The health care industry’s transformational era continues
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Executive summary

In our 2017 Employee Benefits Outlook, Wells Fargo Insurance’s national practice leaders offer their timely insights, which we hope you will find beneficial as you plan for the year ahead.

The theme of our Employee Benefits Outlook report last year was one of rapid changes for the industry, and it appears 2017 will be no different. Many factors, such as rising costs, the health of the U.S. population, the impact of the U.S. presidential election, and the growing role of government, will continue making employee benefits offerings a complex and demanding area for employers in the coming year. The industry will continue to search for affordability and creativity.

Benefit plans are a critical part of an employer’s overall rewards package, especially as the need for qualified talent remains high. Ensuring that benefits are competitive and consistent with an employer’s culture while simultaneously balancing costs is a challenge, and many employers will be focusing on these goals for the next few years.

<table>
<thead>
<tr>
<th>Top 3 employer goals¹</th>
<th>Short-term (next 12-18 months)</th>
<th>Long-term (next 5 years)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Managing the overall cost of health care benefits</td>
<td>Managing the overall cost of health care benefits</td>
<td></td>
</tr>
<tr>
<td>Maintaining current level of benefits offered</td>
<td>Maintaining current level of benefits offered</td>
<td></td>
</tr>
<tr>
<td>Maintaining productivity of employees</td>
<td>Attracting high-quality, new talent</td>
<td></td>
</tr>
</tbody>
</table>

As Donald Trump becomes the 45th president of the U.S., many are wondering what impact his administration will have on health care reform. There have been many predictions on the fate of the ACA leading up to his inauguration. Even after he and the new Congress take office, it will take time for any specific legislative, regulatory, and executive actions to materialize and become effective. We strongly advise employers to continue complying with the statutory and regulatory requirements set forth by the ACA until such time it is altered. Republicans campaigned on a “repeal and replace” strategy, but it is unclear just what will be repealed, what it might be replaced with, or when any changes may take effect. In addition to the “Cadillac” tax, we suspect that the individual and employer mandates, federal tax credits, and exchanges will come under scrutiny. Employers should closely monitor developments.

One possible headwind for employers next year is that the traditional employer-provided health care model is increasingly being questioned. Along with rounding out their compensation and rewards practice to attract key talent, employers also provide benefits for the pre-tax treatment of employer- and employee-paid premiums. Employer-sponsored insurance is the number one tax expenditure in the United States. If the 115th Congress addresses the issue of broad tax reform as many sources believe it will, the federal government would see a loss of revenue in areas that will need to be accounted for, including lost revenue from the excise tax. The speculation is that this lost revenue could be recouped by limiting the tax deductibility of those premiums.

New entrants and solutions are being introduced to the market. Technology is evolving rapidly and can eliminate many administrative challenges, and help bring insurance and the delivery of care into the mainstream digital world. In this Outlook report, we evaluate some key trends for employers to focus on for the next year.

The Affordable Care Act (ACA) will be entering its seventh year and most provisions have been implemented. The last major outstanding item is the excise, or “Cadillac” tax, which is set to take effect in 2020. This tax has been highly criticized, from unions and employers, to providers and legislators. It appears increasingly likely that lawmakers will try to repeal or significantly modify the tax before taking effect, with intense speculation that it could occur in 2017.

¹ Wells Fargo Insurance Services USA, Inc., Employee Benefits Strategies, Actions, and Behaviors Study. 2016
Insurer financial trends and market capacity

- The ACA has provided mixed results for health insurance carriers to date. On the positive side, medical enrollment has increased and the rate of health care inflation has moderated. However, the individual public exchange experience has pressured balance sheets for carriers participating on the state exchanges, noting that the individual exchange business still represents a relatively small proportion of the total industry.

- Smaller insurers remain at a competitive disadvantage under the ACA, and we expect to see continued merger activity regardless of whether the industry’s two largest planned mergers, between Anthem-CIGNA and Aetna-Humana, receive regulatory approval.

- The ACA Risk Corridor and Reinsurance programs are no longer in place after 2016, although the Risk Adjustment program is permanent. As a result, insurers may see more earnings volatility beginning in 2017. Utilization of high-cost prescription drugs continues to pressure insurer earnings as well.

- The health insurance industry tax has been suspended for one year in 2017, which should reduce expense pressure for insurers, and some of this benefit may be passed along to customers by reducing rate increases.

- Membership continues to shift from fully insured to administrative services only (ASO), which provides fee income to health insurers, but reduces overall premium.

- Profit margins continue to be compressed. Ongoing profitability for the sector will rely on regulatory support for necessary rate increases, and net investment yields continue to show contraction due to the prolonged low interest rate environment.

- Despite the ongoing volatility associated with the ACA, most life and health insurers remain adequately capitalized.

Emerging markets and industry consolidation with employee benefits service providers

It’s often a natural reaction to look at industry consolidation in the health insurance space and think it will undeniably be harmful. Similarly, the tendency is to look at emerging markets and believe, on the whole, that the approach will be good for the participants involved. However, neither initial impression encompasses the complete picture. By examining what has happened over the course of just the last year, it’s easy to find examples of trends that are benefiting the industry, as well as several that are increasingly creating cause for concern.

Beneficial trend: Emerging markets and counter consolidation

**Technology in enrollment, benefits administration, and ACA reporting**

New companies seem to be emerging every day in the area of benefits administration and open enrollment. The technology behind the entry-level software is not complicated, and a new business doesn’t require much capital to get up and running. While new players in the market will serve as a catalyst for the development of new ideas and service models, they also pose an operational risk to the consumers of these products.

Providers with unsophisticated technology that also lack a large infusion of initial capital will struggle to meet employer demands for information security and contingency planning. In addition, there is a benefits compliance risk with some vendors, as the applicable rules continue to evolve over time. Nevertheless, there is a huge opportunity to reinvent and fine tune the benefits administration and ACA reporting businesses. Enterprise consumers will benefit from both new business startups and large capital investments by alternative capital sources, such as venture capitalists or private equity firms in this area.
Concerning trend: Industry consolidation

**Insurance companies (carriers)**

At present in the health insurance market, the U.S. Department of Justice is attempting to block the two largest carrier mergers. The first and largest is Anthem’s $48 billion deal with Cigna. The second is Aetna’s proposal to acquire Humana for $37 billion. From the perspective of employer-sponsored plans, it’s easy to understand why the Anthem-Cigna deal is under pressure. Today, there are only four major nationwide players in the employer-sponsored health insurance space: Anthem, Cigna, Aetna, and UnitedHealthcare. In some geographic markets, only two or three of these insurance companies hold any real competitive advantage. To reduce the number of major players from four down to three – and in some geographic markets down to one – creates a visible pricing disadvantage for enterprise health plan consumers.

The potential anti-trust problems with the Aetna-Humana deal are less conspicuous from the employer vantage point. One of the big reasons an acquisition such as this could be blocked is business overlap. Aetna and Humana have business segments that overlap, mostly with respect to individual products, and that has caused concern about consumers facing unfavorable odds against a price-controlling monopoly. It’s difficult to imagine the Aetna-Humana deal materially affecting the group health plan market nationwide, though it could have an impact on employers in a few key markets.

If one or both of these mergers are not approved to proceed, it’s likely that these large health insurance carriers will look for opportunities to bolster their financial and strategic goals through acquisitions of related businesses, such as health care providers, technology or medical management solutions companies, or data analytics companies.

**Brokers and consultants**

The largest merger or acquisition in the employee benefits broker-consultant industry in 2016 was between Towers Watson and Willis. Though there is still plenty of competition in the brokerage arena, there was a tremendous amount of merger activity in 2016, with Towers and Willis simply setting the stage. In 2015, there were a record 456 acquisition deals announced according to a July 2016 article in Business Insurance, with another 400 expected for 2016.

Price competitiveness has not been a key concern for human resource departments across the U.S. looking to hire a broker or consultant. However, with so much ongoing merger and acquisition activity, it is likely to stifle the creativity and innovation that stems from a vibrant small business community in the brokerage industry. This could hurt at a time when employee benefits managers are relying heavily on their consultants for game-changing ideas.

Harmful trend: Blurring lines of responsibility

**A world without middlemen**

Providers, such as hospital systems, have become notably riskier in their scope of activities and in the contracts they negotiate with their carrier partners. Providers are not only more willing to take on payment risk, like they did during the 1990s HMO boom via capitation, but are actively pursuing it. Insurance companies have wisely learned from history, and are now setting up negotiated contracts with providers that put them at some, but not full, risk. In fact, there are now a variety of contracts with hospital systems that run the full spectrum, from traditional contracts to full accountable care organizations (ACOs).

Simultaneously, in some cases hospital systems are directly contracting very specific services to employer groups. Knee replacements are a common example of this. Imagine a large enterprise sending all, or most, of their members who are likely to have knee replacement surgery to a partner hospital. The hospital would ideally have a history of low costs and excellent outcomes for that surgery. While the employer may still need the insurance company to help them administer such an arrangement, they have no need for the contract negotiations that take place between carrier and provider. This begins a dynamic chapter in the relationship between the employer-sponsored community and health care systems.

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Rate and pricing environment

Premiums

Driven by rising health care costs, health insurance premiums have increased 213% since 1999 (Chart A) and continue to rise at an unsustainable rate.\(^4\)

Significant factors driving increasing health care costs include:

**Paying providers based on volume:** The current reimbursement system offers an incentive for most providers to perform more tests and procedures, rather than provide efficient, high-quality care. A greater emphasis on outcomes, health improvement, and provider risk-sharing is being accelerated 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 that hospitals and health care 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. Twenty-three percent of employers said they plan to embrace the shift in provider reimbursement from volume to value in the next five years.\(^5\)

**Consolidation of health care delivery systems:** Health care 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. In the next few years, it’s possible that we will see some markets with no independent health care practitioners.

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Clinical management: Seven factors driving U.S. health care costs

1. Increased Utilization
   - Demand, new treatments, defensive medicine, and aging population with poor lifestyles

2. Aging Population
   - Longevity dictates prolonged and increased health care costs

3. Biologics and New Technologies
   - Expensive drugs, technologies, services and procedures to prolong/improve quality of life

4. Behavior and Lifestyle
   - Choices leading to long-term chronic and associated managing treatments

5. Pharmaceutical Costs
   - More utilization, new and expensive medications, specialty drugs, fewer manufacturers that control price

6. System Inefficiencies
   - Procedure duplications, preventable mistakes, unnecessary treatments and prescriptions, technological inefficiencies

7. Medical Malpractice
   - Higher insurance rates, practice of defensive medicine


Aging populations: According to U.S. Census Bureau projections, the population of people age 65 and older is expected to more than double between 2012 and 2060. While millennials comprise more of the workforce, baby boomers and Generation X still account for the majority of employers’ health care spend, with an annual expenditure rate 6.3 times greater than the younger generations.

As the population ages and longevity increases, the health care 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, or diabetes. Moreover, 34% of Americans are affected by metabolic syndrome, which is a combination of 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. health care spending.

Medical technology: New technologies and treatments are generally more expensive than their predecessors, and are in high demand. While these technologies may shorten hospital stays or patient recovery time, they certainly add to the rising costs.

Lack of information: Today’s consumers do not have accurate information readily available to them about the cost of various health care services, or which providers are most effective and efficient in delivering those services.

System inefficiencies: The health care system is still fairly antiquated. There remain too many instances of procedure duplications, preventable mistakes, and unnecessary treatments. Consumers need to receive care in the right setting, without errors.

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Claims trend

While medical claim trends have remained stable 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 2017 medical trends to be slightly higher than 2016 levels (Chart B), driven mostly by the continued rise in chronic disease and provider charges. With the ACA capping deductible and out-of-pocket levels, and the consolidation of insurers and provider network discounts becoming obsolete, population health is the main lever to pull for employers to influence these trend figures.

Chart C shows our claim trend forecast for 2017. We paired data from our historical chart (Chart B), with our actuarial judgment and market knowledge to provide a range of cost trends for each medical product. The range reflects the variance in health care delivery in a local market.

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

Chart B: Historical medical claims

*Based on probabilistic data provided by survey respondents

Chart C: Medical claims trend forecast*

Wells Fargo Insurance 2017 Medical Trend Forecast and Variance, by Product

*Based on probabilistic data provided by survey respondents
Employee engagement across generations

Defining generations\textsuperscript{12}

<table>
<thead>
<tr>
<th>Generation</th>
<th>Birth Dates</th>
<th>Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Traditionalists/Pre-Boomers</td>
<td>Born in 1945 or earlier</td>
<td>32M</td>
</tr>
<tr>
<td>Baby Boomers</td>
<td>Born between 1946-1963</td>
<td>75M</td>
</tr>
<tr>
<td>Generation X</td>
<td>Born between 1964-1980</td>
<td>66M</td>
</tr>
<tr>
<td>Millennials (Generation Y)</td>
<td>Born between 1981-1997</td>
<td>75M</td>
</tr>
<tr>
<td>Edge (Generation Z)</td>
<td>Born 1998 and later</td>
<td>74M</td>
</tr>
</tbody>
</table>

Millennials are now the largest generation in the workforce, with Generation X and baby boomers closely following. However, by 2020, millennials will make up half of the workforce, so employers should plan now to understand the generational differences that exist among their employees. Focusing on generations at work leads to enhanced recruiting, retention, engagement, productivity, customer satisfaction, client retention, and culture of caring. It may also reduce the potential for liabilities.

Millennials grew up in a time of significant disruption, but perhaps the events that have shaped them the most are the 9/11 attacks and the Great Recession. Many of them entered the workforce during the recession, and are more likely to have financial strain. They tend to postpone marriage and family, are more likely to live with their parents, and are digital natives.\textsuperscript{13} Because millennials are unique, employers must roll out specific strategies to engage them.

According to our October 2016 poll in the webinar, “Generation Y: Optimizing benefits for the millennial workforce”:

- 75% of employers are concerned about retention rates with millennials (114 respondents)
- 28% of companies are planning to make benefit offering changes to accommodate millennials (103 respondents)

\textsuperscript{12} Wells Fargo & Co., Generation birth dates reflect those used by Wells Fargo for marketing segment calculations. Wells Fargo marketing segment generation birth dates differ from People Soft generation birth dates for Generation X and Millennials. U.S. population estimates are based on Census Bureau 2015 population projections.

Millennial traits: Tech savvy, receptive, and engaged in quick-response tools

**Potential solutions:**

<table>
<thead>
<tr>
<th>Telehealth</th>
<th>Digital platforms</th>
<th>Technology tools</th>
</tr>
</thead>
<tbody>
<tr>
<td>Can provide mental health solutions</td>
<td>Holistic solutions on one platform for all benefits promotes engagement</td>
<td>Transparency, treatment decision support, second opinion, and wellness increase engagement</td>
</tr>
<tr>
<td>Decreases time missed from work by allowing fast access to care remotely</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Millennial traits: More likely to experience anxiety and financial stress

**Potential solutions:**

<table>
<thead>
<tr>
<th>Financial wellness</th>
<th>Support tools</th>
<th>Healthy environment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tuition forgiveness incentives for retention</td>
<td>Telehealth, behavioral, and mental health resources (EAP)</td>
<td>Onsite areas for “time out”</td>
</tr>
<tr>
<td>Programs, apps, and education for financial planning</td>
<td>Mindfulness, anxiety-reducing programs and apps</td>
<td>Workspaces that promote better ergonomics, collaboration, personalization</td>
</tr>
</tbody>
</table>

Millennial traits: More likely to engage in unhealthy stress coping behaviors; prefer collaboration over competition

**Potential solutions:**

<table>
<thead>
<tr>
<th>Culture of health</th>
<th>Holistic health programs</th>
<th>Teamwork</th>
</tr>
</thead>
<tbody>
<tr>
<td>Promote a healthy culture</td>
<td>Develop programs for healthy eating, activity, stress reduction, alcohol and tobacco awareness</td>
<td>Leverage social networks and peer groups to promote support</td>
</tr>
<tr>
<td>Make the healthy choice the easier choice</td>
<td></td>
<td>Assign wellness champions/ambassadors</td>
</tr>
<tr>
<td>Create a mission statement for health, support from leadership and peers</td>
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<td></td>
</tr>
</tbody>
</table>

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Although millennials have distinctive generational differences, it is important to unite all generations. Strategic, multi-channel communications can help to accomplish this. Traditionalists and baby boomers tend to prefer verbal, face-to-face communication, whereas Gen X and millennials typically desire electronic formats; however, Gen X and millennials may still want the personal touch. Additionally, consider benefits that cross generations, such as health FSAs, HSAs, financial wellness, and well-being at any age. Mentoring programs may also prove valuable, as each generation has strengths that may be shared with others.

A flexible work environment for individual preference seems to help all generations. Allow for quiet, closed areas as well as open, collaborative areas. Explore additional time off for volunteer projects to not only attract millennials, but also engage and energize older generations. Millennials often do not fully understand the benefits offerings available, so employers can use case studies and personal stories to help educate them. Finally, offer tutorials and demonstrations to help establish the value and convenience of technology solutions for traditionalists and baby boomers.

**Financial wellness**

There is an emerging emphasis on financial wellness in the workplace. Employers are seeing the cost impact of employees’ financial stress on their bottom lines in the form of increased health care expenses and lost productivity. Presenteeism causes increased workers’ compensation and disability claims, while lack of systematic savings can threaten the overall financial health of an employer’s retirement plan. According to our recent survey, employers of all sizes plan to add a focus on financial wellness to their benefits program (Chart D) in 2017 or beyond.15

**Chart D: Companies adding a financial wellness component to the plan**

Financial wellness offerings for employees help them budget for everyday living expenses, set retirement and savings goals, make good financial decisions, and prepare for the future and unexpected expenses. Employees across all generations are expecting their employers to assist them in becoming financially secure.

Offering benefits and financial education beyond the standard retirement plan is a growing trend. Thirty-two percent of employers expect to focus long-term on providing services or programs focusing on financial advice and wellness.16 In addition to a program that addresses long-term savings through 401(k), HSAs, and college savings plans, employers are educating their workforce to create budgets that meet short-term needs, as well as providing coaching for money management around mortgages, credit cards, and student loans. Voluntary

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benefits, such as life, disability, critical illness, and accident insurance, help employees better prepare for unexpected expenses and round out a complete financial wellness program.

**Market focus**

Several insurance carriers have launched financial wellness awareness through annual studies identifying the real effects of monetary stress on employees and their employers. Some of those contributing to this research are MetLife, Prudential, Guardian, and Aflac. The findings in their reports identify common issues among employees. Many individuals live paycheck to paycheck, with little to no savings. They are worried about their finances negatively affecting their health while increasing medical cost. On top of that, during the workday they are less productive as they deal with financial issues while on the clock.

PricewaterhouseCoopers published results from the 2016 Employee Financial Wellness Survey, which tracked the financial and retirement well-being of working adults across the United States. It included five areas of focus in planning for the future: retirement, investing, risk management and insurance, estate planning, and education planning (Chart E).

In order to attract and retain employees, employers must offer a competitive benefits package that includes education as well as new and innovative products and services that address the financial needs of all employees. Financial education should address budgeting, money management, debt reduction, savings, and identifying gaps in benefit coverages that create financial risk for employees from unexpected events. At the same time, employers should be sensitive to potential fiduciary liability and compliance issues that could arise if their financial wellness activities stretch beyond providing general educational and self-service tools.

**Plan of action:**

- Set clear goals for your program.
- Understand each generation of your population.
- Be strategic in the development of your program and think beyond retirement planning.
- Focus on program structure, execution, and solutions
- Survey employees to measure engagement and comprehension of current benefits.

**Chart E: Employee financial wellness needs**

<table>
<thead>
<tr>
<th>Education planning</th>
<th>Estate planning</th>
<th>Risk management/insurance</th>
<th>Investments</th>
<th>Retirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Only 44-52% of employees who plan to fund education are either investigating how much they will need or actually contributing to a savings plan</td>
<td>39% of employees have a will with that increasing to only 50% by age 64</td>
<td>A little more than half of all employees have disability insurance, 56% of boomers and Gen Xers have coverage while only 42% of millennials do</td>
<td>Only 48% of all employees are comfortable selecting investments that are right for them</td>
<td>27% of employees are not currently saving for retirement</td>
</tr>
</tbody>
</table>
Technology-driven change

The use of technology to improve the consumer experience and simplify the lives of HR department staff is expected to continue in earnest. The market is brimming with new and competing providers due to low barriers of entry, as well as continued investments from the financial community. This is creating unprecedented growth in technology companies, but also creating service challenges. For employers, the task is finding which technology providers and products will best serve their strategic objectives, and assist employees in making informed decisions.

Innovation through technology

Historically, innovation has come in the form of private exchanges, benefits administration platforms, and enrollment portals. While each has had varying degrees of success in moving the industry to the digital realm, they have not directly impacted health care costs. Future innovation will come in the areas of employee communications, health care transparency, wearable devices, decision support tools, and mobile and chat capabilities. These innovations will serve to increase employee engagement, both in their health decisions and financial wellness aptitudes (Chart F). Employers that keep their focus on data, transparency, and engagement will have an advantage over their peers.

We also anticipate there will be further consolidation and partnerships of companies to drive scale and fill gaps in business models. These partnerships will join together organizations that historically had no relationship, or perhaps even a competing relationship, within certain product lines. These relationships are sometimes referred to as an “app,” which is a term designed to reflect a certain level of connectivity amongst these different companies, as opposed to an “app” that is downloadable on a mobile device.

Expect to see more solution providers offering “real-time” data connectivity through application program interfaces (APIs). Instead of waiting a week for data to transfer though a traditional interface between systems, the data exchange occurs immediately. For example, these channels will allow a traditional payroll company to interact in real time with a trendy recruiting solution that incorporates social media and other engaging technologies. Or, an API may manifest itself as a more seamless and expanded experience between your benefits technology outsourcer and carriers.

ACA reporting

In 2015, the ACA’s reporting requirements resulted in an unprecedented rush to HR technology companies. Complying with the requirements demands clean and accurate workforce data; unfortunately, many employers discovered they had incomplete or incorrect information spread across multiple technology systems or internal records. Employers looked to change, enhance, or add to their technology solutions in order to more easily meet the ACA reporting requirements.

Most human capital management (HCM), payroll, human resources information systems (HRIS), and benefits administration providers added ACA compliance tools. Many of these providers developed their own integrated ACA solutions, while others partnered with a third-party provider.

Some standalone ACA compliance technology solutions are also available. These can be accessed directly, regardless of other existing HR technologies (or

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Chart F: Changes to employee benefit plans over next five years

<table>
<thead>
<tr>
<th>Change Description</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Greater focus on individual consumers and their engagement in health care decisions</td>
<td>28%</td>
</tr>
<tr>
<td>Greater use of health data to evaluate benefit plan performance</td>
<td>36%</td>
</tr>
<tr>
<td>Greater emphasis on cost/pricing and quality transparency</td>
<td>38%</td>
</tr>
</tbody>
</table>
lack thereof). Standalone solutions are appealing for employers with complex needs, such as union populations or significant part-time or variable-hour employee populations, who desire a partner that is solely focused on ACA compliance. These employers often need help aggregating and interpreting data from multiple-source systems. Standalone solutions are also adopted by clients who have little to no existing HR technology in place.

Our recent Benefit Analytics and Benchmarking Study17 showed that:

- 48% of employers looked to their existing payroll, HRIS, HCM, or benefits administration systems for ACA reporting solutions. Standalone providers were accessed by 20% of employers.

- Regardless of the chosen path, the first round of reporting was challenging for employers and HR technology firms alike. More than half of employers (51%) cited the complexity of the legislation as the most challenging aspect of 2015 ACA reporting, followed by issues with data at 25%.

- Many ACA technology providers shared that their biggest challenge was working with the IRS, as the reporting rules continued to evolve and the IRS developed electronic systems to receive and process the data.

The ACA technology market is still fairly unsteady, and it will take some time to stabilize. Most ACA technology providers, whether standalone or integrated within another platform, are enhancing their products, clarifying their service models, and better defining their scope. We expect 2016 reporting (due in early 2017) to go much more smoothly for employers and ACA technology providers alike.

According to a recent poll,18 56% of companies intend to stay with their current solution at least through 2016 reporting, and of those, nearly 39% indicated they were unhappy with their solution but would stay the course anyway (Chart G). Many employers who had challenges are cutting their providers some slack for year-one reporting, but expect improvements going forward. If those improvements aren’t realized, we anticipate many employers will reevaluate their options in early 2017.

### Plan of action:

- Stay focused on the basic needs of your company.
- Define your strategy.
- Do a “market check” on technology solutions to stay apprised of the latest innovations.
- Don’t get caught up in the latest “shiny” product without appropriate due diligence.
- Begin exploring mobile tools to determine how they can impact employee engagement, recruiting, and retention.
- Stay actively engaged with your technology providers at a partnership level.
- Consider evaluating a new solution if your 2016 ACA reporting process experiences significant challenges.
- Evaluate HR technology options if you have current gaps or a lack of technology, specifically within the benefits administration functions.
- Monitor your overall HR technology strategy, particularly if you expect significant growth within your organization.

### Chart G: How are you planning to accomplish 2016 ACA reporting?

<table>
<thead>
<tr>
<th>Option</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>I am going to do it myself</td>
<td>80</td>
</tr>
<tr>
<td>I am happy with my solution, and I’m sticking with it for another year</td>
<td>135</td>
</tr>
<tr>
<td>I am not happy with my solution, but I’m sticking with it for another year</td>
<td>56</td>
</tr>
<tr>
<td>I haven’t decided</td>
<td>57</td>
</tr>
<tr>
<td>I have selected or am planning to select a new solution</td>
<td>36</td>
</tr>
</tbody>
</table>

17 Wells Fargo Insurance Services USA, Inc., Benefit Analytics and Benchmarking Study. 2016.
18 Wells Fargo Insurance Services USA, Inc. “Lessons learned and best practices for ACA Reporting” Webcast poll, September 15, 2016.
Delivery of health care

Technology is certainly driving changes to both the employer and employee benefits experience. It’s also a trend that’s changing the delivery of health care, along with consumerism, cost-containment strategies, medical management, value-based pricing models, and the addition of narrow networks and reimbursement models.

This integration of technology will continue to change the face of health care delivery for the foreseeable future.

Technology

Telehealth and virtual care: This type of technology provides patients with convenient access to health care services. A wide range of care, such as lactation support, diabetes counseling, urgent and acute care, and pharmacy medication management is available. These technology-driven services can also improve the patient experience, via ways such as allowing monitored physical therapy in the comfort of a patient’s home. Many employers that have implemented a telehealth and virtual care strategy have seen a positive return on their investment through the reduction of high-cost services.

Digital tools: This type of technology is also becoming widespread, and includes tools for treatment as well as decision support for employees. As employers have embraced new technology to comply with ACA reporting requirements, and conduct electronic benefits administration and online enrollment, these systems have also included various resources for employees. These include benefit election tools, electronic links with pricing transparency information, and medical treatment support.

Lifestyle management tools: Technology plays a valuable role in lifestyle management. Devices can help employees monitor sleep patterns, exercise, nutrition, and a host of other data points that allow them to focus on healthy behaviors. Fitness bands are expected to hold a majority of the market share, followed by smart watches and other wearable health devices.

Monitoring tools or “therables”: Technology also increases the options in care management for employees with chronic conditions and therapies. For example, a patient can wear a device to help monitor blood sugar levels, heart rhythms, hydration, or stress levels, and to ensure proper management of their health condition. These wearable therapy devices are often referred to as “therables.” In addition, highly sophisticated digital portals are becoming widespread, which allow patients to share information and access virtual support and second opinions for medical treatment decisions.

Technology security: In 2017, this area will continue to see challenges. The Internet of things (IoT) is the network of devices embedded with electronics, software sensors, or network connectivity to collect or exchange data on the internet, such as wearable therapy devices. The vision of IoT has evolved to support the integration of technologies including real-time analytics, sensor networks, and wireless communication. Obviously, the application is much broader than health care, and with the continuing addition of more “things” connected to the network without sufficient security, it creates a precarious situation for protecting data. More resources will be needed to thwart threats and protect systems and data. The IoT has already shown its vulnerability, with hackers bringing down the internet by flooding servers with a very high volume of requests from a large group of internet protocol (IP) addresses.

Cost-containment strategies

Employers are becoming much savvier about cost-containment strategies and medical management. Bundled payments, referenced-based pricing, and centers of excellence will be topics leading many conversations for larger, self-funded employers. The discussion beyond value-based pricing models will include claims and vendor audits, and a renewed focus on medical management.

Bundled payments: This model reimburses health care providers (such as hospitals and physicians) on the basis of expected costs for clinically defined episodes of care, similar to the diagnosis-regulated groups used for hospital reimbursement by the Centers for Medicare & Medicaid Services since 1983. Such payments have been described as a hybrid between fee-for-service reimbursement, in which providers are paid for each service rendered to a patient, and capitation, in which providers are paid a “lump sum” per patient regardless of how many services the patient receives.
Reference-based pricing: This model encourages employers to set a pricing cap on the maximum amount they will cover for certain medical services that may have wide cost variations in a given geographical location, such as imaging tests or knee replacement surgery. In the near future, employers may partner with providers who have developed a process for determining the reference-based price structure, and who will contractually guard against providers billing the employee for the balance.

Centers of excellence: As larger, self-funded groups look to combine various medical economic solutions, they will put an increasing focus on determining centers of excellence and the related travel to get to those destinations. Bundled payments or reference-based pricing, domestic medical tourism, second opinion, and positive clinical outcomes through strict medical management can all be achieved by utilizing a center of excellence.

Audits and medical management: Self-funded employers will also be seeking tools to better help them assess, manage, and mitigate their health care costs, including claims and vendor audits. They will scrutinize how their health care dollars are spent, and ultimately want to know if the services provided are bringing value to the company. There will also be a renewed concentration on medically managing the entire population by mitigating risk, and focusing on managing the population currently utilizing the health care system. Reevaluation and a tighter management model will be required to help an employer determine how they have been managing employees with chronic conditions, and the catastrophic, high-cost claimants who drive the vast majority of their overall health care expenditures.

Smaller networks, PCMH and ACOs to control care and cost

Narrow networks: These are gaining in popularity and drive savings through a tighter network of practitioners, specialists, and place of service. In some networks, those providers are lower cost, while in others they may be of higher quality. Benefits may be “tiered,” meaning that the number of providers isn’t restricted, but individuals seeking care from high-quality providers will incur less out-of-pocket costs than those visiting a less cost-effective provider. According to our 2016 Strategy, Actions, and Behaviors Study, 13% of employers said they would reduce the size of their provider network in 2017.

Patient-centered medical home (PCMH): Some insurers are also combining a narrow network with a PCMH, which is a team of care providers accountable for a patient’s holistic, physical, and mental health needs. This includes acute care, prevention and wellness, and chronic care. Care is coordinated across all elements of the broader health care system, including specialty care, hospitals, home health care, and community services. Patients are typically able to access services with shorter waiting times, and are typically eligible for immediate “after hours” care and 24/7 electronic or telephonic health guidance and care. This is made possible by creating a strong communication network and electronic medical record, which is available to all caregivers. Clinicians and staff work to enhance quality improvement to ensure that patients and families make informed decisions about their health.

Accountable care organizations (ACOs): ACOs are groups of doctors, hospitals, and other health care providers who partner to provide synchronized, high-quality care to their patients. Some ACOs function under one roof, while others may be connected through referral patterns. Instead of focusing on the volume of services, the goal of an ACO is to focus on quality and value. When done correctly, an ACO ensures that patients receive the right care at the right time, without the need for duplicative or excess services. Most carriers are now offering this as part of their portfolio of network options. In some markets, the cost for ACO options can be up to 8-16% less expensive than their open-access counterparts.

While these options provide different ways of delivering care, some employers have yet to embrace them, as local-based care can be difficult for multi-state employers to implement. Other employers have asked themselves whether they want to be in the care direction business. Each employer needs to weigh many factors.
At the workplace

**Onsite clinics:** While not a new concept, onsite clinics continue to grow in popularity. Considering both the expense and diminished satisfaction levels with the current health care system, the trend is an understandable one as employers seek to provide better options for employees’ health care. Employees find value in the convenience, and improved, personalized health care delivery experience. Employers are realizing the restructured health care offering is timelier, with more clinically effective care. This increases compliance, satisfaction, and employee productivity. Employers are also seeing the benefits of onsite clinics in mitigating or reducing their overall health care expenses.

**Lifestyle modification and wellness programs:** These types of programs continue to underpin the foundation of prevention. Recently enacted regulations have made guidelines for these programs more substantial when administering a plan, but recently filed court cases challenging those regulations will play out through 2017. Benefits compliance teams are challenged to distribute the information in a timely and valuable fashion. Regardless of the legal considerations, the benefits of promoting health improvement have not diminished.

**Voluntary benefits:** These offerings continue to be attractive for both employers and employees. When voluntary benefits are offered at work, employees can choose the right coverage for their needs, at a lower cost than what they could purchase on their own. As companies increasingly settle in with high-deductible health plans (HDHP), they are realizing the value of voluntary benefits as part of their overall package in helping to bridge the gap of increasing deductibles for employees.

**Bricks and mortar**

The traditional health care delivery system still plays an important role in a comprehensive care strategy. However, more brick-and-mortar options are available today than ever before. Patients can visit convenience care clinics in many grocery stores or pharmacies across the country. While not an option for conditions requiring extensive care, they are quick and convenient for minor illness and issues. These alternative settings are becoming more attractive to consumers, particularly as access to primary care becomes more difficult.

The role of the primary care physician may be evolving, but the importance of the family physician and mid-level clinician is still paramount to a cohesive and thorough care plan. For a more immediate need and higher level of care, urgent medicine is the solution. Urgent care is one step above a convenience clinic for complexity of care, but remains a step below an emergency room experience. While urgent care centers and retail clinics have increased the convenience level for consumers, their growing use has been a factor in keeping medical trend at an inflated rate. Ambulatory surgery centers are generally a lower-cost option than surgery at a hospital operating room. However, for the highest level of care, and equally the most expensive driver of cost, hospital systems are still a mainstay of our health care delivery.

Options and innovative solutions remain the trend for health care delivery in 2017. It is important to offer efficiency, cost effectiveness, and the ability to receive care when and how employees want to receive it.

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**Plan of action:**

- Review your current provider networks and how care is reimbursed in that network.
- Review your current medical management programs.
- Explore accountable care organizations and/or patient center medical homes.
- Review employee cost-sharing requirements for urgent care/retail clinics/telemedicine.
Pharmacy

Costs for pharmaceuticals have risen for the past few years (see Chart H), and that trend is anticipated to continue through the remainder of the decade. Several factors are driving the increase in costs: manufacturers raising prices and the changing the composition of drugs, the growth in specialty medications, the consolidation of pharmacy benefit managers (PBMs), and increased utilization driven by poor overall health.

- While medical claim trends for employer plans have been fairly stable as shown in Chart B on page 8 of this report, prescription drug claim trends have risen sharply since the beginning of 2014 (Chart H), and will remain high in 2017. Pharmacy trend consists of four main dynamics: drug price inflation, specialty medications, patent expirations, and the impact of direct-to-consumer advertising.

- According to the Express Scripts 2015 Drug Report, specialty medications account for 37.7% of total drug spend, and costs are expected to increase to 50% by 2018. While specialty pharmacy is not new, specialty medications have gotten the most scrutiny recently because of their substantial price tag, and because there are many more of them in circulation today.

- Twenty-three percent of employers said they will put greater focus on utilization and coverage of specialty pharmacy. Further, the majority of the pharmacy pipeline consists of specialty drugs, so while no major drug is threatening to dominate costs, specialty drugs will require additional monitoring.

- Fewer drugs have come off patent in the last two years, driving costs. We forecast that composite prescription drug claim trend could remain approximately 13% for the next year (Chart H).

Chart H: Prescription drug claim trends

Prescription drug costs were a primary topic on the presidential campaign trail for Donald Trump, but since the election, the issue has not been addressed and has been removed from the list of key agenda topics on his website. Employers looking for government intervention or relief in this area may not see action this year.

Plan of action:

- Review your current benefit design and pharmacy data.
- Review your current PBM contract to ensure that the most aggressive unit cost and appropriate-use strategies are in place.
- Ask your current PBM what measures are in place to review providers that may have opioid prescribing issues.
- Utilize evidence-based prior authorization and ensure price protection provisions are included for specialty pharmacy.

19 Wells Fargo Insurance; National Healthcare Claims Trend Survey, Fall 2016
The health care industry’s transformational era continues 2017 Employee Benefits Market Outlook

Conclusion

The cost of employee benefits plans accounts for a significant portion of a company’s expenses, and pressures on those costs continue. As their workforce transforms, diversifies and fragments, employers should understand their benefits offering will have to evolve as well.

With costs expected to increase in 2017 for many companies (Chart I), it’s critical for employers to explore any and all solutions to determine how they can impact their cost trajectory, while still attracting the key talent needed to be successful.

How can we help?

Wells Fargo Insurance can help employers navigate the complex world of employee benefits by developing strategic programs that provide the best value for your business in 2017 and beyond. For more information, please contact your local Wells Fargo Insurance sales executive or visit us online at wfs.wellsfargo.com.

Chart I: 2017 health care costs change estimate after all potential revisions have been made to the plan compared to 2016

- **69% Increase**
  - Increase by 10% or more
  - Increase by 5 to 10%
  - Increase by up to 5%
  - No change
- **13% Decrease**
  - Decrease by 5% or less
  - Decrease by 5 to 10%
  - Decrease by 10% or more

*10% higher than those expecting an increase in 2016

Additional Resources

- Wells Fargo Insurance “2016 Strategies, Actions, and Behaviors Study: Perspectives from the C-suite and HR/Benefits Managers”
- Wells Fargo Insurance “Benefits Benchmarking and Analytics Study”
- Wells Fargo Insurance “Using voluntary benefits to improve employee financial wellness and your bottom line”
- Wells Fargo Insurance “A balancing act: Managing specialty medications and mitigating spending”
- Wells Fargo Insurance “The role of employer-based onsite clinics: Total population management strategy”

Wells Fargo Insurance Contributing Authors:

- Dan Gowen, National Practice Leader, Benefits Strategy & Market Relations
- Nick Allen, National Practice Leader, Customer Analytics & Actuarial Services
- Jenny Bedeaux, National Practice Consultant, Benefits Technology
- Jeanne Brandon, National Practice Consultant, Voluntary Benefits & Enrollment Solutions
- Holly Halter, Employee Benefits Product Manager
- Debbie Hancock, Benefits Specialty Customer Consulting Leader
- Frasier Ives, National Practice Leader, Benefits Compliance
- Jeanne Langlois, National Practice Consultant, Health & Productivity
- Julie McFarland, National Practice Consultant, Benefits Technology
- Melissa Tucker, National Practice Consultant, Clinical Solutions