2016 Employee Benefits Outlook

Change continues at a rapid pace
Key trends

• Moving from well-being to total population health management. The goal of population health is to foster improved clinical, well-being, and productivity outcomes across the organization, while lowering or mitigating the total cost of care. A population health risk management approach uses data from across the healthcare continuum to improve the quality of programming, while providing the right intervention at the right place and time, unique to each employee’s needs. Thoughtful, engaged programming will produce better clinical outcomes, increase well-being, and improve productivity. By establishing a population health risk management strategy, the employer will be able to provide tools to support employees as they engage in gaps-in-care closure and behavioral changes, which will ultimately lead to better health and productivity.

Wellness programs have long been used by employers to help address healthcare costs. The traditional programs target physical health, and many have recently added financial incentives to foster participation.

According to our 2015 Employer Benefits Trends Survey, adding incentives or penalties and increasing health and wellness offerings are the most frequently occurring changes coming in 2016. In addition, employers are strategically shifting to address not only physical well-being, but also chronic condition management and mental, financial, and social well-being. In order to engage employees, employers are taking a multi-pronged approach.

• Industry consolidation. From insurers to providers to prescription benefit managers, the health insurance market is rapidly shifting to bigger and fewer players. Health insurers are merging to create payor powerhouses, with the hopes of increasing negotiating leverage, improving quality and affordability of care, and accelerating changes to care delivery. If these large insurer mergers are approved, they are expected to close in the middle of 2016, thereby reducing the number of options employers have. Medical systems are buying up competition to control more and more of the patient experience and to combat pressure on their margins as expenses exceed reimbursements. This consolidation
has more healthcare providers considering offering their own insurance plans to compete with the aforementioned powerhouse carriers. By assuming the risk of the population, the provider can avoid splitting their savings with a traditional health insurer. Even benefit advisors are merging to gain new technologies and create additional scale. Regardless of the stakeholder, how will this consolidation impact the consumer?

- **Provider network cost structure.** There is an emerging trend in the market to overhaul how provider networks are constructed and evaluated. The days of broad provider networks that include almost every doctor and hospital in-network are waning. Insurers are increasingly moving to narrow networks that contract with a smaller percentage of providers in the market with a goal of creating a cost advantage. One byproduct of the narrow network is an option to reimburse the provider using reference-based pricing. This method caps the amount the plan will reimburse for any given service, with the aim to drive high-cost providers back to a more competitive price. Further, the evaluation of the networks is changing. Historically, networks were reviewed based on the negotiated discounts that the insurer had in place with the providers. However, that approach only covers part of the cost equation. Network evaluations are now reviewing the total cost of care, which factors in the discount as well as the medical management. This shift will more sufficiently demonstrate the ability of health insurers to manage the total medical cost.

- **Technology.** Using technology to help deliver, administer, and enroll employee benefits has grown substantially over the years and will likely quicken in 2016, further disrupting the market. With a competitive and changing workforce that will be dominated by millennials in the next few years, an ever-evolving shift from paternalism to consumerism, and continued cost pressures, technology will play a bigger role. The consumer benefit experience will need to become more mobile-friendly; tools like personal electronic devices will increasingly help companies collect and consolidate data, create comprehensive electronic records, and reduce wasteful spending. This shift will lead to a number of new entrants and products, all looking for a piece of the potential revenue. A cautionary note: as technology solutions and insurance products become more bundled, transparency as to what services are included, where the revenue goes, and what it covers, will be critical for employers to understand.

- **Personal responsibility.** As employees take on more of the healthcare cost burden, the benefits decision-maker role is rapidly shifting from the employer to the consumer. Plan choice and cost transparency are 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, and will therefore need to provide proactive education and more evolved navigation tools, including those that allow employees to compare the cost of procedures and the quality of outcomes. Social media, telemedicine, on-site clinics, and transparency tools will play a much greater role in helping individual consumers attain value from their insurance products and healthcare.

There will also be a continued demand for voluntary benefits, such as critical illness, accident, and life insurance. These products allow individuals to further customize their insurance needs to fit their lifestyles.

- **Global employee benefits.** Companies of all sizes continue to explore new markets abroad, initially engaging expatriates and, in time, employing local national personnel, organically or by acquisition. Certainly, having competitive benefits is a top priority. However, as we’ve seen in the U.S., legislated benefits are becoming more prevalent across the globe. Examples include auto-enroll pensions in the United Kingdom and compulsory private medical insurance in France. Multinational employers now face escalating healthcare costs, which raises the need for not only cost management of private health plans, but also wellness and productivity initiatives for the employees’ issues abroad. Monitoring and managing benefit plans in foreign countries to ensure market competitiveness, cost effective programs, and compliance remains a challenge for all multinational employers.

- **Financial wellness.** Employers recognize that employees are less productive at work when they are
concerned about financial problems. Employers are expanding their emphasis on retirement savings by helping employees save for the future and protect against risks that are unpredictable and may have serious financial consequences. The focus is on employee financial wellness through education and voluntary benefit solutions. Providing choices and improved risk mitigation helps ensure individual employees meet their goals.

- **Monitor the Affordable Care Act (ACA) excise (“Cadillac”) tax.** Late in 2015, Congress approved a spending bill that, among other things, included a delay in the tax to 2020. This was welcome news as employers generally expected their medical plan costs to exceed the thresholds for the original effective date in 2018. Even with the delay, the possibility of a 40% excise tax on costs above pre-determined limits will require employers to closely monitor legislative developments, track their plan performance, and implement changes in 2016 to avoid or mitigate their Cadillac tax exposure.

**Insurer financial trends and market capacity**

- Capital and surplus levels for the health insurance industry remain robust as carriers continue to post modest profits.

- While medical costs have moderated somewhat, expense ratios have been pressured by ACA fees and we anticipate that overall insurance carrier margins will remain compressed in 2016. This is one factor driving the merger activity between insurance companies.

- Revenue will continue to grow due to rate increases and macroeconomic trends that impact enrollment.

  - Enrollment levels are the highest in a decade. Medicare and Medicaid membership continues to increase, driven by ACA Medicaid expansion, the individual mandate, and demographic trends.

  - The revenue impact is somewhat dampened by a decline in group benefit premiums, due to an increase in self-insurance and stop-loss programs.

- Several major insurer mergers have been announced, pending regulatory approval. Merger and acquisition activity is likely to continue as both insurers and providers look for diversification and scale to mitigate expense pressure.

- Vertical integration continues, with hospitals purchasing medical providers and some provider groups becoming insurance companies. For the most part, these insurers are less profitable and more thinly capitalized than their independently-owned counterparts.

- Many health insurers have anticipated recoveries from the ACA Risk Corridor program. This temporary program protects against inaccurate pricing in the individual and small-group market by sharing risk on allowable costs between Health and Human Services and qualified health plans. These recoveries have been delayed, and will not be fully collectible due to congressional change in the regulation that governs this program.

  - The loss of revenue from the Risk Corridor program has negatively impacted consumer operated and oriented plans (CO-OPs) the most. In 2015, the CO-OPs for Iowa, Kentucky, Nebraska, Nevada, and Utah announced shutdowns, partially due to risk corridor shortfall. This revenue loss may impact other CO-OPs in 2016.
Rate and pricing environment

Premiums

Driven by rising healthcare costs, health insurance premiums have increased 203% since 1999 (Chart A) and continue to rise at an unsustainable rate.

Significant factors driving increasing healthcare costs include:

- **Paying providers based on volume.** The current reimbursement system offers an incentive for providers to perform more tests and procedures, rather than provide efficient, high-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 (moving from fee-for-service to fee-for-value). Medicare is impacting the way hospitals and providers are reimbursed for services, as Medicare reimbursements are quickly transitioning to bundled episodic payments rather than reimbursing providers on a fee-for-service basis. Medicare payment reform mandates hospitals and healthcare providers integrate their delivery of care, giving rise to more Accountable Care Organizations (ACO) and Patient-Centered Medical Homes (PCMH). This shift is also beginning to affect the commercial market as methodologies, such as primary care incentives, bundled payments, shared risk, and global capitation, are introduced. As the public payment model changes, the private payment model will follow wherever possible. More than 20% of employers said they plan to embrace the shift in provider reimbursement from volume to value in the next five years.¹
• **Consolidation of medical delivery systems.** Medical providers are gaining market share and reducing competition through increased mergers and acquisitions. This enables them to better control costs, manage more medical services, and improve outcomes, but also to demand higher prices. It’s possible that we will see some markets with no independent practitioners in the next few years.

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

• **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, and diabetes. Moreover, 34% of Americans are affected by metabolic syndrome, which entails elevated blood pressure and blood glucose, abnormal lipids, and high levels of body fat around the waist. Metabolic syndrome compounds the risk of heart disease, stroke, and diabetes. Chronic disease accounts for more than 75% of annual U.S. healthcare spending.

• **Medical technology.** New technologies and treatments are generally more expensive than their predecessors, and are in high demand. ICD-10 (International Classification of Diseases, 10th edition), implemented in late 2015, is a medical code that will provide more specific diagnostic and procedural information for a patient. The purpose is to improve clinical communication, but it may also lead to additional procedures being covered than in previous editions. This could lead to additional claim dollars, as well as more appeals and denials of claims.

• **Lack of information.** Today’s consumer does not have accurate information about what medical services cost and who is most effective and efficient in delivering those services.

### Claims trend

While medical claim trends have decreased over the past couple of years, they remain in the high single digits — levels that are higher than indexes such as the medical consumer price index. These trends are unacceptable for most employers. We anticipate 2016 medical trends to be slightly higher than 2015 levels (Chart B), driven mostly by the continued rise in chronic disease and provider charges.

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**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
Pharmacy trend

From 2010 to 2014, the average revenue growth for top-selling prescription drugs more than tripled the growth in demand for prescriptions (Chart C).

While the rise in medical claim trends is modest, prescription drug trends are increasing sharply, primarily due to the growth and cost of specialty drugs as well as a large increase in cost for some of the most highly utilized drugs. Some specialty drug companies have established patient support systems to help alleviate the financial burden that the employee has to bear, but those costs are being shifted to the employer plan. Another factor driving pharmacy trend is the consolidation of the prescription drug benefit managers (PBMs). These PBMs may be able to drive better discounts, but could also negatively impact utilization of certain pharmacies and drugs. We forecast that composite prescription drug claim trend could be near 13%, a level not seen in group plans in nearly seven years (Chart D). This projected rise in pharmacy costs will result in heavy scrutiny and much debate amongst politicians, patient advocacy groups, and medical providers.

For ancillary coverages, dental costs are projected to rise slightly due mostly to an increase in the cost of services. Disability pricing is projected to remain competitive in the upcoming year.

Employee benefits offerings

According to our 2015 Employee Benefits Trends Survey, 35% of companies plan to increase their employee benefits budgets in 2016. In addition, compared with 2014, the short-term focus in the C-suite has shifted from employee productivity to expanding voluntary benefits.

Following the trend of personal responsibility, employers are making additional changes to medical plans for 2016. For all employers with more than 50 employees, 33% will increase the co-insurance feature, 33% will increase the percentage that employees pay toward medical premiums and 30% will add a high deductible health plan offering. These changes will place additional obligations on the employee to make intelligent healthcare decisions.

Companies are also looking to steer employees toward more efficient healthcare professionals, whether through centers of excellence for certain high-risk procedures or tier-one providers (recognized for quality of care) in order to hold down costs, improve clinical outcomes, and increase member accountability. The steerage is done either via incentive through the plan design or through employee contributions.

With a changing employee demographic (Generation Z begins entering the workforce in 2016), employers will want to ensure their benefits packages are aligned with
the needs of their specific workforces and that the benefits are communicated in ways that will reach all generations and instill confidence in what they purchase. From 2014 to 2015, we saw a big decrease in the use of employee meetings to communicate the benefits package and the biggest increase was in the use of social media.\(^1\)

**The Affordable Care Act**

While the ACA will be almost six years old as 2016 dawns, employers still have great uncertainty with the tremendous fluidity of its mandates and other requirements, which pose new challenges and create disruption in their business operations. The ACA is also expected to be a popular topic of discussion during the year’s presidential elections.

**ACA reporting requirements**

The ACA rollout continued in 2015 with employers preparing to comply with reporting requirements under Internal Revenue Code § 6055 and 6056 that will become effective in 2016. During 2015, employers with 50 full-time and full-time equivalent employees, struggled to identify the most effective way to comply with the new requirements, as the IRS requires the reported data to be aggregated and that data may come from many sources. Most employers discovered the need to enhance their existing HR technology system(s) and/or payroll system(s) or contract with an independent third party ACA reporting vendor to address this new mandate.

There was an unprecedented demand in 2015 for HR technology that could address requirements to monitor employees’ work hours (manage measurement periods) as well as ACA reporting requirements. We expect 2016 to bring additional movement in this industry, with vendors and employers continuing to define and improve their HR technology strategies.

**Small employers**

For some smaller employers (51 – 100 employees), 2016 may bring some good news. The ACA originally stated that the definition of the small-group market would expand to include employers with 51 but fewer than 101 employees. This change would have forced more employers into the ACA community rating environment as well as required those employers to cover all essential health benefits. Many felt that this change would increase costs for employers with 51 – 100 employees; therefore, many employers pursued an early renewal strategy to delay complying with these requirements. In October 2015, the expansion of the small group definition was repealed, but states including California, Colorado, Maryland, New York, Vermont, Virginia, and Washington, D.C. will proceed with the expansion of small group market rules to include employers with 100 or fewer employees.

Although employers in this market segment may have avoided complying with the ACA market reform changes in 2016, they will face a greater challenge, complying with the ACA Employer Shared Responsibility mandate (“Play or Pay” mandate). Employers who employed 50 – 99 full-time (FT) and full-time equivalent (FTE) employees in 2014 and qualified for transition relief; or new employers who employed on average 50 FT and FTE employees during 2015, will become subject to the Play or Pay mandate in 2016. Small employers will be required to offer full-time employees (those working on a regular basis 30 hours or more per week) minimum essential coverage, which is minimum value (60% actuarial value) and is affordable for employee-only coverage (cost may not exceed 9.66% of the individual’s household income or 9.66% of one of the three IRS affordability safe harbors). Failure of employers to meet this criteria may result in a penalty if a full-time employee purchases subsidized coverage from an exchange or marketplace.

**Non-traditional providers**

It seems that every industry is seeing the emergence of new, non-traditional companies whose goal is to create additional partners or direct competition. The benefits industry is no different. The demand for solutions that lower cost, simplify administration, and/or improve employee health continues to grow. Entrants into the marketplace will continue at a quickened pace in 2016, due to both the availability of private equity investments and the aforementioned demand. While employers should evaluate these options, it is important to thoroughly review the product and avoid the traps of “free” services, glitzy front-end technology, and aggressive marketing.
Health and productivity

Integrating health and safety

Employers of all sizes are seeking approaches that increase productivity and lead to a healthier workforce. For many employers, this starts with wellness. According to our recent survey, 41% of companies expect to increase their wellness offerings in 2016, and 37% will add wellness incentives or penalties to their programs in 2016. Wellness programs that promote healthier living and increase employee productivity are a great place to begin. For many companies, sound wellness programs have established the baseline; companies are now looking to further drive change and more broadly integrate a culture of health. To do this, integrating data from all facets of your program will be critical.

Rising medical costs continue to have a significant impact on workers’ compensation claims. In the past, the indemnity portion of the claim (that is, the lost time and impairment ratings) tended to garner the larger share of costs. Today, nearly 60% of all workers’ compensation claim dollars pay for actual medical treatment. While the concept of integrating health plan benefits and workers’ compensation for the purpose of risk mitigation has been longstanding, barriers to progress exist. Whether it is disparate risk management departments within an organization, or autonomous carriers with stringent laws guiding benefit administration, organizations can indeed overcome the various obstacles to integrating programs and achieving measurable results. Successful employer-based integrated health and safety programs demand a collaborative approach that makes use of all interventional programs in an efficient and cohesive manner. The programs involve sharing information and developing a culture that is committed to the overall well-being of its population.

Rise of on-site nurses

According to a white paper recently released by Optum, new technologies continue to evolve in the health and productivity space, while face-to-face interactions for complex members are making a comeback via nurse case managers. Ideally, a health and productivity program will seamlessly integrate mobile technology (such as gaming, wearables, and health challenges) with health coaching, chronic condition management, and case management.

On-site, face-to-face engagements can include a wide scope of services, ranging from case management to all of the following:

- Acute, preventive, and chronic condition care
- Telehealth (connecting clinicians to members, wherever they are)
- Workers’ compensation and safety initiatives
- Coordination of care
- Pricing and quality transparency
- Treatment decision support
- Health advocacy
- Health coaching
- Nutrition counseling

Having health coaches and clinicians on-site can promote rapport, better continuity of care, potentially higher engagement rates, and improved clinical outcomes.

Inclusion of spouses in health and productivity programs

The Equal Employment Opportunity Commission (EEOC) has proposed new wellness regulations with regards to the Genetic Information Non-Discrimination Act (GINA). The EEOC is proposing guidelines that will allow employees to disclose their spouse’s current or past health status in connection with employer-sponsored wellness programs. If the law is passed, the conditions imposed will require most employers to restructure their consents and disclosures and possibly change the amount of inducements they are offering. Because of the proposed regulations, companies may feel freedom to include spouses in their total population management programs with clearer guidance from the regulators. Spousal surcharges and spousal elimination for healthcare coverage has the potential to save money for employers, but these strategies do not align with many company cultures. Therefore, including spouses in the employer-sponsored wellness program assists with having a more holistic view of population health management.
Private exchanges

Exchanges are no longer a new concept, but they remain in a “version 1.0” state and have not seen the adoption rate that many had predicted or hoped. The original versions of exchanges were more rigid and were focused on enrollment and creating a positive shopping experience. The next version of private exchanges will need to:

• Improve back-end administration
• Add or improve transparency and decision-making tools
• Personalize the consumer experience more

The growing demand for technology to act as a solution and the continued focus on cost will drive some companies to examine a defined contribution approach. As such, exchanges will be considered as a possible product that can fulfill employers’ strategies. It is important to remember that exchanges are a platform for delivering benefits, not a direct cost control mechanism. Growth is anticipated to be modest again in 2016, and we may see exchanges start to scale in order to become more relevant.

Conclusion

There are many pain points that will continue to keep healthcare in the public eye, ranging from a continued shortage of primary care physicians in the U.S. to concerns about the sustainability of Medicare to the strain that healthcare puts on the budgets of the states as well as employers. Costs are expected to increase in 2016 for many companies (Chart E), so continuing to explore any and every solution will be critical to managing those costs, while still attracting the key talent every organization needs to be successful.

How can we help?

We can help employers address many benefits-related concerns, in 2016 and beyond. For more information, please contact your local Wells Fargo Insurance representative or visit us online at wfis.wellsfargo.com.