2013

Executive Summary

Employee Benefits Practices in Hospitals and Health Systems Survey

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Sullivan Cotter 360

EMPLOYEE BENEFITS PRACTICES IN HOSPITALS AND HEALTH SYSTEMS SURVEY

2013 EXECUTIVE SUMMARY

INTRODUCTION

For over 20 years, Sullivan, Cotter and Associates, Inc. (SullivanCotter) has been a recognized leader in providing consulting services within the health care industry, in particular to hospitals and health systems. Our experience led us to discover an unmet need: how could such organizations benchmark themselves against other industry peers? In 2012 we performed our first annual survey of employee benefits practices in hospitals and health systems. For 2013, the survey has grown, asking more questions of more participants. This year, we compiled and analyzed information from 189 participants, up from 178 in 2012. Roughly 80% are health systems and 20% are freestanding hospitals. In total, participating organizations represent 2.1 million employees.

All participants are hospitals and health systems, in contrast to many other surveys, which include insurance companies, pharmaceutical manufacturers and other health care-related entities in their data. Hospitals and health systems warrant special consideration because, unlike other health care organizations, they play a unique role as both employer and provider of health care. In many cases, they are also the payer, through a private-label system-run health plan.

The 2013 survey sought to gauge the continuing impact of health care reform on participating organizations, specifically its effect on revenue and the pressures on operating costs. We asked questions about our participants' benefits structure and strategy, medical care plan design, cost-sharing practices, prescription drug cost management and health improvement strategies. Survey questions also asked about participants' approaches to paid time off and disability benefits and looked for trends in retirement plans.

The 189 participants include the following:

- 149 health systems.
  - $816 million median net revenues.
  - 7,175 median employees.
- 40 hospitals.
  - $371 million median net revenues.
  - 2,600 median employees.
- 61% secular organizations.
- 95% not-for-profit organizations.

Our findings indicate that participants expect 2013 to be a challenging year. So the need for comprehensive, industry-specific information should prove especially valuable, as organizations seek to improve their performance metrics by comparing their own practices to those of their peers.

This executive summary highlights key findings from the 2013 survey, conducted from October 2012 through January 2013, and based on 2013 plan year data. By using our inaugural 2012 survey as a baseline, we have identified differences that may indicate noteworthy trends.

NEW IN 2013

NEW SURVEY QUESTIONS FOR 2013

To help quantify participant spending practices, we asked new questions for 2013 about how much of total operating expense goes to labor spend (i.e., total compensation) and about benefits expense as a percentage of total payroll.

This year's survey also featured new questions about differences in benefits that may exist within an organization. To that end, we added additional questions regarding the labor relations environment for organizations with union employees and also asked about benefits differentials for multihospital systems and those organizations with medical groups, nursing homes and long-term care facilities.

IMPACT OF HEALTH CARE REFORM

Our findings show that hospitals and health systems expect 2013 to be a difficult year as they continue to respond and adapt to the changes brought about by the Affordable Care Act (ACA). In our 2012 survey, 55% of participants said they expected a decrease in revenue. This year, that figure jumped to 63%.

TABLE 3.1 – Impact of Health Care Reform on Organization Revenue

	Percentage (n=176)
Potentially Decrease (e.g., Changes in Reimbursement Rates, Employer Design Reaction May Decrease Revenue)	63%
I Don't Know	23%
Potentially Increase (e.g., More Covered Individuals May Yield Higher Revenue)	9%
Little Impact, if Any, on Revenue	5%

To add further context to the question about health care reform, we asked participants about their payer mix to understand the sources of revenue and how changes in each will affect their bottom line. We found that, on average, slightly more than half of participants' revenue comes from Medicare and Medicaid, which points to an environment where revenues are declining, putting more pressure on controlling operating costs. Managing labor spend, including benefits costs, is proving to be particularly important, since total compensation represents a substantial percentage of participants' operating costs.

LABOR COSTS

A significant portion of operating expense is the cost of human capital. To help quantify spending, we asked participants to report on the percentage of operating expense that is allocated to total compensation. Findings indicate that total compensation, including pay and benefits, amounts to about half of operating expense.

TABLE 2.7 – Estimated Total Compensation Expense as a Percentage of Total Operating Expense

	n	25th Percentile	Mean	Median	75th Percentile
Estimated Total Compensation Expense as a Percentage of Total Operating Expense	135	46%	51%	52%	58%

Secondly, we asked about four main categories of benefits expense – legally required benefits, voluntary health and welfare benefits, voluntary retirement benefits and pay for time not worked – as a percentage of payroll. The average health care organization has benefits expenses that are 34% of payroll, which means that benefits compose 25% of total compensation (pay and benefits). With an average total compensation expense equal to 51% of total operating expense, that implies benefits costs make up approximately 13% of operating expense.

TABLE 2.8 – Estimated Benefits Expense as a Percentage of Total Payroll

	n	25th Percentile	Mean	Median	75th Percentile
Legally Required Benefits (Unemployment, Workers' Compensation, Social Security, Medicare)	111	6%	8%	7%	8%
Voluntary Health and Welfare Benefits (Medical or Prescription Drug, Dental, Vision, Life Insurance, STD, LTD)	109	10%	13%	11%	15%
Voluntary Retirement Benefits (Defined Benefit, Defined Contribution, 403[b] Plan)	106	4%	6%	5%	8%
Pay for Time Not Worked (Vacation, Holidays, Personal, Bereavement, Sick Leave)	104	6%	8%	8%	10%
Total Benefits Expense as a Percentage of Total Payroll	126	26%	34%	30%	37%

NEW IN 2013

UNION EMPLOYEES

Our study found that more than 63% of all participants do not employ any bargained employees and 87% of respondents have 25% or fewer bargained employees. Five percent of those surveyed indicated their population is more than 50% unionized or bargained.

TABLE 2.5 – Percentage of Union Employees

Percentage of Union Employees	Frequency	
	Health System (n=144)	Hospital (n=40)
0%	59%	75%
1%-10%	17%	0%
11%-25%	12%	8%
26%-50%	8%	5%
51%-75%	3%	7%
76% or More	1%	5%

Of those participants who have union employees, two-thirds have contracts expiring in 2013. Sixty percent of participants indicated that health care benefits would be a key bargaining issue for management. Forty-four percent said retirement and other benefits would be relevant to negotiations.

Survey questions also addressed the degree to which benefits differ for union employees. More often than not, we see that most benefits are the same. In organizations where benefits differ, they are more likely to pertain to non-nursing unions – approximately one-third of these have different provisions for non-nursing unions versus one-quarter for nursing unions. In both cases, when benefits or cost sharing differ, they tend to be more generous for union employees. With the "Cadillac plan" excise tax looming in 2018, employers who are currently engaged in bargaining sessions may have to seize this opportunity to address the increasing costs of health care benefits.

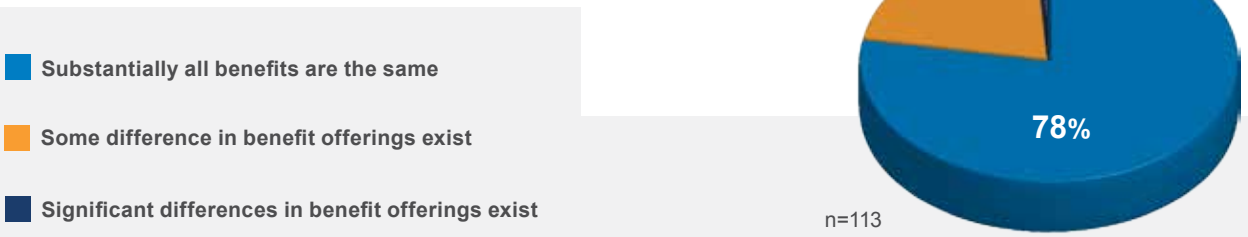
NEW IN 2013

BENEFITS DIFFERENCES WITHIN HEALTH SYSTEMS

Over the past several years, consolidation has driven the desire for administrative simplicity and benefits parity for employees working side by side, so we sought to understand the degree to which benefits differ within a health system. Multihospital systems tend to consolidate benefits, with 78% of respondents offering the same benefits system wide. Our findings indicate that, where benefits differ, the differences are not significant.

We see an emerging trend in today's environment of bigger systems with more diverse business lines. Twenty-two percent of health systems report that they have different benefits. Benefits are typically higher for physicians and lower for employees who work in nursing homes, long-term care or hospice.

CHART 3.5 – Multihospital Organization Benefit Offerings

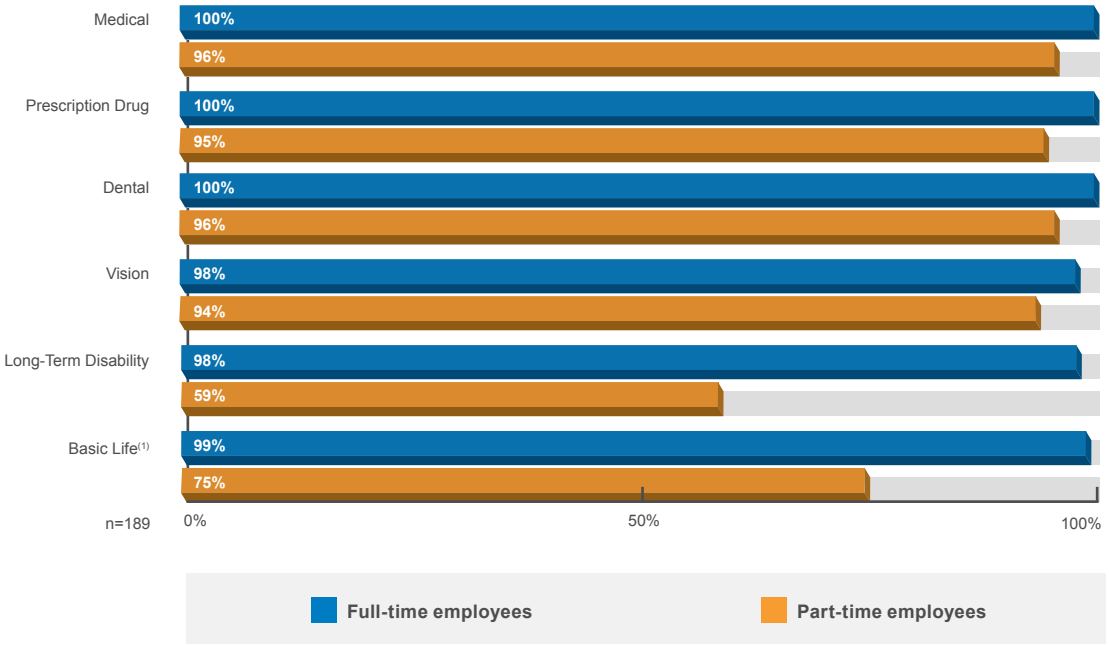


Years ago, the emergence of flexible benefit plans signaled an understanding that the one-size-fits-all approach to benefits did not meet the needs of a diverse workforce. In today's environment, some health systems are applying that same concept to their enterprise-wide offerings, creating a "corporate flexible benefits" approach. With this approach, an organization may offer the same options and price tags system wide, but each business unit would have the flexibility to contribute different credits to employees toward the purchase of benefits. Business units that traditionally provide lower benefits could choose to provide fewer credits, thereby matching the benefit cost structure with their business needs.

PREVALENCE OF BENEFITS

In terms of program offerings, virtually all employers are offering health and welfare benefits to all employees. All survey participants offer medical, dental and prescription drug benefits to full-time employees. Compared to other industries, the health care industry shows a higher prevalence of offerings for part-time employees, with 96% offering medical benefits, as shown in the chart below.

CHART 3.7 – Prevalence of Health and Welfare Benefit Offerings

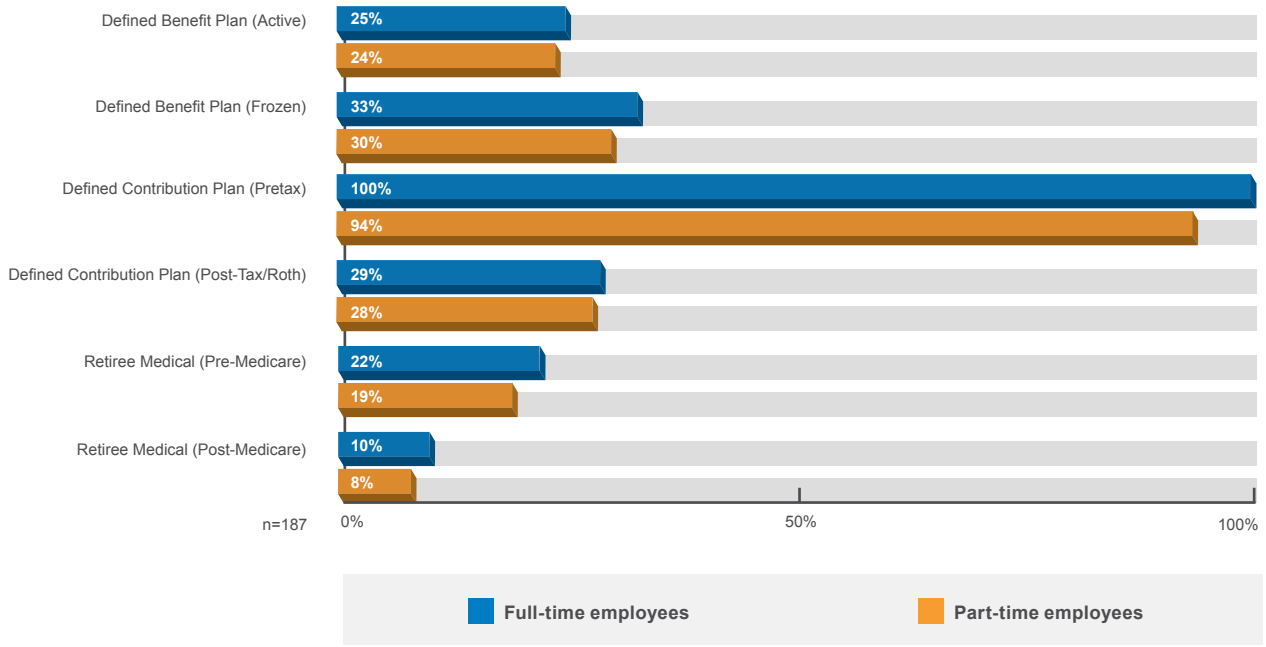


(1)Supplemental voluntary life insurance is offered by 98% of employers. Dependent life insurance is offered by 96% of employers.

PREVALENCE OF BENEFITS (CONTINUED)

For retirement benefits, all participants offer defined contribution plans. A small minority offers retiree medical benefits. Although other industry surveys indicate that more than 50% of hospitals offer defined benefit (DB) plans to new hires, our survey indicates that only 25% are still offering DB plans to newly hired employees. This suggests that hospitals are lagging slightly compared to other industries, but less so than other surveys would suggest.

CHART 3.8 – Prevalence of Retirement Benefit Offerings



NEW IN 2013

BENEFITS STRATEGY – CURRENT AND FUTURE YEARS

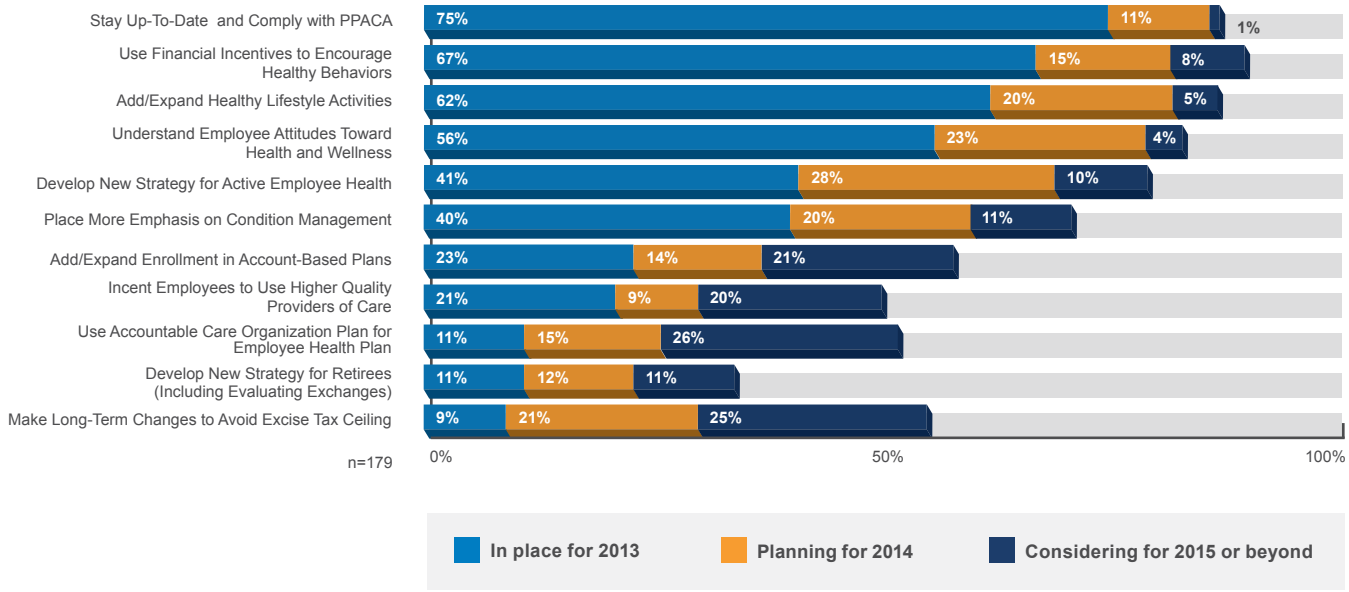
The 2013 survey introduced several forward-looking questions to help the industry understand not only what organizations are doing today but also where the market is moving. The top area of focus in health care benefits strategy was compliance related, as participants contend with the implications of health care reform under the ACA. For 2014, nearly three in 10 respondents plan to develop an entirely new health care strategy for active employees. Based on our discussions with survey participants, the implementation of a new strategy is a direct result of health care reform legislation.

For the long term, findings indicate a shift to improving employee health and emphasizing employee accountability. Over the next couple of years, more than one-third of participants are looking at using accountable care organization (ACO) plans and consumer-driven or account-based plans, as well as increasing incentives.

With respect to account-based plans, health care organizations have to be extremely careful when designing plans. Current best practice approaches typically focus on encouraging the use of highly efficient domestic providers, while consumer-driven plans typically remove that incentive and allow plan participants to spend company-provided dollars at any provider they wish to use. While organizations may realize some utilization savings as a result of "consumerism," the overall cost of providing care could increase substantially and have an adverse effect on organizational revenues.

Less than 10% of respondents indicate they have begun thinking about how to avoid the excise tax ceiling and only half of the other respondents have this issue on the radar for 2014 and 2015.

CHART 3.10 – Health Care Benefit Strategy Areas of Focus



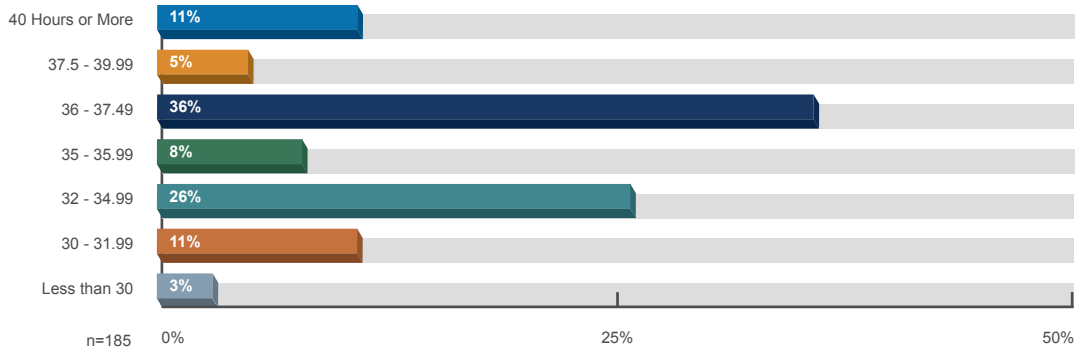
ACA "30-HOUR RULE"

In order to avoid significant penalties, large employers are required to offer minimum essential coverage to *substantially all* (i.e., 95% or more) full-time employees. The ACA defines full-time employees as those working, on average, 30 or more hours per week. This provision could require a number of organizations to evaluate workforce structure for 2014, given how most organizations currently define full-time eligibility. More than half of respondents use a full-time eligibility standard of 36 hours per week. In addition, many also employ "PRN" or per diem employees who may work 30 hours or more per week but are typically not eligible for benefits. As a result, these organizations may be contending with eligibility issues for these employees.

In addition, affordability issues may arise for those part-time employees who are generally paying about twice as much as full-time employees pay for health care coverage.

These findings indicate the importance of understanding how the 30-hour rule will affect an organization's workforce and the importance of developing the appropriate strategy for both coverage offerings and employee contributions.

CHART 3.2 – Minimum Weekly Hours Required for Full-Time Benefit Eligibility

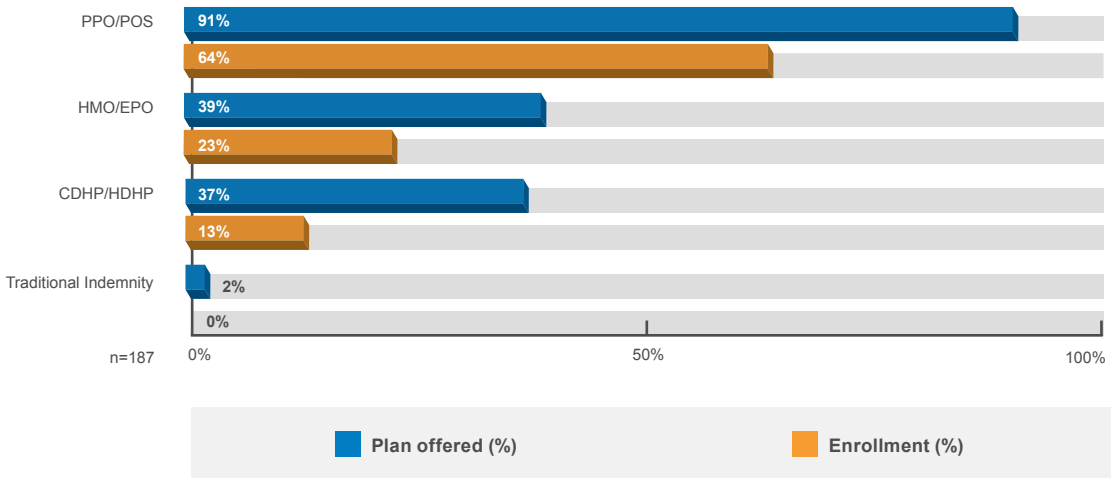


MEDICAL PLAN OFFERINGS

Choice remains the industry standard, with more than three-quarters of survey participants offering multiple plan options to employees. Thirty-two percent offer two plans, 29% offer three plans and 16% offer four or more plans. Even so, in practice, organizations that offer two or more plans tend to target the contribution strategy around a particular "core" plan in an effort to mitigate the risk of adverse selection.

Although CDHP and HDHP offerings are as common as HMOs and EPOs, enrollment remains low. Health care organizations are finding it challenging to strike a balance between encouraging utilization of domestic providers versus giving employees accounts that they can spend anywhere. Developing an appropriate contribution strategy for CDHPs is another area of concern; historically, employers have underpriced these plans to encourage enrollment, which can lead to such plans being more costly in the long term.

CHART 4.2 – Type of Medical Plans Offered



Note: Results for plans offered will not equal 100% as respondents could choose more than one option.

NEW IN 2013

EMPLOYER SUBSIDIES AND COST SHARING

To help organizations benchmark cost sharing more holistically, the 2013 survey included new questions on total cost sharing, considering plan design and payroll deductions

In terms of actuarial value (i.e., the value of the plan design), HMO and EPO plans have the richest design, due to low deductibles and copayments. These plans cover about 90% of the allowed charges, leaving covered participants to cover about 10% of the cost through deductibles, coinsurance and copayments. PPO and POS plans typically cover about 85% of allowed charges, while CDHPs and HDHPs cover slightly more than three-quarters of the allowed charges.

In total, factoring in both "point-of-care" cost sharing (i.e., deductibles, copayments, coinsurance) and employee contributions (i.e., payroll deductions), the total employer subsidy is typically 65% to 75%, depending on the plan type, with consumer-driven plans on the lower end and HMO and EPO plans on the higher end. Overall, employers are covering approximately 68% of total costs.

TABLE 4.6 – Actuarial Value of Medical Plans

Plan Type	Actuarial Value	
	Mean	Median
PPO/POS (n=59)	85%	85%
HMO/EPO (n=15)	90%	90%
CDHP/HDHP (n=19)	77%	76%

TABLE 4.7 – Percentage of Total Plan Cost Subsidized by Employer

Plan Type	Percentage of Total Plan Cost Subsidized by Employer	
	Mean	Median
PPO/POS (n=66)	69%	68%
HMO/EPO (n=17)	75%	77%
CDHP/HDHP (n=24)	66%	65%

The cost-sharing mix for full-time employees is similar to the 2012 survey findings with employers contributing about 80% and employees contributing 20%. In general, dependent tiers are about 3% to 4% higher than employee-only tiers. Part-time cost sharing is nearly double that of full-time employees.

MEDICAL PLAN DESIGN

From a plan design perspective, the three-tier PPO is the most common approach, particularly for an integrated delivery system. Overall, 70% of survey participants are using a domestic tier of benefits to encourage the use of system-owned facilities and affiliated providers. Although this percentage is much higher than reported in other surveys, it is consistent with the practices of SullivanCotter Clients. Note that this type of plan design would not work for all health systems (e.g., children's hospitals).

TABLE 4.1 – PPO/POS Deductibles, Coinsurance and Copayments

	PPO/PPS[1]		
	Domestic	In-Network	Non-Network
Deductible (Single/Family)	$250/$600	$500/$1,000	$1,000/$2,000
Out-of-Pocket (Single/Family)[2]	$2,000/$4,000	$2,500/$5,500	$5,000/$10,000
Coinsurance (Inpatient/Outpatient)	10%/10%	20%/20%	40%/40%
Coinsurance (Other Services [e.g., Lab, X-Ray])	10%	20%	40%
PCP Copayment	$20	$20	$30
Specialist Copayment	$30	$35	$40
ER Copayment	$100	$100	$100

[1]For Rx plan design elements see page 49.
[2]Includes deductible.

ANNUAL SPEND AND TRENDS

Per employee per year (PEPY) costs and year-over-year trends would be two key benchmark numbers in a typical industry benefits survey. However, benchmarking PEPY costs are more difficult for hospitals due primarily to differences in accounting practices used for domestic claims, as well as variances in plan design, demographics and other factors.

For participating organizations, PEPY projected gross medical and prescription drug costs amount to just over $11,000. Year-over-year results are showing an average trend of 4% to 6%, which varies based on plan type. Given that many employers have been in a wait-and-see mode with respect to health care reform, these results are encouraging.

TABLE 4.15 – 2012 to 2013 Premium Increases

2012 to 2013 Trend Rates	25th Percentile	Mean	Median	75th Percentile
PPO/POS (n=150)	0%	4%	3%	8%
HMO/EPO (n=62)	0%	5%	5%	9%
CDHP/HDHP (n=60)	0%	6%	4%	9%

Note: For each plan type, the results capture the most prevalent non-bargained plan of that type offered by a given organization.

ACCOUNTING TREATMENT FOR DOMESTIC CLAIMS

The accounting treatment of domestic claims is very complex and it can make a significant impact on both the medical plan budget and organizational revenues. Because of the impact on organizational revenues and expenses, this is an assumption that is typically driven by finance. More than half of survey participants are using a standard carrier-negotiated discount rate for domestic claims, but nearly three in 10 are using a deeper discount that more closely resembles the actual cost of providing care. We found that the median discount is approximately 45%; however, despite the significance of this factor, more than one-quarter of survey participants did not know the discount rate for their organization.

Participants indicated that nearly two-thirds of care is delivered domestically, which highlights the importance of the accounting method as it relates to the impact on medical plan costs.

TABLE 4.12 – Domestic Claims Accounting

Domestic Claims Accounting	Percentage (n=156)
Billed Charges for Domestic Claims are Discounted at the Carrier Negotiated Rate (Market Rate)	52%
Billed Charges for Domestic Claims are Discounted at Cost to Charge Ratio (Variable Plus Fixed Costs)	4%
Billed Charges for Domestic Claims are Discounted at Marginal Cost Only	2%
Billed Charges for Domestic Claims are Discounted at a Level Deeper Than Carrier Rates	18%
Billed Charges for Domestic Claims are Discounted 100% (Allowed Charges Equal $0)	5%
Billed Charges for Domestic Claims are Not Discounted at All (Allowed Charges Equal Billed Charges)	6%
Other	13%

TABLE 4.13 – Percentage of Claims Costs Incurred and Paid at Domestic Providers

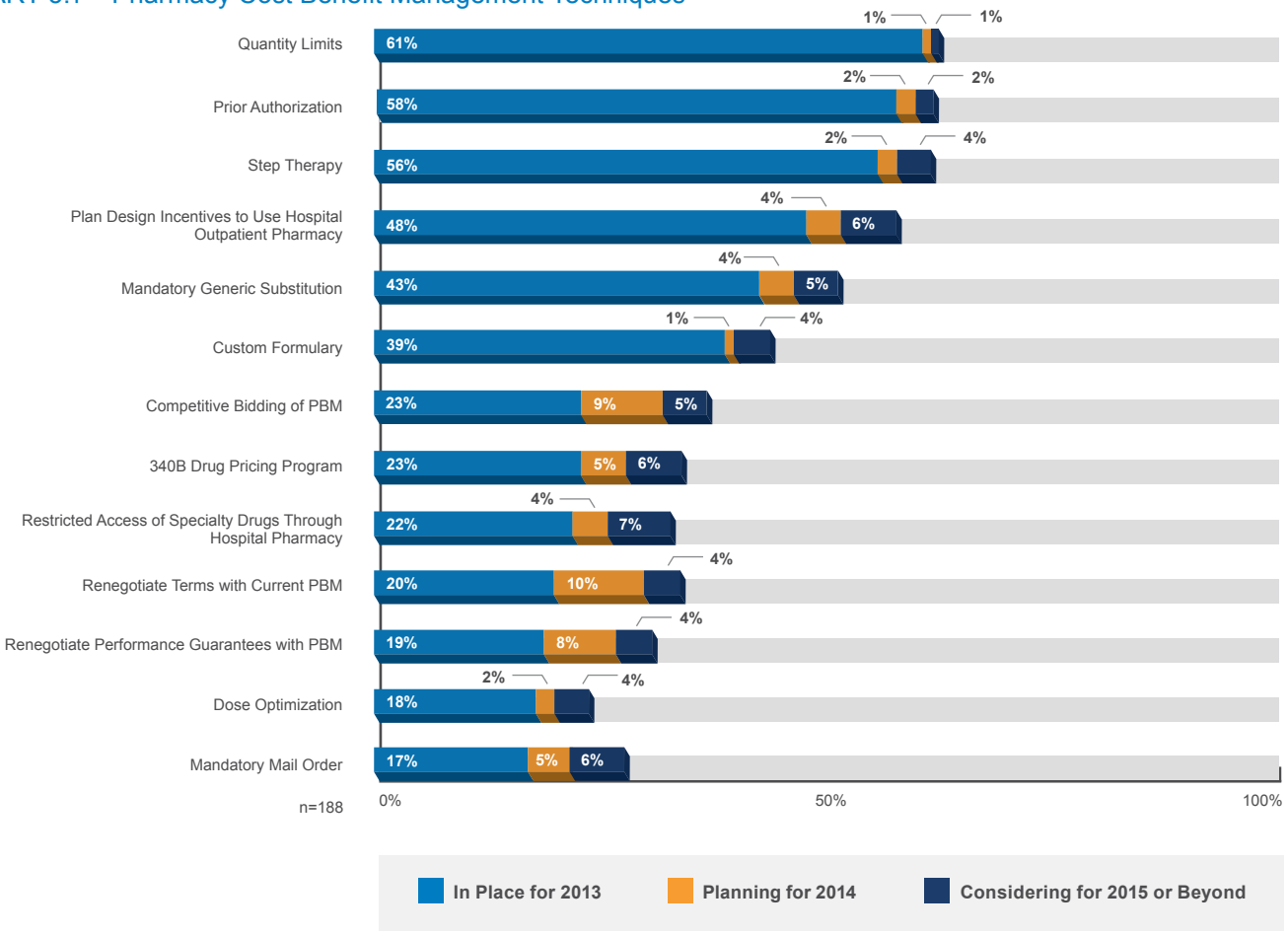
Percentage of Claims Costs Incurred and Paid at Domestic Providers	Mean	Median
Facility (n=120)	66%	71%
Professional (n=100)	45%	40%
Prescription Drug (n=97)	46%	50%
Total Plan (i.e., weighted average of above) (n=87)	64%	63%

COST MANAGEMENT TECHNIQUES FOR PRESCRIPTION DRUGS

Our findings revealed a substantial opportunity for organizations to achieve more efficiency with prescription cost management techniques. The most common pharmacy cost management techniques are quantity limits, prior authorization and step therapy (used by about 60% of organizations). General industry usage for these features is typically 70%. All other techniques are used by less than half of respondents.

A number of participating organizations that qualify for the 340B Drug Pricing Program are not using it. Institutions that qualify could realize significant savings by leveraging this program for their employee health plan.

CHART 5.1 – Pharmacy Cost Benefit Management Techniques



Note: Respondents could choose multiple options.

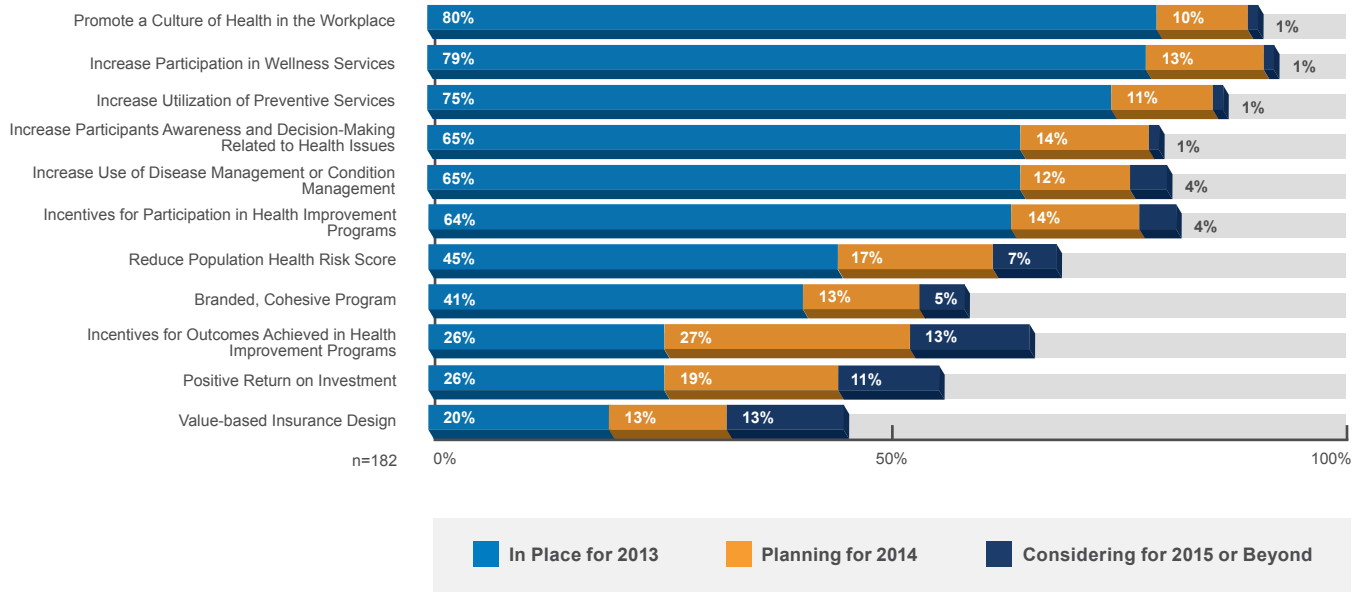
HEALTH IMPROVEMENT STRATEGIES AND PROGRAM OFFERINGS

We made health improvement a key section of this year's report because it was a noteworthy priority for 2012 survey participants.

For 2013 we see a continued focus on increasing participation and improving communications. Eighty percent of survey participants are promoting a culture of health in the workplace and 79% are making efforts to increase participation in wellness services (while an additional 13% are planning to do so in 2014). In 2014 and beyond, survey participants plan to place more emphasis on demonstrating a positive return on investment (ROI) through reducing measurable health risks and achieving outcomes.

More than 70% of organizations offer programs such as health risk assessments, tobacco cessation, health and wellness fairs, discounted gym memberships, weight management and biometric screenings.

CHART 7.1 – Health Improvement and Wellness Strategy Areas of Focus



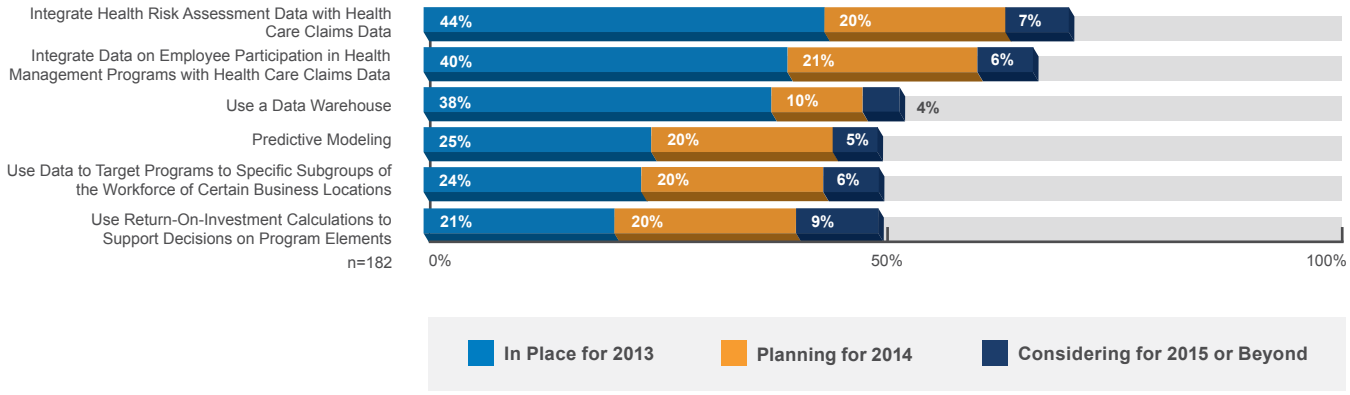
HEALTH IMPROVEMENT ENVIRONMENT, MEASUREMENT AND INCENTIVES

Participating institutions are placing a great deal of emphasis on creating a work environment that supports the health of employees such as a tobacco-free campus (87%), healthy options in the cafeteria (82%) and vending machines (57%).

While the use of employee testimonials as well as visible support from senior leadership is already in place for over half of respondents, for 2014, these are two key areas of focus, in addition to the implementation of location-based wellness champions.

As the graph below demonstrates, measurement of these initiatives will be a priority for 2014. The key is leveraging data and creating targeted interventions to reach the right population and then demonstrating the outcomes.

CHART 7.4 – Steps to Optimally Manage Health Improvement Programs and Measure Effectiveness



Survey respondents offer sizeable incentives for health improvement activities such as completing a health risk assessment (65%), biometric screening (58%), completing lifestyle modification classes (35%), participating in fitness challenges (26%) and coaching services (24%). In an environment with scarce dollars available for investment, we think there will be significant pressure to demonstrate ROI. Organizations will also need to navigate the impact of health care reform on wellness incentives, in particular how these incentives may affect the “affordability” of employee contributions.

TABLE 7.1 – Maximum Annual Incentive for Health Improvement Program Participation

Maximum Annual Incentive	n	25th Percentile	Mean	Median	75th Percentile
Employee-Only Incentive	117	$222	$463	$360	$600
Family Incentive	92	$260	$630	$520	$900

VACATIONS AND PAID TIME OFF

Eighty percent of organizations surveyed use a combined time off (CTO) approach to administer paid time off or vacation programs. These findings are similar to our 2012 findings. Employers typically save between five to seven days using CTO versus a separate days approach. Prior year respondents requested the addition of exempt and nonexempt categories for 2013. We found that only about 30% of employers have different paid time off or vacation schedules for these employee categories. When comparing only those employers who have a different schedule for nonexempt employees, nonexempt employees are typically offered four to five fewer days than exempt employees.

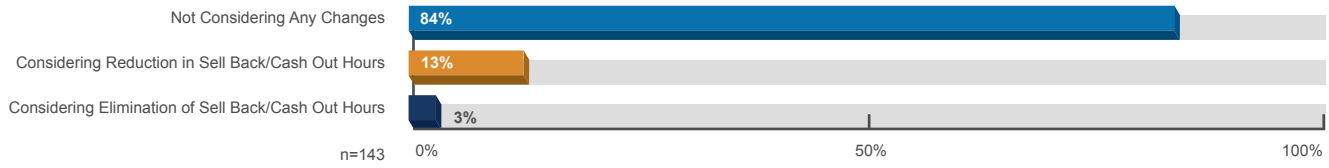
TABLE 9.3 – Median Number of CTO Pool and Total Time Off Days Accrued Annually

Years of Service	Exempt Employees (n=149)		Non-Exempt Employees (n=142)	
	Median Number of CTO Pool Days	Median Number of Total Time off Days	Median Number of CTO Pool Days	Median Number of Total Time off Days
Zero Years	23	25	23	24
One Year	23	25	23	24
Five Years	28	29	27	29
10 Years	31	33	30	32
15 Years	33	34	33	34
20 Years	34	35	33	35
25+ Years	34	36	34	36

Note: Not all respondents, who use a CTO approach include all forms of time off in the CTO pool (e.g., employees may have sick leave in addition to the CTO pool), which is why total time off days is slightly higher than CTO pool days.

The cash out (or sell back) of paid time off (PTO) is one of the most expensive benefits that organizations provide, because the cost of PTO is already accounted for in an employee's base salary. Seventy-five percent of participants allow employees to cash out unused PTO; in those organizations, an amount of two-plus weeks is typical. In our experience, the best practice is to provide cash out opportunities for those who require replacement workers, since the cost of cashing out is often lower than the cost of replacing them, but to eliminate cash out opportunities for other employees, particularly management and executives.

CHART 9.8 – Considering Changes to Cash Out Approach



RETIREMENT

When it comes to retirement, nearly 60% of organizations surveyed have DB plans; however, the majority (57%) of those plans are either fully or partially frozen. In total, only 25% of respondents have ongoing plans. When an ongoing DB plan is offered, cash balance plans are more common than traditional (e.g., final average pay) designs.

More than 90% of survey respondents make contributions to defined contribution (DC) plans and nearly 80% make matching contributions. When all DC contribution types are combined (i.e., matching, fixed and discretionary), the total median contribution is 4%.

TABLE 13.6 – Employer Contribution Design

	Mean	Median
Maximum Employer Matching Contribution (n=142)	3.3%	3.0%
Maximum Fixed Contribution (n=44)	5.3%	4.8%
Most Recent Discretionary Contribution (n=30)	3.2%	3.0%
Combined Maximum Contribution (n=157)	5.1%	4.0%

With our 2013 findings, we compiled an "all sources" view of retirement in an attempt to normalize employers that provide different plan types. The pie chart below shows that nearly 20% of employers provide both a DB and a DC plan, while only 3% offer no employer-funded retirement benefits. When we factor in all different types of retirement programs, the median total retirement benefit is approximately 6% of pay.

CHART 13.14 – Employer Contributions By Plan Type

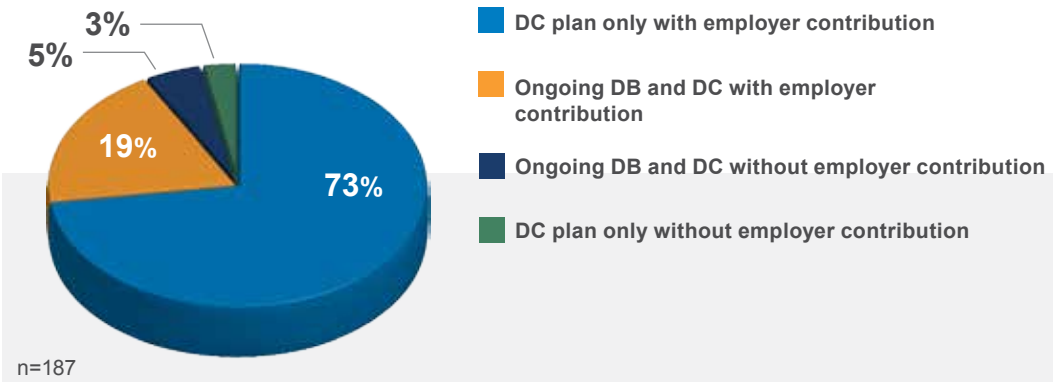


TABLE 13.7 – Average Total Employer-Provided Retirement Benefit as a Percentage of Pay

(n=136)	25th Percentile	Mean	Median	75th Percentile
Average Total Employer-Provided Retirement Benefit as a Percentage of Pay	4.0%	5.9%	6.0%	7.0%

The health care industry has changed dramatically over the past 20 years, when DB plans were the norm. Many hospitals and health systems have shifted from DB to DC plans primarily for lower cost volatility, simpler and more cost-effective administration, incentives for personal savings (through matching contributions) and the transfer of investment risk to employees, following the trend we have seen in general industry. DB plans remain a good fit for certain organizations, as they provide for secure benefits and insulate employees from most investment and longevity risks.

Hospitals and health systems would be well-served to periodically review their retirement program, whether using a DB approach, a DC approach or a combination of both. Such reviews should be at the board level and performed by independent experts.

CONCLUSION

SullivanCotter thanks the 189 participating organizations featured in our second annual report of the *Employee Benefits Practices for Hospitals and Health Systems Survey.* We look forward to continuing our momentum in the years to come, as we make each year's survey an improvement on the last – identifying trends, pinpointing best practices and providing essential benchmarking information for hospitals and health systems. As we prepare for future research endeavors for 2014 and beyond, we welcome participant feedback.

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