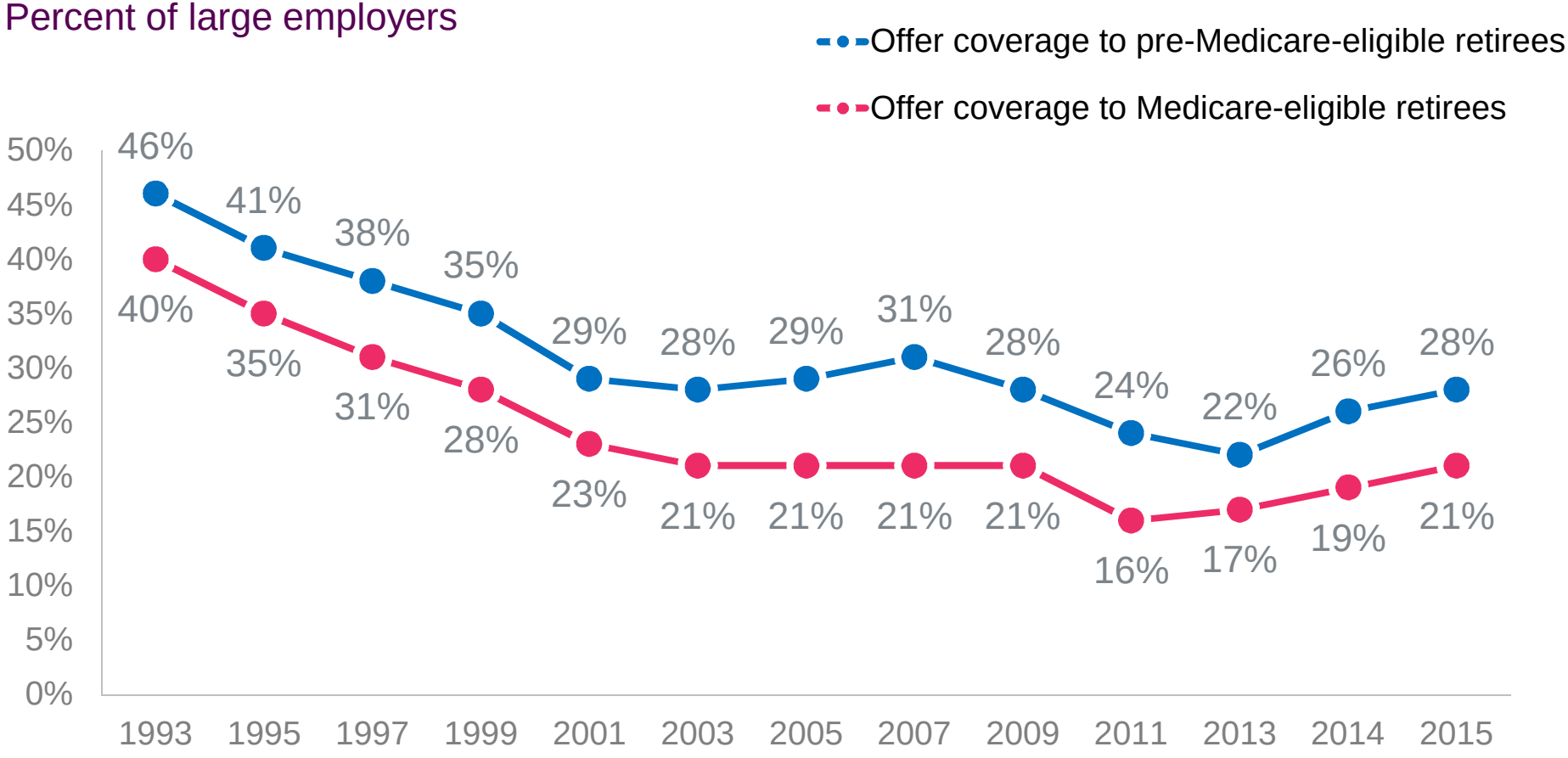
- Plan includes separate lifetime benefit maximum for orthodontic services 96%
- Individual lifetime maximum (median) $1,500

RETIREE HEALTH CARE



SLIGHT INCREASE IN OFFERINGS OF RETIREE MEDICAL PLANS* (INCLUDING EXCHANGES) FOR PRE-MEDICARE-ELIGIBLE RETIREES

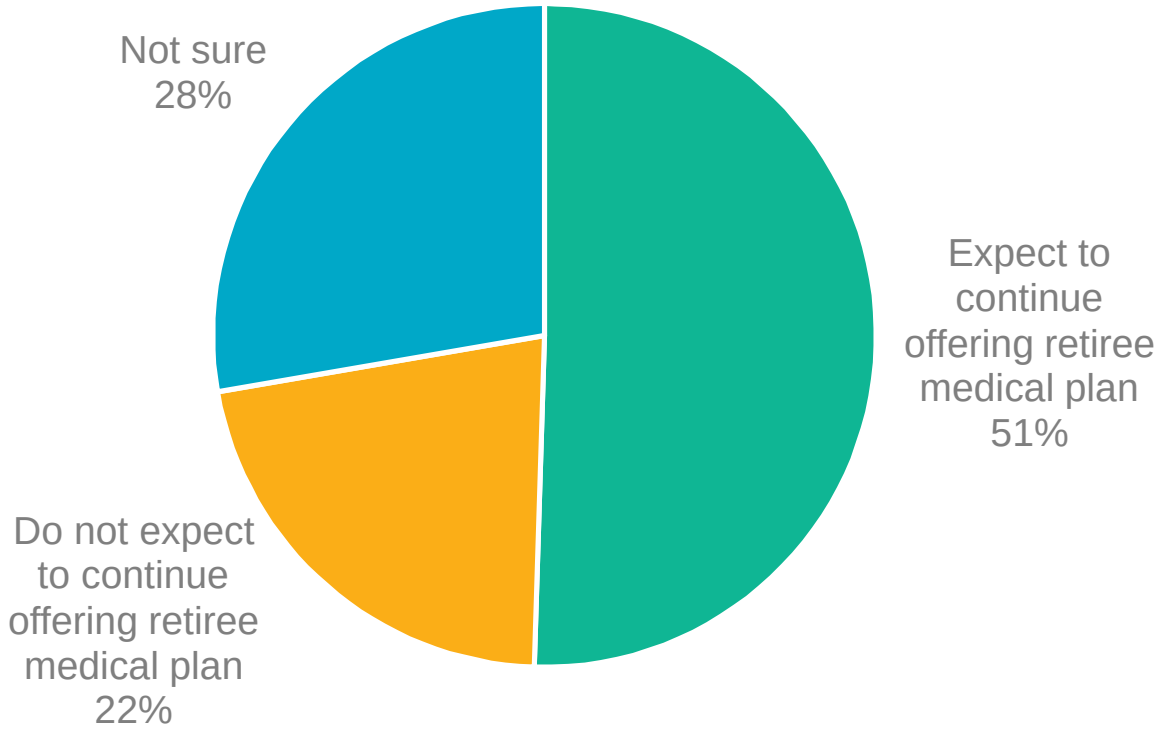
Percent of large employers



*Plan must be offered on an ongoing basis (i.e., new hires are eligible). Includes plans with no employer contribution. Beginning in 2014, offerings include private exchanges.

ONLY ABOUT HALF OF SPONSORS ARE CONFIDENT THEY WILL CONTINUE TO OFFER A RETIREE MEDICAL PLAN TO NEW HIRES FOR AT LEAST THE NEXT FIVE YEARS

Large retiree plan sponsors



MAKE TOMORROW, TODAY

MERCER