WELLS FARGO INSURANCE

2015 Employee Benefits Outlook

A year of continued evolution

National Employee Benefits Practice

Together we'll go far

Introduction

The 2015 employee benefits outlook provides insights from the practice leaders at Wells Fargo Insurance, which we hope you will find beneficial in the year ahead.

Employers who offer benefits packages to their workforce remain concerned about their ability to continue to do so in the future, due to both the pressures of rising healthcare costs in addition to the increasingly complex regulatory environment. The employee benefit marketplace saw a historic year in 2014 with the rollout of the public exchanges, the individual mandate, elimination of pre-existing condition clauses, and changes in the pricing of individual and small group policies. The tumultuous ride for employers will continue in 2015, with the employer mandate taking effect for groups with more than 100 employees, as well as new reporting requirements.

Key trends

- **Convergence of insurance and technology.** As the purchase of insurance continues to evolve from a paper or group enrollment meeting environment to an online purchasing setting, we expect insurance and technology to increasingly intersect.
- **The lines between healthcare insurer, healthcare provider, and healthcare adviser are blurring.** What were formerly black and white roles are now gray. Healthcare providers are examining ways to take risk by operating health insurance plans, insurers are considering providing medical care directly, and some advisers are moving into a manufacturing role with the development of their own exchanges and insurance products.
- **Increasing compliance requirements.** The Affordable Care Act (ACA) imposes even more reporting requirements on employers, making the role of plan sponsor more difficult. The flurry of additional regulatory guidance and complexity promises to continue in 2015 as two more healthcare coverage reporting requirements take effect in 2016: minimum essential coverage reporting and large employer reporting. Employers will need to implement solutions to address these ACA reporting requirements.
- **Shifting costs to employees.** In an effort to mitigate costs, employers will continue to ask employees to share more of the cost burden. Two ways to do this are through (1) plan design, like increasing deductibles and out-of-pocket limits, or (2) greater monthly contributions, such as implementing a surcharge for spouses or increasing contributions for larger families.
- **Personal responsibility.** As employees take on more of the healthcare cost burden, the benefits decision-maker role is shifting from the employer to the consumer at a quickened pace. Plan choice is becoming more popular in order to meet the needs of a diverse workforce. Employers expect consumers to be more engaged in their healthcare buying decisions and lifestyle choices. Social media, telemedicine, and transparency tools will play a much greater role in helping individual consumers attain value from insurance products.

Market capacity

- The health insurance industry remains profitable and well-capitalized, although margins are under pressure due to ACA provisions, increased competitive pressure, the sustained low interest rate environment, and overall sluggish macroeconomic growth.
- The new ACA environment will affect insurers in different ways:
  - The winners are likely to be large carriers with substantial market share, increased efficiencies and scale, and diversified sources of revenue.
  - Smaller insurers operating in restricted geographic areas may struggle, particularly after 2016, when some of the ACA risk-sharing provisions will no longer apply.
  - While they have accumulated capital in recent years, BlueCross BlueShield carriers may be hit harder than others, as they are generally lower-cost providers and are more active on the state exchanges.
  - Commercial group carriers will see changes in 2015 due to implementation of the delayed employer mandate.
  - Medicare Advantage and Medicaid insurers will face pressure as reimbursement rates decline.
  - This is a challenging market for startup carriers, including those created by providers and hospital groups, as vertical integration continues.
- Accountable care organizations (ACOs) are gaining momentum and the new payer-provider models are still relatively untested. The impact of ACOs on insurer profitability is not yet clear.

Rate and pricing environment

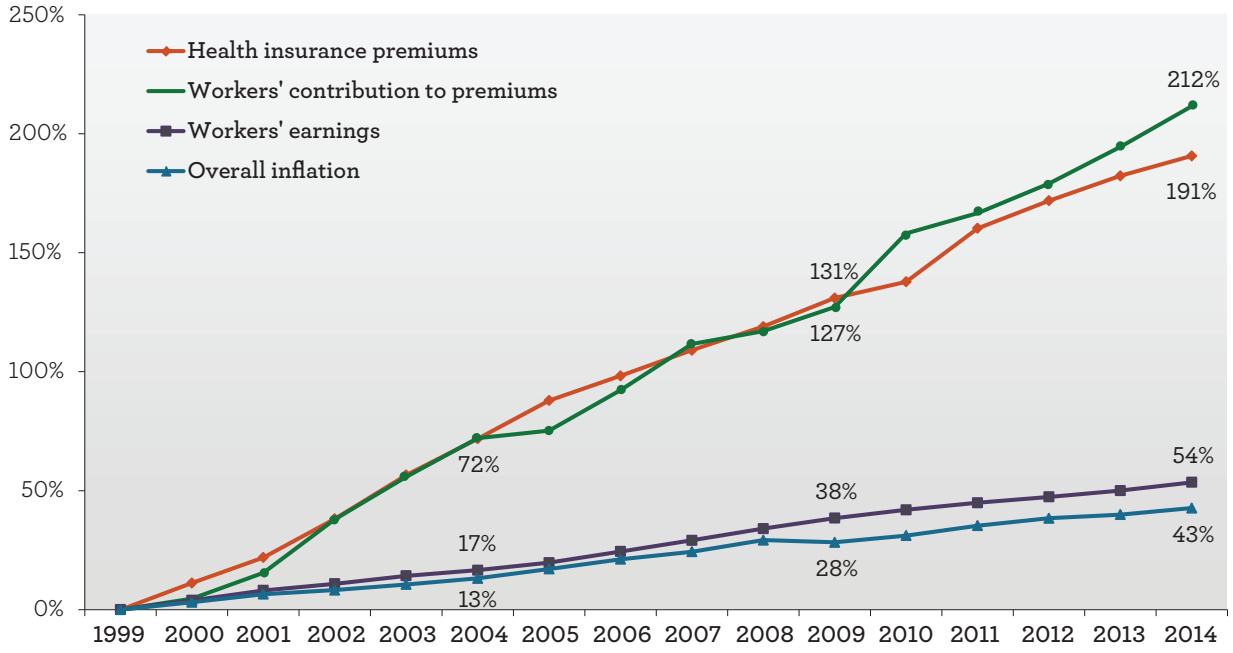
Premiums

Driven by rising healthcare costs, health insurance premiums have increased 191% since 1999 (Chart A[1]) and continue to rise at an unsustainable rate.

- **Aging populations.** According to U.S. Census Bureau projections, the population of age 65 and older is expected to more than double between 2012 and 2060.[2] As the population ages and longevity increases, the healthcare system will be challenged to continue treating patients while controlling costs.

Chart A

Cumulative increases in health insurance premiums, workers' contributions to premiums, inflation, and workers' earnings, 1999 – 2014



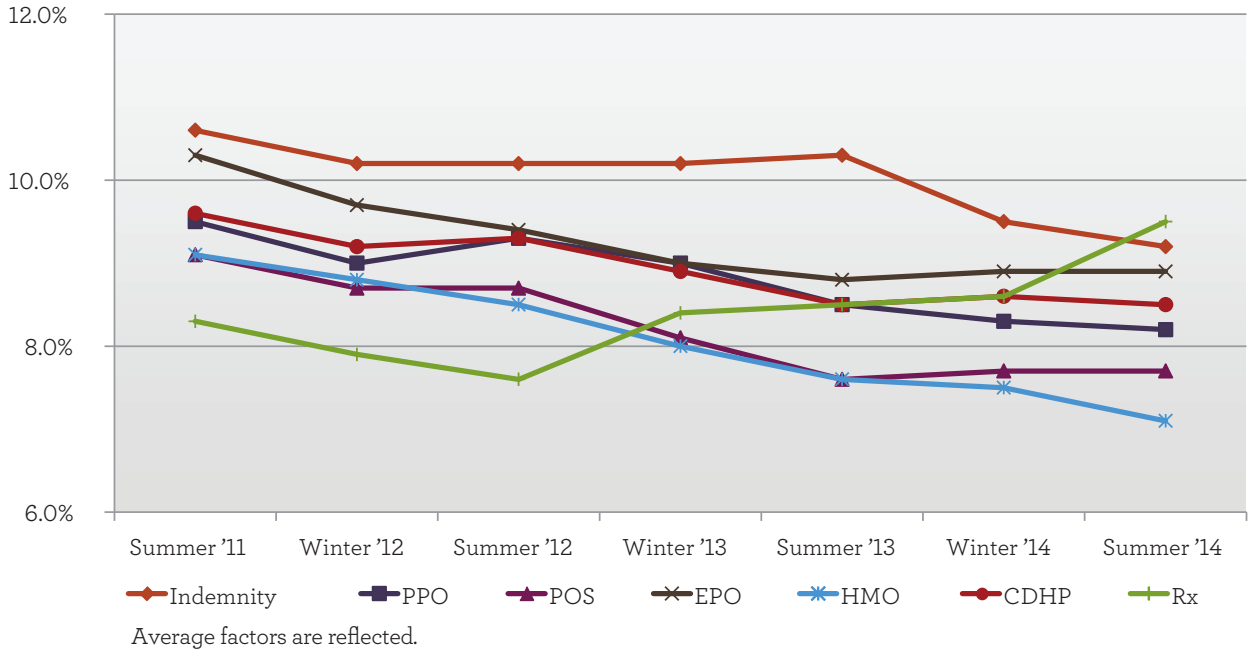
Significant factors driving increasing healthcare costs include:

- **Paying providers based on quantity, not quality.** The current pay-per-service system incents providers to perform more tests and procedures, rather than to provide efficient and quality care. A greater emphasis on outcomes, health improvement, and providers sharing in the risk of their patient population is expected by insurers and employers.
- **Consolidation of medical delivery systems.** Medical providers are gaining market share and reducing competition through increased mergers and acquisitions, enabling them to better control costs and improve outcomes, but also demand higher prices.
- **Rise of chronic illness.** Nearly 50% of the U.S. population has one or more chronic health conditions, such as asthma, heart disease, obesity, cancer, or diabetes.[3] Chronic disease accounts for more than 75% of annual U.S. healthcare spending.[4]
- **Medical technology.** New technologies and treatments are generally more expensive than their predecessors and are in high demand.

Claims trend

While medical claim trends have decreased over the past couple of years, they remain at unsustainable levels in the long term for most employers. We anticipate 2015 medical trends to remain at or slightly below 2014 levels (Chart B[5]).

Chart B
Historical medical and pharmacy trend



Average factors are reflected.

In contrast, prescription drug trends are increasing, primarily due to a combination of maximizing generic utilization and significant increases in specialty drug cost and utilization, such as the new therapies developed to treat Hepatitis C. Specialty medications are expected to account for more than half of total pharmacy spending — approximately $235 billion — by 2018.[6]

For ancillary coverage, dental costs continue to increase slightly and, despite an increase in claims incidence and age of claimants, disability pricing is projected to remain competitive in the upcoming year.

Employee benefits offerings

Employers will continue to explore a variety of means to control healthcare costs, including:

- Shifting more of the financial burden to employees through monthly contributions
- Transitioning to consumer-driven health plans
- Implementing additional health and productivity measures, including incentives
- Offering more limited medical provider networks
- Reducing the actuarial value of plan design
- Expanding the offering of voluntary benefits

What is trend?

Trend is the percentage by which a group's historical claims experience is increased to project future cost.

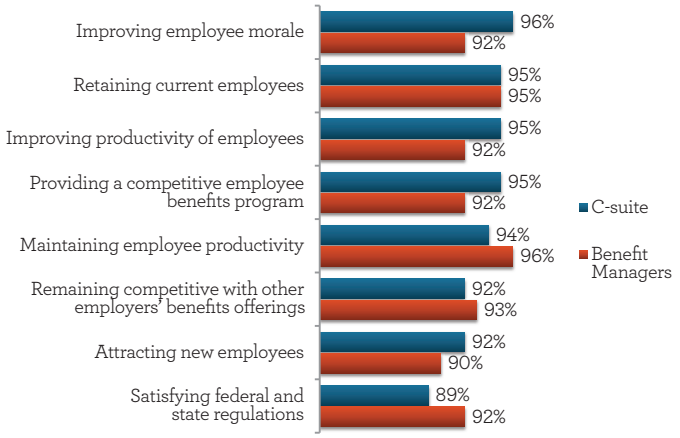
Factors that influence trends

- Price inflation or deflation (changes in unit prices for the same services)
- Increased utilization of services
- Aging of the population
- Leveraging effect on benefit design
- Changes in provider treatment patterns
- Improvements in technology and drug therapies
- Changes in federal and state legislation
- Cost shifting (from public payers, such as Medicare, to private plans)
- Costs of medical malpractice

In 2014, Wells Fargo Insurance commissioned a survey of C-suite executives and benefit managers from across the United States. The Employee Benefits Trends Survey was designed to better understand how organizations are responding to healthcare reform requirements while providing a competitive benefits strategy for employees. The key findings were:

1. Employee productivity, retention, and morale are the top objectives for employers' human capital strategies (Chart C).

Chart C
Importance of areas to success of human capital strategy

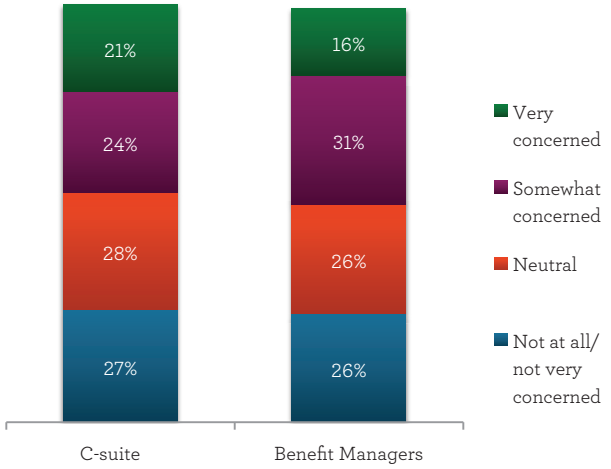


2. Management of strategy and benefits most often occurs at the executive committee level.

3. Short-term benefit program goals (through 2015) include maintaining the current level of benefits offered, maintaining current employee productivity, and managing the cost of the plans. Long-term goals consist of managing overall plan costs and improving employee productivity.

4. While there is little agreement on how the ACA will affect business, nearly half of C-suite executives and benefit managers surveyed indicated that they have at least some concern the law will have an impact on attracting new employees and retaining current ones (Chart D).

Chart D
Concern for employee attraction and retention due to changes caused by ACA



5. The top two changes respondents said their company has made or will make to its benefits program because of the ACA are offering wellness programs and increasing the percentage employees contribute to the total premium. Workplace wellness and incentive programs will be a continued trend:

   - 46% of respondents have a wellness program and 21% plan to implement a wellness program by 2015
   - 55% will have implemented incentives/penalties by 2015
   - 93% of C-suite respondents believe that wellness programs will continue to improve and increase in importance in the next five years

Private exchanges

Private exchanges are a bundling of components: multiple medical plans and/or carriers, employee decision support tools, modified benefits administration, defined contribution administration, and consumer engagement through wellness programs with available incentives. Their purpose is to organize the buying and selling of insurance in an online environment with abundant plan choices and to facilitate a shift from defined benefit plans to a defined employer contribution.

We anticipate a slightly higher adoption rate over 2014 as employers continue to explore private exchanges in 2015. Employers will have to ask themselves what they are trying to accomplish by moving to an exchange. Certain employers and industries may find private exchanges to be a good fit, including those with post-65-year-old retirees or a large part-time workforce. Many employers have already implemented and practice the components listed above and will continue to pursue other strategies to control costs, such as stronger health and productivity measures, telehealth, and narrow networks.

The biggest question around private exchanges is whether they will reduce costs. Exchanges by themselves do not lower costs and do not address the issue of chronic disease. An employer who takes the exact same plans offered in a non-exchange environment and places them onto a private exchange will not reduce costs. Costs can be lowered when either the unit cost or utilization of healthcare is affected. This is done through myriad strategies set by the employer, and private exchanges may help facilitate some of those opportunities.

Defined contribution

Defined contribution, while not a new concept, is a different way employers are thinking about health insurance for their employees. This is due in part to the rise in private exchanges, as well as the continued increase in costs. Instead of defining the benefit offered, employers offer a contribution they fix and control on an annual basis. This is administered through a third-party vendor and may or may not be tied to a private exchange offering. By shifting to a defined contribution model, employers are transferring the risk of medical cost trends to the employees.

Defined contribution offers employers a more predictable way to budget, but they should be aware this will accelerate cost shifting to employees, further eroding their total compensation. Employers need to fully understand the tradeoffs associated with this philosophy.

Health and productivity

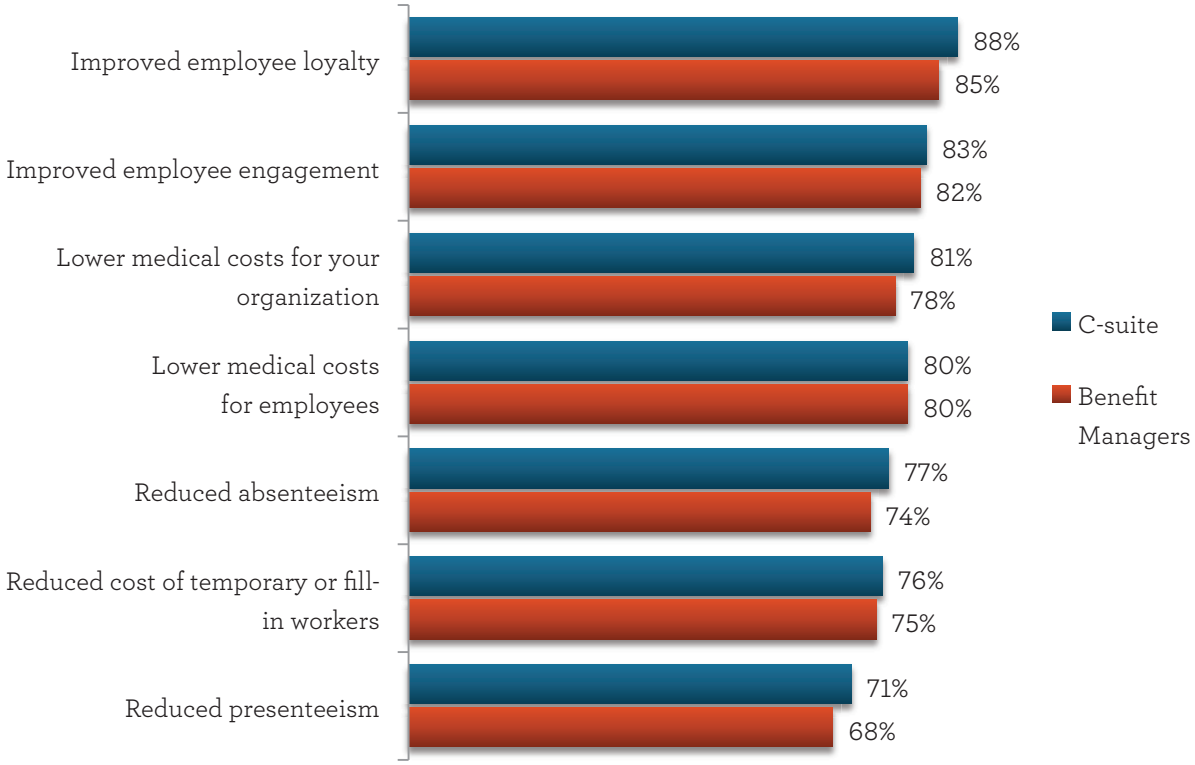
For the past few years, employers have looked to wellness programs as a way to curb rising healthcare costs. While these programs remain a critical component of an overall benefit strategy, the employer mindset is shifting to broader clinical and productivity solutions that focus on total population health and well-being.

A successful strategy will manage the total health of the population, combining the medical, pharmacy, dental, disability, workers' compensation, wellness, and disease management programs together holistically. In this fully-integrated approach, the goal is to manage the total financial impact of health on an employer, including both direct (medical and benefit plan) and indirect (absenteeism and presenteeism) costs. This way, the employer investment is directed to programs best suited to maximize the dollars spent.

Play or Pay

Large employers — those with 100 or more full-time equivalent employees — will be adjusting to the new employer Play or Pay mandate, which will generally take effect in 2015. Those employers with between 50 and 99 employees have until 2016 to comply, but will need to plan their changes throughout 2015. While the excise tax, which imposes a 40% tax on the costs of health coverage above a set threshold, does not go into effect until 2018, we anticipate many employers will continue to make plan changes in an attempt to keep their costs below the applicable thresholds.

Chart E
Impact of employee benefits program on organization



Conclusion

The Wells Fargo Insurance 2014 Employee Benefits Trends Survey revealed that employee benefits have a critical impact on an organization's level of employee loyalty and engagement (Chart E).

As the insurance market continues to shift and the business environment becomes more competitive, having an adviser who understands the landscape and can help maximize the employer's benefit investment is paramount. Wells Fargo Insurance is here to help employers drive the most attainable value.

How can we help?

For more information, please contact your local Wells Fargo Insurance representative or visit us online at wfis.wellsfargo.com.

Sources

[1] Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2014. Bureau of Labor Statistics, Consumer Price Index, U.S. City Average of Annual Inflation (April to April), 1999-2014; Bureau of Labor Statistics, Seasonally Adjusted Data from the Current Employment Statistics Survey, 1999-2014 (April to April).

[2] United States Census Bureau. (December 12, 2012). U.S. Census Bureau Projections Show a Slower Growing, Older, More Diverse Nation a Half Century from Now [Press Release]. Retrieved from http://www.census.gov.

[3] Centers for Disease Control and Prevention. (2014). Chronic Diseases and Health Promotion. Retrieved from http://www.cdc.gov.

[4] Centers for Disease Control and Prevention. (2009). The Power to Prevent, The Call to Control: At A Glance 2009. Retrieved from http://www.cdc.gov.

[5] Wells Fargo Insurance 2014 National Healthcare Trend Survey.

[6] Lotvin, A.M., et al. (October 2014). Specialty Medications: Traditional And Novel Tools Can Address Rising Spending On These Costly Drugs. *Health Affairs*. 33:101736-1744; doi:10.1377/hlthaff.2014.0511.