University of Nebraska

SENIOR VICE PRESIDENT AND CFO

November 21, 2016

Senator Heath Mello
Chair, Appropriations Committee
PO Box 94604, State Capitol
Lincoln, NE 68509

Dear Senator Mello:

LB 620, enacted during the 2013 legislative session, requires the University of Nebraska to present, on or before December 1 of each year, its plan regarding the management of the university's health care insurance programs and its health care trust fund to the Appropriations Committee of the Legislature.

Enclosed is the University's report for the year ended December 31, 2015. The report provides an overview of the University's health plan, chronicles financial activity for the year, and offers insights into the plan's trends.

The University of Nebraska is proud of the prudent management of its health plan, which has positioned us to provide competitive, affordable benefits to our employees – our greatest asset – and their families. These are challenging times for health care, but we are committed to offering quality health benefits that meet the needs of our employees and help us retain and attract additional talent for Nebraska.

If you should have any further questions about the University's plan, please do not hesitate to contact me.

Sincerely,

David E. Lechner
Senior Vice President and CFO

cc: Kathy Tenopir, Legislative Fiscal Office

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University of Nebraska
Health Insurance Plan Annual Report

Year Ended December 31, 2015

Executive Summary

The University of Nebraska's health insurance plan enjoyed good operating results during calendar 2015 as indicated by several measures. Most importantly, the Board of Regents and management were able to provide employees with a benefit that is highly valued by employees and prospective employees alike. In one national survey, 73 percent of workers said that the insurance provided by their employer was a "very important" factor in their decision to take or keep a job[i].

In 2015, the University's health plan costs increased $5.1 million or 4 percent when compared to the prior year and was primarily attributable to increased medical and pharmacy costs. Despite the cost increases, premiums offered to active employees did not change for 2015, reflecting the eighth time out of the last ten years that the University has not had to raise premiums for active employees.

Based upon strategic discussions with legislative leadership, University management, in concert with Board members, did not offer a premium holiday in December of 2015, as it had the previous two years. Instead, the premium holiday was deferred and offered in April, May and June of 2016. This change in timing is the primary reason for the $14.4 million, or 12 percent, increase in income for 2015 (2015 had twelve months of premium income, while 2014 had eleven months of premium income due to the premium holiday offered in December of 2014). The holiday was part of an overall strategy to draw down trust reserves while staying true to the purpose for which the trust was established.

The University of Nebraska is proud to provide a competitive, cost-effective health insurance plan to its employees and their families. We believe the University's plan is well managed, provides competitive benefits, and is favorably positioned to serve employees' future health needs despite the increasingly uncertain challenges facing the health care industry.

University of Nebraska Strategic Objective:
Recruit and retain exceptional faculty and staff

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Plan Overview

The University of Nebraska offers a preferred provider (PPO) "self-insured" health plan providing medical, dental, and pharmacy coverage to its employees. Most employers the size of the University are self-insured for medical coverage as it gives them more control over plan design. In addition, any 'profits', typically built into insurance company prices, are retained by the plan and its participants.

The University utilizes the expertise of the following outside parties to assist in the administration of the plan:

Entity	Description of Service Provided
BlueCross BlueShield of Nebraska	Third party administrator for medical and dental claims
CVS Caremark	Third party administrator for pharmacy claims
Wells Fargo	Trustee bank
Milliman	Independent actuaries – provide projections used to set premiums

The plan, which operates on a calendar year basis, collects premiums through payroll deductions from eligible, participating employees and combines them with employer (University) premium contributions. The plan deposits these funds into a trust account held by a trustee bank, Wells Fargo. Under state law, the Board of Regents is fully empowered to establish trust accounts, as they ensure the funds are protected and, in this case, can only be spent for health care purposes.

When covered employees and their dependents incur medical expenses, health providers (hospitals, doctors, pharmacies) send their bills to either (a) BlueCross BlueShield of Nebraska (BCBSNE) for medical and dental claims or (b) CVS Caremark (CVS) for pharmacy claims. BCBSNE and CVS, as third-party administrators, assure that the submitted claims are valid using coverage criterions, limits, deductibles and co-pays as set by the University. When BCBSNE and CVS pay claims, they are reimbursed by Wells Fargo, the trustee bank, for the claims cost plus a monthly administrative fee.

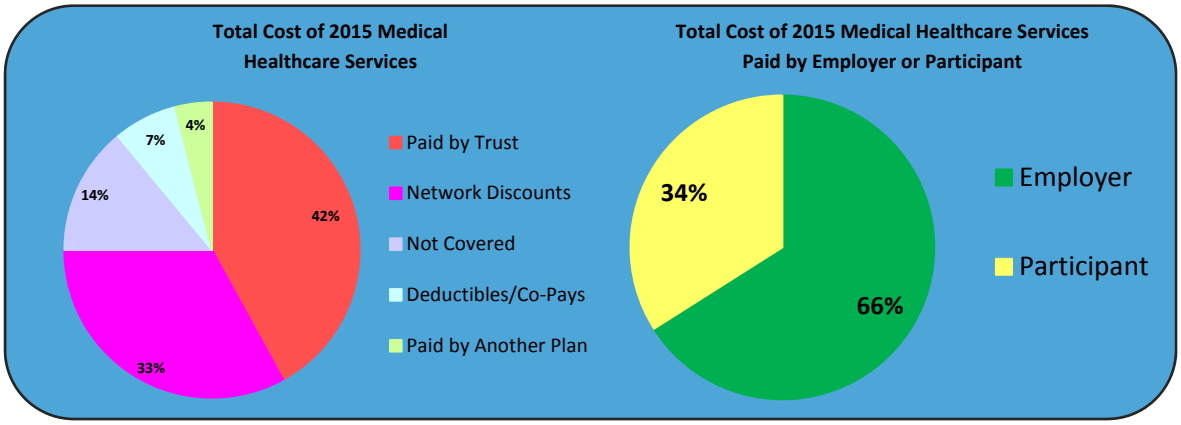
Premiums charged to both the employer and employees are designed to cover the plan's projected claim costs plus administrative expenses. Any potential changes in premiums, which become effective on January 1, are established by University management each fall after analyzing Milliman's actuarial expense projections, which are based on a combination of University internal experience along with Milliman's book of business experience. University management reviews the plan's projected premiums and anticipated expenses with the President and Chancellors before finalizing employee premiums for the upcoming year.

For the years ended December 31, 2015 and 2014, 78 percent of premium income was contributed by the employer and 22 percent of premium income was contributed by the employee. University employees selecting basic coverage pay between 20 percent and 29 percent of the total medical premium depending upon the coverage selected. While the University offers a variety of coverage options, a majority of the employees are enrolled in basic coverage for a

"family" or "employee+one", both of which have close to a 79 percent/21 percent employer/employee contribution ratio, as noted in the table below:

	2015 Monthly Premiums - Basic Coverage		
	Employee	Employer	Total
Family	$ 270	$ 1,091	$ 1,361
Employee+One	$ 212	$ 777	$ 989
Employee+Dependent(s)	$ 178	$ 580	$ 758
Employee Only	$ 132	$ 324	$ 456

It is also worthwhile mentioning that the healthcare costs paid by the health trust are but a portion of the total cost of healthcare services provided under the University's plan. A substantial portion of the cost of healthcare services is paid for by another plan (for example, Medicare), paid for by the participant through deductibles and co-pays, discounted through network agreements, or simply not covered, as demonstrated in the graphs below:



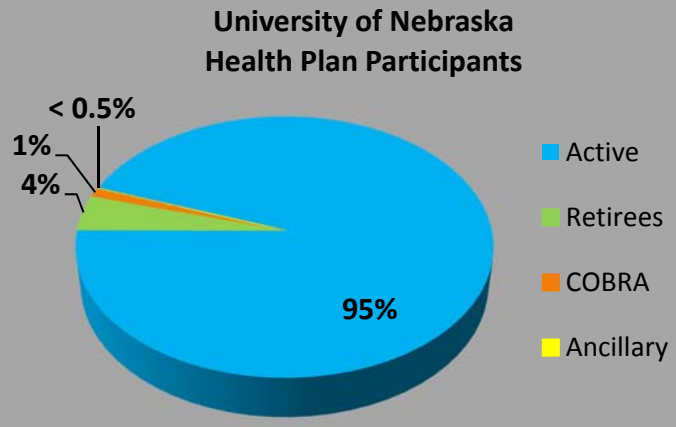
It should be noted that the total cost of 2015 medical healthcare services paid by the employer and participant is based upon amounts paid by the Trust and deductibles/co-pays paid by the participant. It is likely that the total cost of healthcare services paid by the participant is greater than 34 percent, as a portion of healthcare services "not covered" or "paid by another plan" were possibly costs ultimately borne by the participant.

Members of the Board of Regents are kept apprised of the plan's performance through updates provided to the Business Affairs Committee.

Enrollment and Demographics

The University's health plan had almost 11,300 participants as of December 31, 2015, about 200 more than the prior calendar year. When including dependents, the plan served approximately 26,100 covered lives.

Active employees, by far the largest membership group in the plan, and Cobra electees increased in 2015. Participant groups comprised of ancillary employees and retirees remained unchanged or declined in 2015.



University of Nebraska
Number of Health Plan Participants

	Dec 2015	Dec 2014	Change Number	Change Percent
Active Employees	10,651	10,469	182	2%
Retirees	493	530	(37)	(7)
Ancillary Members	3	3	-	-
Cobra	121	98	23	23
Total	11,268	11,100	168	2%

University retirees are allowed to belong to the plan but must pay the entirety of their premium, which is computed separately by plan actuaries from that of active employees. The number of retirees in the plan decreased 7 percent, a percentage comparable to 2014. This is attributed to a number of favorably priced "gap" polices available in the marketplace (when combined with a base of Medicare coverage) that are financially more attractive than the premium offered by the University.

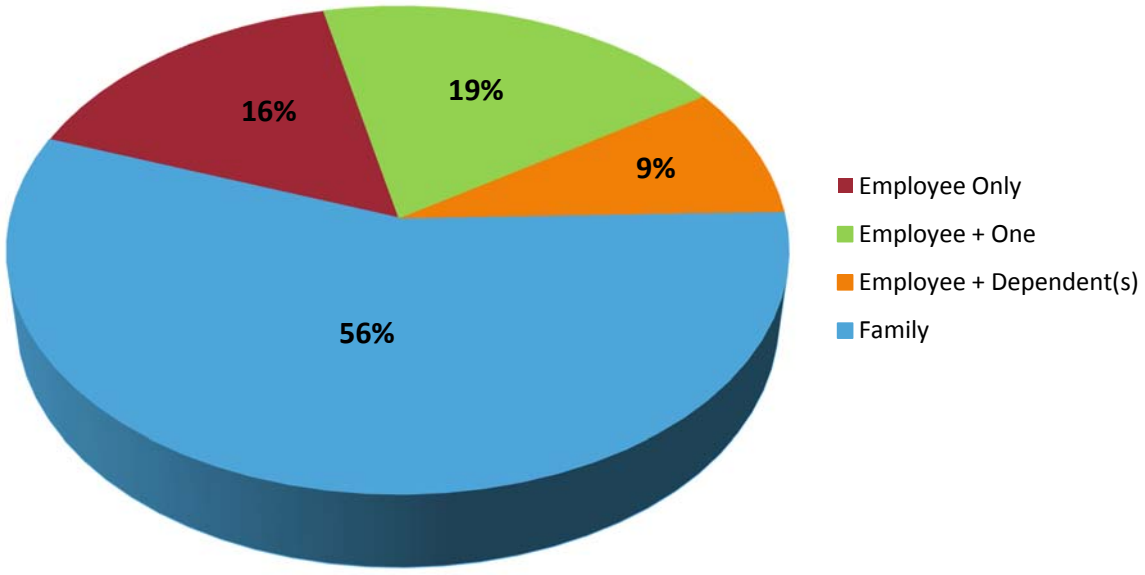
University ancillary members, who are specifically approved for membership by the Board of Regents, also pay the entirety of their premiums without any University contributions. Presently, the National Strategic Research Institute is the primary ancillary member.

Demographically, covered lives were about 51 percent female and 49 percent male. Average age for all covered lives was 36 years which remained stable from 2014.

In terms of covered lives, the average number of members for 2015 remained relatively stable. Enrollment increased slightly for Employee Only and Family coverages and decreased slightly for Employee+One and Employee+Dependent(s) coverages. Net, these changes resulted in 225 additional covered lives in 2015.

	Average 2015		Average 2014		% Change	
	Members	% of Total	Members	% of Total	Members	%
Employee Only	4,176	16%	4,124	16%	52	1%
Employee + One	4,895	19	5,024	19	(129)	(3)
Employee + Dependent(s)	2,222	9	2,254	9	(32)	(1)
Family	14,832	56	14,498	56	334	2
Totals	26,125	100%	25,900	100%	225	1%

University of Nebraska
Health Plan Membership by Coverage



The plan offers three levels of coverage: low, basic, and high, with each (respectively) offering increasing levels of coverage. The high plan has much lower deductibles and co-insurance but higher premiums compared to the low plan. Enrollments in each of the levels has stayed fairly stable on a historical basis, with about 75 percent of members choosing the basic plan, 15 percent the low plan, and 10 percent the high plan.

The University of Nebraska's health plan covers approximately 26,000 lives (employees plus their dependents)

Financial Performance

The University health plan's financial results for the years ended December 31, 2015 and 2014 are shown below (cash basis in thousands). A more detailed description of the plan's income, expenses and calendar year activities is provided in the following sections.

Plan income exceeded plan expenses in 2015, resulting in a $9.3 million increase in net activity as compared to 2014. This excess of income over expenses was entirely attributable to the timing of premium holidays, which were offered in December of 2014 but then not again until April – June of 2016.

If a premium holiday had been offered in December of 2015, there would have been a decrease in net activity as compared to 2014 in excess of $1 million due to escalating healthcare costs attributable to the factors outlined below:

- Medical claims expense in 2015 increased 3 percent from 2014. This growth was driven primarily by an increase in utilization and cost of outpatient and professional services from 2014.
- Pharmacy claims expense in 2015 increased 9 percent from 2014. This growth was driven primarily by a 26 percent increase in specialty drug costs. Specialty drugs are costly medications prescribed for the treatment of complex, chronic conditions such as rheumatoid arthritis, multiple sclerosis and cancer.

University of Nebraska Health Plan
Schedule of Income, Expenses, and Net Activity
Cash Basis (thousands)

	Actual 2015	Actual 2014	Year-over-Year Change Dollars	Year-over-Year Change Percent
Employer Premiums	$ 99,927	$ 89,774	$ 10,153	11%
Employee Premiums	27,410	24,872	2,538	10
Retiree, Ancillary, Cobra Premiums	5,539	5,628	(89)	(2)
Trust Investment Income	2,729	2,842	(113)	(4)
Other Income	3,636	1,722	1,914	111
Total Premiums and Income	139,241	124,838	14,403	12
Medical Claims	93,437	91,024	2,413	3
Pharmacy Claims	29,988	27,433	2,555	9
Dental Claims	7,789	7,300	489	7
TPA, ACA, and Other Expenses	5,843	6,242	(399)	(6)
Total Claims and Expenses	137,057	131,999	5,058	4%
Net Activity	$ 2,184	$ (7,161)	$ 9,345	

Note, the University implemented a one month premium holiday for both the employer and employees in Dec 2014.

Also note that beginning in 2015, NU Credits (an amount included in employee wages which employees can spend on benefit coverages they select) are considered part of Employee Premiums, rather than Employer Premiums as in the past. 2014 has been reclassified accordingly to be consistent with the 2015 presentation.

Income

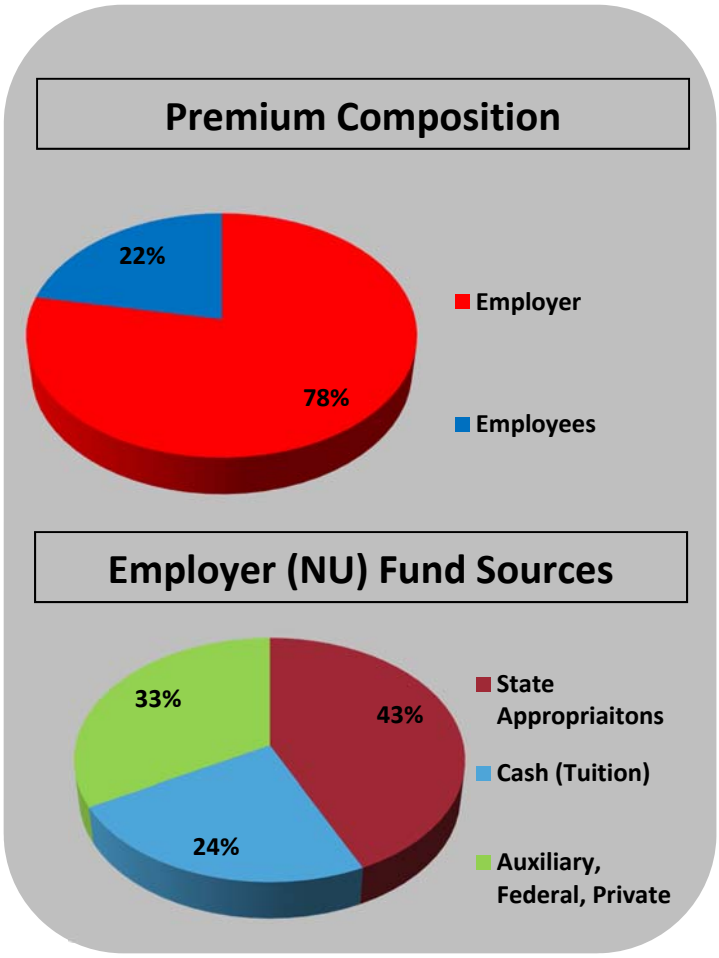
The University's health plan is funded from a variety of sources, although employer and employee premiums account for the bulk (92 percent) of the plan's income. Employer premiums are funded primarily from state appropriations (43 percent), cash funds such as tuition (24 percent), and other self-supporting business-type activities (auxiliaries) and federal grants and contracts (33 percent).

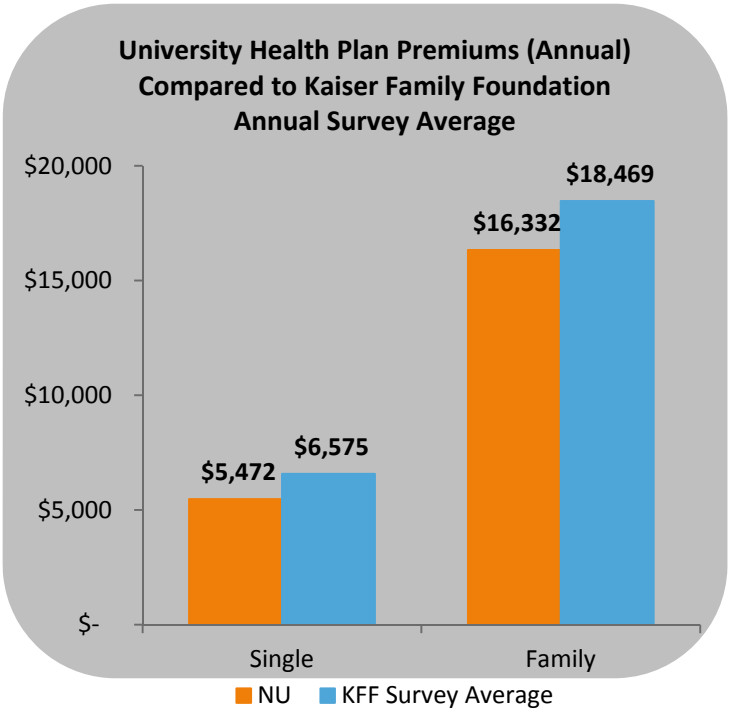
The plan's remaining income comes from retirees, ancillaries, and Cobra electees (4 percent), and investment income and pharmacy rebates/discounts (4 percent).

For the year ended December 31, 2015, the plan's income from employer and employee premiums increased by 11 percent. This was primarily the result of there being no premium holiday offered in 2015.

Trust investment income declined 4 percent for the year ended December 31, 2015. The plan will continue to see low earnings into the future on its fixed income portfolio because of artificially low interest rate strategies being employed by the Federal government in its efforts to stimulate economic recovery. In spite of the lower returns, trust cash earnings saved the University and employees almost $3 million in premiums again this year.

As pharmacy claims continue to climb, so do pharmacy rebates/discounts, which increased from $1.7 million in 2014 to $3.6 million in 2015 and are included in other income. The rebates/discounts are a result of the University's membership in the Employers Health consortium, a buying coalition that offers additional rebates and discounts to the plan based on combined purchasing power.





The University offers a very competitive premium pricing structure. Premiums (employer plus employee) under the University's plan are lower than the average as reported in the Kaiser Family

Foundation and HRET Employer Health Benefits 2015 Annual Survey[ii] by approximately 17 percent on single and 12 percent for family coverage.

Expenses

Medical Expenses

The plan's medical claims increased by 3 percent for the calendar year. Medical claims in 2015 and 2014, arrayed by amount of claims per covered lives, were as follows:

University of Nebraska
2015 Claims Distribution (Claims in Thousands)

Total Claims/Member	Covered Lives	Percent of Lives	Amount	Percent of Claims $$
Less than $200	6,224	25%	$ 10	< 1%
$200 - $999	9,094	36	4,391	5
$1,000 to $4,999	6,409	26	14,739	16
$5,000 to $9,999	1,340	5	9,665	10
$10,000 to $29,999	1,398	6	22,846	25
$30,000 to $49,999	276	1	10,544	11
$50,000 and above	289	1	30,862	33
	25,030	100%	$ 93,057	100%

Note: only persons presenting claims are included in this analysis. An estimated 1,100 persons had no claims. Claims are per BCBS.

University of Nebraska
2014 Claims Distribution (Claims in Thousands)

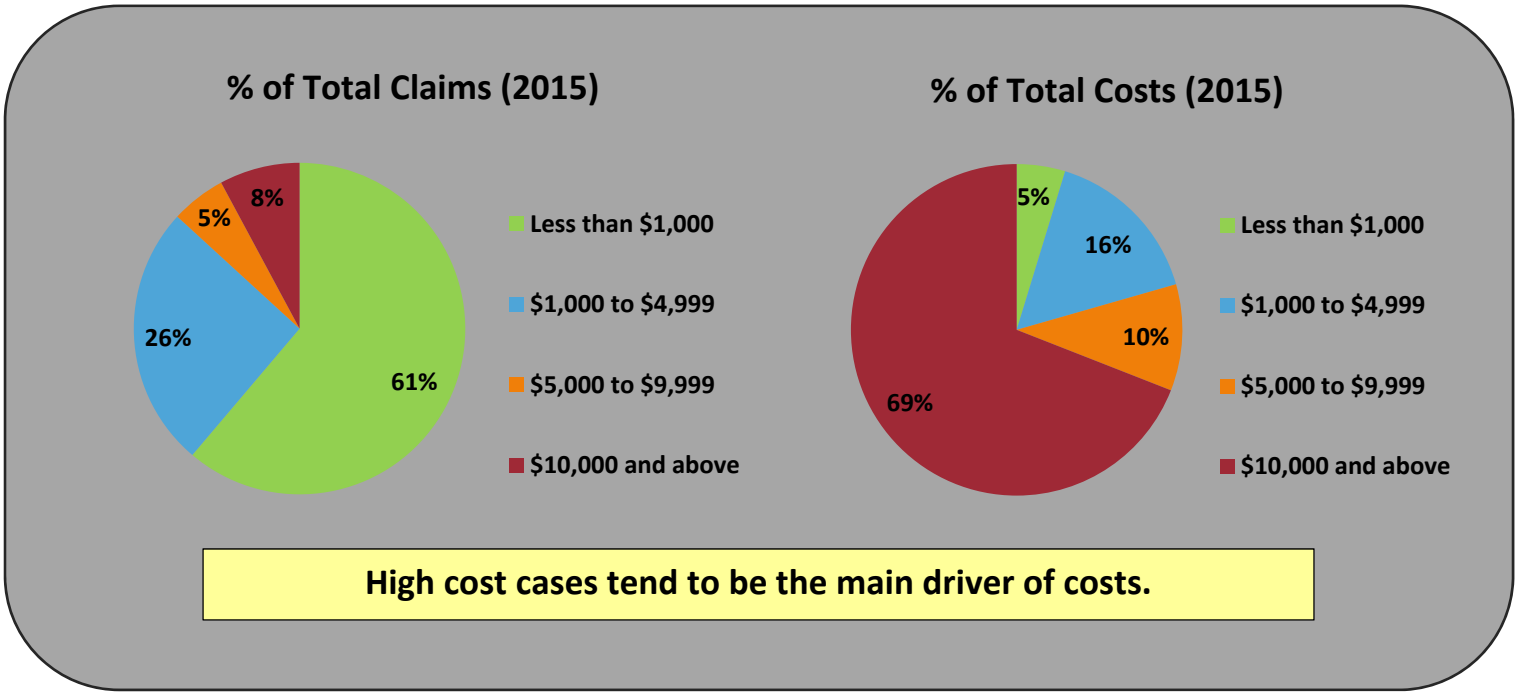
Total Claims/Member	Covered Lives	Percent of Lives	Amount	Percent of Claims $$
Less than $200	6,756	27%	$ 78	< 1%
$200 - $999	8,835	36	4,236	5
$1,000 to $4,999	6,057	25	13,921	15
$5,000 to $9,999	1,270	5	9,134	10
$10,000 to $29,999	1,324	5	21,768	24
$30,000 to $49,999	261	1	9,874	11
$50,000 and above	284	1	31,544	35
	24,787	100%	$ 90,555	100%

Note: only persons presenting claims are included in this analysis. An estimated 1,100 persons had no claims. Claims are per BCBS.

Note that the table above shows medical claims paid by Blue Cross Blue Shield of Nebraska (BCBSNE) during the reporting period and therefore may not be consistent with amounts paid by the trustee.

As is typical in health plans, high cost cases tend to be the main driver of costs. As can be seen in the table above and the charts below, in 2015 (with parentheticals showing 2014 figures):

- The top 2 percent of the covered lives accounted for 44 percent (46 percent) of medical costs.
- Total claims equal to or greater than $10,000 accounted for 69 percent (70 percent) of medical costs.
- 61 percent (63 percent) of the covered lives had total claims of less than $1,000.

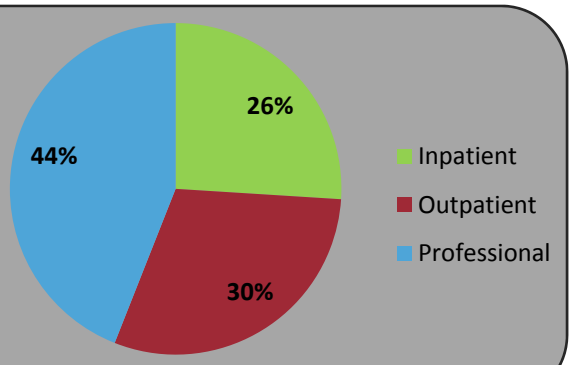


Medical costs are comprised of inpatient, outpatient and professional services. Inpatient services represent the costs that come with a hospital/facility stay. Outpatient costs are comprised of procedures that do not require a hospital stay, such as ambulatory surgery, emergency room visits, radiology and dialysis. Professional costs encompass all the services provided by physicians and other clinicians, ancillary services and medical services/supplies.

Net payments by service type as reported by BCBS in 2015 and 2014 were:

University of Nebraska
2015 Net Payments by Type (millions)

	2015	2014	Change Dollars	Change Percent
Inpatient	$ 24	$ 26	$ (2)	(7)%
Outpatient	28	27	1	5
Professional	41	38	3	8
	$ 93	$ 91	$ 2	3%



Inpatient

Inpatient costs fell 7 percent, to $24 million in 2015 when compared to 2014. The average price paid per admission decreased from $14,769 to $13,225, a decrease of 10 percent. However, this decrease was negated in part by an approximate 3 percent increase in number of admissions/1000.

These major diagnostic categories combined for approximately 58 percent of total inpatient spend in 2015:

- Diseases and disorders of the musculoskeletal system/connective tissue
- Pregnancy and childbirth
- Diseases and disorders of the digestive system
- Diseases and disorders of the circulatory system

The top 10 diagnostic categories combined to account for approximately 85 percent of total expenses.

Outpatient

Outpatient costs were relatively comparable between years, coming in around $27-$28 million. The cost of a typical outpatient service was up slightly, offset in part by a slight decrease in number of visits/1000.

Most of the costs in the outpatient classification are comprised of ambulatory surgery and radiology, which were down a little on a per member basis from last year. This decline was offset by increases in other outpatient categories, primarily a 12 percent increase in emergency room costs paid on a per member basis.

Professional Costs

Professional costs rose 8 percent, to $41 million in 2015 when compared to $38 million in 2014. Participant visits to physicians, clinicians, and others were up approximately 5 percent year-over-year on a per member basis. The average cost per visit increased from $160 to $164. Costs are divided evenly between primary care and specialty visits, with office visits accounting for about 61 percent of the total paid expenses.

Medical Benchmarking/Statistics

There are several medical benchmarks and statistics worth noting that allow us to compare the plan's current year results to those seen in the industry or provide trend considerations:

- The average age of covered lives under the University's plan is 36 compared to the Blue Cross Blue Shield of Nebraska's (BCBSNE) book of business average of 34.
- The average age of the University's employee participant is 48 compared to the Blue Cross Blue Shield of Nebraska's (BCBSNE) book of business average of 45.
- Utilization in all categories (inpatient, outpatient and professional) was higher than the BCBSNE benchmark. The financial impact of this was offset by prices per service, which were approximately 23 percent and 18 percent below the BCBSNE benchmark for inpatient and outpatient services, respectively.
- The average cost for claimants with total paid claims of $30,000 or greater was about $73,000, with musculoskeletal and connective tissue, neoplasms, and circulatory accounting for 49 percent of the approximate $41 million of costs for this group.
- Preventative care services were utilized by almost 67 percent of members, up from almost 65 percent in the prior year. Over 7 percent of paid claims went to these services in both 2015 and 2014.
- Number of persons with at least one chronic disease is comparable in 2015 and 2014 at between 17 percent and 18 percent.
- Hypertension is far and away the most prevalent chronic condition, followed by hyperlipidemia and diabetes.

Pharmacy Expenses

Pharmacy claims are handled through a third party administrator, CVS Caremark. The University also belongs to the Employers Health consortium, a buying coalition that offers additional rebates and discounts to the plan based on combined purchasing power. Rebates and discounts received in 2015, which are reported as other income, totaled approximately $3.6 million.

In 2015, pharmacy costs were up 9 percent to $30.0 million. Approximately 9,300 members utilized the plan's pharmacy program each month. The average annual net claim per participant totaled almost $3,200.

The increase in pharmacy costs is primarily attributable to specialty prescription costs, which were 37 percent of total pharmacy costs in 2015 compared to 32 percent in 2014. Specialty prescription costs increased about 26 percent, driven in part by price inflation and in part by utilization.

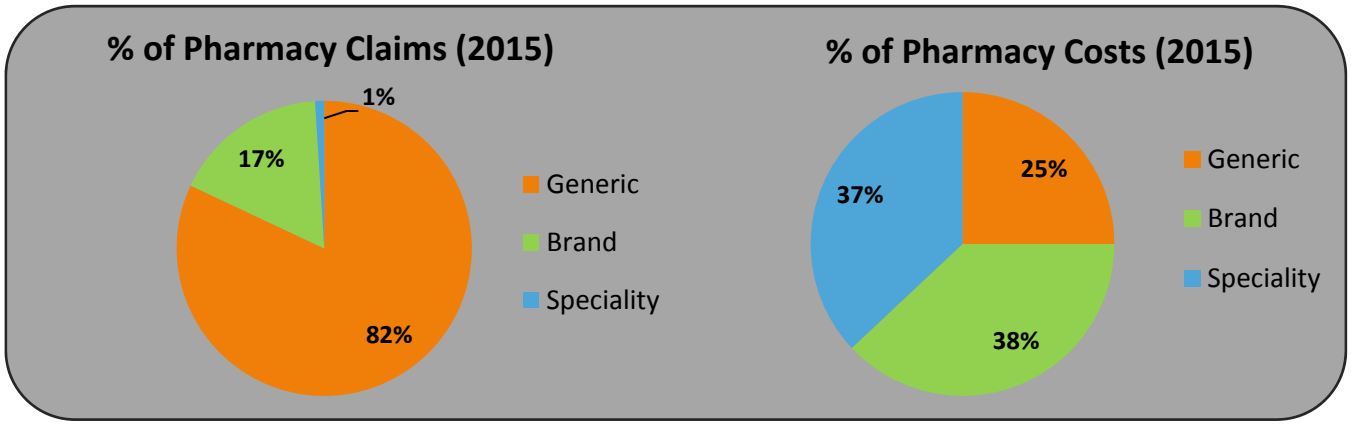
Pharmacy expenditures by category of drugs were as follows for the past two years:

University of Nebraska
Pharmacy Spend/Number of Claims
(Claims Net Cost in thousands)

	Claims Net Cost		Claims Cost as Percent of Total		Total Claims		Percent of Total Claims		Cost Per Claim	
	2015	2014	2015	2014	2015	2014	2015	2014	2015	2014
Generic	$ 7,340	$ 7,567	25%	28%	227,639	223,738	82%	81%	$ 32	$ 34
Brand	11,400	10,825	38	40	46,787	50,553	17	18	244	214
Specialty	11,048	8,907	37	32	3,071	1,826	1	1	3,597	4,878
	$ 29,788	$ 27,299			277,497	276,117				

Note that the table above shows pharmacy claims paid by CVS Caremark during the reporting period and therefore may not be consistent with amounts paid by the trustee.

The importance of generic drugs in controlling costs can be gleaned from the foregoing table and the charts below. While generics represent 82 percent of total prescriptions, they only account for 25 percent of pharmacy costs.



The generic dispensing rate increased from 81 percent in 2014 to 82 percent in 2015. The University of Nebraska's success in adoption of generics is underscored by the fact that its 2015 generic dispensing rate equals or exceeds that of its university peers in 5 of 10 top therapeutic classes. Generic use for analgesics – anti-inflammatory, anticonvulsants, antidepressants, antihyperlipidemics, antihypertensives, endocrine and metabolic agents, and ulcer drugs exceeded 85 percent. The difference in prices is dramatic: for new generic launches in 2016 alone, the University's projected savings for 2016 was approximately $200,000.

Conversely, specialty drugs are 1 percent of the plan's prescriptions, but account for 37 percent of the costs. 9 out of the top 10 prescription drugs used were specialty drugs. Primary among the specialty classes are multiple sclerosis, rheumatoid arthritis, oncology, hemophilia, hereditary angioedema and hepatitis C. There are 305 users of specialty drugs, accounting for over $36,000 of cost per user per year.

Reserves and Fund Balances

Reserves are amounts needed to be held in the health trust at Wells Fargo in order to pay health benefit claims. An incurred but not reported ("IBNR") reserve represents claims that have been incurred, but have not yet been presented to the health trust and its trustee for payment. A claims fluctuation reserve ("CFR") represents the financial impact if the University were to encounter an unusually high volume of claims or unexpected number of claims that exceeded the claims estimate utilized to establish premium rates for the plan. A stop-loss reserve represents the amount by which individual claims are estimated to exceed $500,000. Each of these reserves is based upon the results of an annual actuarial study performed by Milliman.

Fund balances are the cumulative amounts of cash left over after expenses are paid and sufficient reserves have been set aside.

Reserves and fund balances are the cornerstone of financial flexibility. Much like a savings account, they are one-time resources that provide the health plan with options for responding to unexpected issues and a buffer against shocks and other forms of risk.

Through a combination of proper pricing, aggressive management of deductibles and co-pays, prudent planning regarding potential cost increases, and favorable claims experience resulting from staying on the forefront of health care trends, the University has accumulated (over several years) fund balances that could be utilized for one-time health related purposes. As of December 31, 2015, the University's health plan had a trust fund balance of approximately $118 million, with a net balance of over $99 million after subtracting estimated reserves. This represents a fund balance equal to about 9 months of plan expenses. However, as discussed in the following section, adverse claim experience since December 31, 2015 and the strategic granting of premium holidays in three months in 2016 have, subsequent to the reporting period covered by this report, thoughtfully lowered the fund balance.

Conclusions and Looking Ahead

The University's trust fund balance increased in 2015 as a result of the University not offering employees a premium holiday as it had done in December of 2014 and 2013. However, it is important to note that if a premium holiday had been offered in December of 2015, the trust fund balance would have actually declined due to escalating healthcare costs. There were a couple factors that contributed to the upward trend in healthcare costs:

- Increased cost of medical claims, which were driven upward by an increase in utilization and cost of outpatient and professional services.
- Increased cost of pharmacy claims, which were driven upward by an increase in costs associated with specialty drugs.

Going forward, University management must continue to focus on chronic disease management, including case management and lifestyle behaviors. We also must continue to promote preventive services to our members given the aging of our workforce.

In terms of pharmacy, the biggest challenge going forward is to control the use of specialty drugs. Potential future pharmacy opportunities include:

- Getting a handle on specialty drugs to assure the drugs match the diagnosis.
- Movement of pharmacy costs out of medical and into the pharmacy pipeline to assure consistent treatment for members.
- Increasing generic pharmacy by mail and creating incentives to do so. While incentivizing is currently contrary to state law, the financial impact of generics when used versus name brands is profound, thus further discussions about the current statute may be warranted.
- Continued focus on step therapies. Under this concept, high-priced drugs are not available without having tried generics first.

With the upcoming change in the United States of America presidential administration on January 20, 2017, the future of the Affordable Care Act ("ACA") is uncertain. Presently the overall plan continues to be "grandfathered" in regards to the ACA, but it will be increasingly difficult to maintain that status. Should that status be lost, the University would be required to expand its offerings to meet federal dictates in the areas of required coverage, definitions around medical necessity, and the combining of medical and pharmacy deductibles and co-pays.

Looking ahead, on a last-twelve-month basis through June of 2016, the trust fund balance has declined from $121 million to $78 million. A significant portion of that decline was strategic in nature - upon the consent of legislative leadership, University management, in concert with Board members, chose to offer University employees premium holidays in April, May and June of 2016 to effectively lower the trust fund balance, resulting in total income declining more than 13 percent. Meanwhile, overall claims and expenses are up approximately 11 percent. Medical claims are up more than 12 percent, pharmacy claims are up about 11 percent, and dental claims are up almost 5 percent. Subtracting estimated reserves, the June 30, 2016 net trust fund balance represents about 4.5 months of plan expenses.

The University of Nebraska is proud of its prudent management of its health plan, which has positioned us to provide competitive, affordable benefits to our employees – our greatest asset – and their families. These are challenging times for health care, but we are committed to offering quality health benefits that meet the needs of our employees and help us attract and retain additional talent for Nebraska.

Endnotes and References

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[i] Duchon L, Schoen C, Simantov E, Davis K, An C. Listening to Workers: Finding from the Commonwealth Fund 1999 National Survey of Workers" Health Insurance. New York. The Commonwealth Fund; 2000.

[ii] Kaiser Family Foundation and HRET Employer Health Benefits 2015 Annual Survey, http://files.kff.org/attachment/report-2015-employer-health-benefits-survey