FRESH PERSPECTIVES ON GROUP BENEFITS
THE LATEST THINKING FROM PLAN SPONSORS, MEMBERS AND INSURERS

ACCOMPASS RESEARCH 2017
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OPPORTUNITY—BEYOND BENCHMARKING

Change is a constant. And it’s no surprise that the group benefits landscape continues to shift beneath our feet. Rising costs, new treatments, boomer retirements and the rapid rise of a younger generation of employees is changing wants and needs—for both employers and employees.

It raises some important questions:

- Is there a gap between what plan members hold valuable in benefits plans versus what plan sponsors believe is valuable?
- Are plan sponsors maximizing value for their benefits plan spend, from both this employee “perceived value” perspective and from the standpoint of meeting their organization’s goals for offering a plan?
Clearly, for employee welfare and improved productivity goals, knowing what plan members want and need are critical considerations. But even for the 40% of organizations that offered a plan for competitive reasons, benchmarking alone may not suffice in ensuring competitiveness, as shifts in wants and needs can change the perceived value of benefits.

We’re pleased to provide some insights, from several different angles. Our report is based on three surveys conducted in late 2016 and early 2017—of insurers, plan sponsors, and individual Canadians, including individuals who don’t currently participate in a benefits plan.

The results of this research are not meant to be prescriptive—as every organization has different needs, a different workforce, and is in different competitive positions. They are, however, designed to help you be more strategic in your actions, and we encourage you to consider this information through the lens of your benefits plan’s unique goals and purpose.
OVERALL SATISFACTION LEVELS

Yes, even millennials want benefits
Our research provided good news when it comes to plan member satisfaction with their benefits plan.

**PLAN MEMBER SATISFACTION WITH THEIR BENEFITS PLAN**

94% of plan members say that their benefit plan very much (58%) or somewhat (36%) meets their needs. That number is consistently high across all generations in the workforce.

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<th>Satisfaction Level</th>
<th>Percentage</th>
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<tr>
<td>Very much</td>
<td>58%</td>
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<tr>
<td>Somewhat</td>
<td>36%</td>
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**WOULD YOU ACCEPT A JOB THAT DIDN’T OFFER BENEFITS?**

It’s clear that once people gain benefits coverage, they don’t want to lose it. For individuals who currently have benefits coverage, 80% say that they wouldn’t accept a job that didn’t offer benefits. This compares to just 50% of people who don’t currently have benefits.

**Individuals who currently have benefits coverage,**

80% say that wouldn’t accept a job that didn’t offer benefits.

**Individuals who currently don’t have benefits coverage,**

50% say that wouldn’t accept a job that didn’t offer benefits.
WHAT PLAN MEMBERS WOULD LIKE TO IMPROVE

If there was anything to change, here’s what plan members would like to improve when asked for their top two priorities:

- **30%** Higher limits
- **25%** Easier claims process
- **24%** New types of coverage
- **24%** More flexibility
- **20%** Reduced co-pay or deductible
- **20%** Expanded list of drugs covered

While many of these are obvious expectations for a plan member wish list (more coverage, higher limits) the ranking of “easier claims process” at #2 suggests that plan sponsors should continue to factor “process” into benefit plan improvements, as “ease of use” is clearly of value to plan members. It’s notable that among the youngest generation of workers (Gen Z from ages 18 to 24) “easier claims process” was the number one desired improvement (35%), outranking higher limits and new types of coverage.
THE DESIRE FOR WELLNESS

As group benefit plan costs rise, health promotion through wellness programs continues to be an area of interest, for plan sponsors and plan members alike. So what do plan members want? We asked them to pick up to three wellness benefits that they would value from a list of six. Here’s what we found:

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<thead>
<tr>
<th>Benefit</th>
<th>Percentage</th>
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<td>Gym or subsidized gym membership</td>
<td>51%</td>
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<tr>
<td>Personal financial planning</td>
<td>27%</td>
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<tr>
<td>Subsidized healthy food/juice bar</td>
<td>25%</td>
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<tr>
<td>Onsite health assessments</td>
<td>20%</td>
</tr>
<tr>
<td>Nap/meditation/prayer/yoga room</td>
<td>19%</td>
</tr>
<tr>
<td>Games room</td>
<td>15%</td>
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A GENERATIONAL PERSPECTIVE

Here’s what we found from a generational perspective:

- A gym membership was the top pick of every generation.
- A games room was ranked as least favoured by millennials (ages 25 to 34) and Boomers (age 55 and older)—and was ranked either last or second last by every generation.
- An onsite health assessment was least favoured by Gen Z (ages 18 to 24) and Gen X (ages 35 to 54).
WHAT PLAN SPONSORS WOULD CONSIDER

We gave plan sponsors the same wellness options, and asked them what lifestyle or wellness benefits they don’t currently offer that they would consider offering in the future. Here’s what plan sponsors would consider.
HOW WELLNESS WISHES FOR PLAN SPONSORS AND PLAN MEMBERS COMPARE

Based on these results, the wishes of plan sponsors and plan members overlap in three ways:

1. The desire by plan members to have gym memberships (or subsidized gym memberships) and the willingness of plan sponsors to consider providing this.
2. A desire for and willingness to consider providing personal financial planning.
3. The lack of interest in using or providing a games room.

THE DISCONNECT BETWEEN PLAN SPONSORS AND PLAN MEMBERS

The disconnect comes with the strong desire of plan sponsors to consider onsite health assessments (this was valued by only 20% of plan members), and the desire of plan members for healthy food at work (which would only be considered by 14% of plan sponsors).

The mechanics of providing healthy food at work is likely one factor in the low potential uptake by employers, despite the desire of employees. And while employees don’t express a high value for onsite health assessments, such programs could provide important direction for plan sponsors in choosing future wellness or benefit offerings—future initiatives that employees might ultimately value down the road.
Personal financial planning is another wellness initiative [ranked highly by both plan members and plan sponsors] that could yield direct benefits, as money matters are clearly a source of stress in the population. A national 2014 survey conducted by Leger found that 42% of Canadians rank ‘money’ as their greatest stress, far surpassing stress caused by work (23%), personal health (19%) and relationships (17%). Other studies have yielded similar results. With high degrees of stress linked to both physical and mental health problems, financial planning as a benefit at work could be a win-win for employers and employees alike.

In our 2016 report, we outlined one of the key issues with wellness programs—the fact that on average only 11% of plan members are regular users, and many of those are already among the healthiest employees. Less than a third of those with poor or very poor health participate at all.

This is not to say that wellness programs are not a good investment—only that they must be very strategic in their design and implementation to be effective, and too many are not. For this reason, the results of our survey concerning wellness benefits must be considered in light of the unique needs of your workforce.

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2 2015 Sanofi Canada Healthcare Survey
WITH WELLNESS IN MIND

What’s the best way to deliver?
Wellness programs as part of a group benefits plan is hardly a new concept, but interest and belief in these programs remains high.

When we asked plan sponsors: “Do you believe that an investment in wellness can prevent or manage chronic illness and ultimately reduce benefit costs (both in medical as well as disability)?” 90% of respondents said that this type of investment in wellness would “very much or somewhat” prevent or manage chronic illness and reduce costs (nearly 57% said “very much”).

FINANCIAL HEALTH OF EMPLOYED CANADIANS

And there are wellness/lifestyle areas—such as financial health—where employees across Canada could clearly use help and support. For example, almost half (48%) of Canadians say it would be difficult to meet their financial obligations if their pay was delayed by just one week—and 24% state that they likely could not come up with $2,000 if an emergency arose in the next month.3

At the same time, three-quarters of plan sponsors (76%) said that they would not reduce existing benefits in order to add lifestyle or wellness benefits. It’s clear that if wellness initiatives are added, this would be a new cost in most cases, with hope for benefits savings down the road.

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3 2016 Canadian Payroll Association Research Survey of Employed Canadians
Plan members were also reluctant to reduce existing benefits to gain more wellness options, although the answers varied across generations, with a greater willingness in younger generations to reduce existing benefits.

**PLAN MEMBERS WHO WOULD BE WILLING TO REDUCE OR ELIMINATE EXISTING BENEFITS TO GET ONE OR MORE WELLNESS BENEFITS**

<table>
<thead>
<tr>
<th>Generation</th>
<th>Willing to Reduce or Eliminate</th>
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<tr>
<td>Gen Z (18-24)</td>
<td>45%</td>
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<tr>
<td>Millennials (25-34)</td>
<td>41%</td>
</tr>
<tr>
<td>Gen X (35-54)</td>
<td>37%</td>
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<tr>
<td>Boomers (55+)</td>
<td>25%</td>
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With group benefit plan costs rising each year, it’s asking a lot of organizations to add new costs by implementing wellness programs, even if it leads to cost savings years later. However, our research brings into question whether at least some dollars allocated to Health Spending Accounts (HSAs) may in some cases be better allocated to more directed wellness benefits.

One thing is clear—HSAs remain a hot topic, with some seeing them as a central cog in their plan designs. And there are several reasons why the benefits industry and plan sponsors want to make them work:

- They maximize flexibility for employees;
- They can simplify plan design;
- They provide some cost certainty for the employer.

**COULD A REALLOCATION FROM HEALTH SPENDING ACCOUNTS BE THE ANSWER?**
But the HSA may not be the best fit for every group plan. Previous research has found that HSAs are under-used when part of a benefits plan. In a 2015 survey, more than half of plan members (57%) with HSAs did not use them at all in the past year, and those who did used only 50% of the funds available on average.4

**TOP BENEFITS TO BE REDUCED OR ELIMINATED BY EMPLOYEES**

Our 2017 research suggests that HSAs are also under-valued by employees. Almost 1/3 of employees (29%) who currently have benefits said they would be willing to reduce or eliminate an existing benefit to cover the cost of a wellness benefit. The HSA was the top pick to be reduced or eliminated.

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4 2016 Canadian Payroll Association Research Survey of Employed Canadians
WHAT BENEFITS ARE MOST VALUED

This is consistent with results of a subsequent question on what current benefit plan members valued the most. Dental and prescription drug coverage were first, with each ranked number one by 30% of respondents. The HSA was last at 5.9%. Indeed, the HSA was also the least desired benefit for those who currently don’t have coverage. When Canadians who did not currently have benefits were asked which benefits that they would value most in a benefits plan, dental, paramedical, drug, and vision care topped the list (ranging from 44% to 62% of respondents) with health spending accounts finishing last at 24%.

CANADIANS CURRENTLY WITHOUT BENEFITS

62% 48% 45% 44% 37% 24%
Dental Paramedical Vision care Insurance HSA
coverage (chiro, prescription drug coverage coverage life, disability) care coverage)

PLAN MEMBERS CURRENTLY WITH BENEFITS

30% 16% 30% 7% 8% 6%
Dental Paramedical Prescription Vision care Insurance HSA
coverage (chiro, drug coverage coverage life, disability)

5 Not every plan offers an HSA, which was a partial contributor to this low percentage.
Despite the low usage and “perceived value” by employees, the industry continues to push forward with new HSA-based plans. But could the current move to Health Spending Account-based plans be the same as the move to defined contribution (DC) pension plans in the 1990s?

At that time, defined benefit (DB) plans were seen as poorly designed for the modern mobile workforce, and an “employer knows best” approach that was condescending to employees. Employers wanted to rid themselves of funding uncertainty, and employees were happy to get lump sum contributions that they could “invest for success” and carry with them to their next job.

Fast forward 20 years and the guaranteed lifetime income that DB plans deliver is the gold standard for retirement financial health, and the complexity of saving enough and investing well in the DC plan environment has created enormous challenges, so much so that the DC retirement industry is pursuing target benefit plan arrangements that focus on both investment returns and income delivery.

With the actual usage and perceived value of the HSA so low, are we reaching a similar tipping point on the benefits side? Could it be that HSAs—while offering great flexibility—simply don’t offer enough solid, guaranteed coverage?

With current plan members expressing a desire for wellness benefits such as gym memberships (51%), personal financial planning (27%), subsidized healthy food (25%) and onsite health assessments (20%), employers have room to be more directive in terms of where they allocate their benefit dollars. Plan sponsors with an HSA might consider channeling those HSA dollars into more directed wellness benefits that could improve the life and health of employees.

Which begs the broader question: with seemingly modest value and low usage stats, is it time to rethink the role that HSAs play in benefit plan design? For plan sponsors, that question is well worth considering.
THREE REASONS WHY HSAs MAY NOT BE HIGHLY VALUED

NOT KNOWING IT’S THERE
To use an HSA, employees need to remember that they have one. With so many plans now automating the health expenses reimbursement process (drug cards, electronic submission of dental claims), employees have to work a little harder with an HSA. If communication isn’t constant, too often the HSA is out of sight, out of mind.

NOT KNOWING HOW TO USE IT
E-claiming and drug cards have simplified the reimbursement process, but HSA claims can be “one off” events that require employees to “find out” how to claim and use their HSA benefit in some cases original receipts need to be mailed in with the claim. This is an additional barrier that could partially explain low usage rates.

EMPLOYEES NEED TO UNDERSTAND FORFEITURE RULES
HSA account balances don’t last forever. Employees need to be educated about the forfeiture rules, and be reminded if account balances are getting close to expiring. With the “use it or lose it” tax rules, too often employees forget and “lose it.”
TRENDS IN PLAN USE

Costs and controls
While wellness initiatives and HSA usage are important discussion topics, prescription drug coverage and dental benefits are the benefits valued most by plan members.

For both benefits, 30% of plan members cited it as their most valued in our survey—almost twice the next most valued benefit (paramedical, at 16%).

Of course, prescription drug trends also drive plan expenses more than any other benefit. As such, trends in drug plan use, costs, and controls are important ones to monitor. For this reason, we ask Canadian insurance companies each year about their group benefit offerings, with a primary focus on drug coverage and cost-management solutions. Here are highlights of our findings.
In 2017, the average insurance company health trend factor (the year-over-year cost increase or decrease) remains in the 11% to 12% range—in line with previous years dating back to 2012. While these costs increases are far ahead of inflation, the cost trends you experience will be unique to your organization. At Accompass, our clients often see trends that are 3% to 4% lower than the average carrier trend factor.

2016 INFLATION TRENDS

1.4% CPI Inflation
1.3% CPI Health Care
2.52% Employers’ Average Increase in Salary Budget
5.6% Insurers’ Dental Trend Factor (excluding fee guide)
11.8% Insurers’ Drug Trend Factor
11.7% Insurers’ Health Trend Factor

RISING COSTS—THE 2017 HEALTH TREND FACTORS

Biologic drugs continue to be most expensive on a cost of claims basis. Last year, we reported that Harvoni—the Hepatitis C biologic drug—was one of the top three most costly drugs in many private plans. Because Harvoni is a cure for Hepatitis C in as little as eight to twelve weeks, we anticipated that it would not stay at the top for long.

Indeed, Harvoni is no longer listed by any insurer in the top three drugs by cost of claims. However, Remicade and Humira continue to top the list, despite the fact that subsequent entry biologics like Inflectra are now on the market. Other drugs making an appearance on the top three drug list by cost of claims are Enbrel, Stelara, and Concerta.
Pharmacogenetics matches medications and doses to a person’s genetic makeup, with the goal of improving the success of prescribed medications. It’s an emerging area that’s being carefully assessed. One insurer has begun integrating it for LTD claims, and another insurer is considering the possibility of including such testing in the future. It remains an important area of treatment innovation that we are watching closely.

While annual prescription drug cost increases have come down from their 15% levels pre-2012, costs are still a major concern. A number of cost management strategies are readily available from insurance providers—and can make a significant positive impact in terms of controlling rising plan drug costs. These include:

- **Mandatory generic**
- **Step therapy**
- **Managed formularies**
- **Fixed formularies**

The use of tiered managed formularies has increased slightly, with one insurer reporting 15% to 25% of their clients now using a two or three-tiered managed formulary. However, most insurers still report their uptake of tiered managed formularies at 5% or less of their private payor clients.

With drugs representing such a significant portion of overall plan costs, it’s important to stay on top of cost-management developments, and to make use of the solutions available to you.
CHRONIC ILLNESS MEDICATIONS—A COMPETITIVE ADVANTAGE TO THOSE WHO COVER THEM?

While the treatment of plan members who have a chronic health condition can certainly increase plan costs, proper coverage is a small price to pay to have healthy, productive employees at work, rather than on disability or sick leave because of poorly managed conditions.

In addition, offering a benefits package that includes coverage for chronic illness medications without a drug cap could be a key competitive advantage. Employers who offer such coverage could be drawing from a wider pool of talent, compared to those organizations that are tempted to introduce lower drug caps as a measure to control drug plan costs.

A notable finding from our survey of individual Canadians is the startling difference between those who have a benefits plan and those who do not, as it relates to taking medication for chronic health conditions.

<table>
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<tr>
<th>26%</th>
<th>42.5%</th>
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<td>of Canadians without a benefits plan currently taking medication for a chronic illness</td>
<td>of Canadians with a benefits plan currently taking medication for a chronic illness</td>
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The results can mean two things, assuming the incidence of chronic conditions is equal across the population:

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<tr>
<td>1.</td>
<td>People who don’t have a benefits plan are less likely to take medication to treat their illness (affordability concerns)</td>
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<tr>
<td>2.</td>
<td>People with a chronic illness specifically choose employers who offer group benefits, so they can be reimbursed for the medication expenses they incur and can afford treatment</td>
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If the latter is true, employers with less restrictive prescription drug coverage for chronic conditions will be more attractive to prospective employees, and could enjoy a competitive advantage in the acquisition of talent.
INTERPRETING THE RESULTS

Through the lens of your plan strategy
Employers offer a group benefits plan to employees for a variety of reasons, and it’s important to view any research findings of interest through the lens of your organization’s specific reasons and plan goals.

But how specific are those reasons and goals? When asked whether they have a written group benefits document or “charter” that sets out their reasons for offering a plan and their goals for the plan, just 31% of plan sponsors said yes. This could be a missed opportunity for those without a plan charter, as clearly thinking through and setting out reasons and goals—and measuring against those goals—can help ensure that a group benefits plan meets its purpose and remains valued by employees, both now and in the future.

**TIMES WILL CHANGE, AND PLAN DESIGNS WILL CHANGE**

When plan sponsors were asked if their benefit plan design would be different in 10 years’ time, given evolving needs and trends, 100% said their plan design would be somewhat, quite, or very different a decade from now. Having a firm understanding of the foundational reasons for offering a plan can help guide these changes strategically, and ensure a good match between your benefit plan rationale and your plan design.

We trust that the information in this report will further you along this path—and we encourage ongoing discussion about the issues raised. If you have any questions about our findings, please talk to any of our Accompass benefits consultants.
ABOUT OUR 2017 SURVEYS

11
CANADIAN INSURANCE COMPANY PROVIDERS
In November 2016, we surveyed 11 Canadian insurance company providers of group benefits plans. The survey covered a number of areas, but focused primarily on benefit costs and drug trends, including the design and management of drug plans.

1,623
CANADIANS
In January 2017, we asked 1,623 Canadians their views on a range of group benefit plan issues, from what benefits they valued most, to their desire for wellness benefits, to how likely they would choose a job that didn’t include a benefits plan.

183
PLAN SPONSORS
In January and February, 2017, we reached out to 183 plan sponsors representing plans of every size—small, medium, and large—and asked for their input on a number of benefit plan topics, from how their plan meets organizational goals to whether they expect their plan to change in the future.