EXHIBIT A

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MINNESOTA

SERGIO NAVARRO, THERESA GAMAGE, DAYLE BULLA, JANE KINSELLA, AND ERICA MCKINLEY, on their own behalf, on behalf of all others similarly situated, and on behalf of the Wells Fargo & Company Health Plan and its component plans, Plaintiffs, v. WELLS FARGO & COMPANY, Defendant.	Civil Action No. 0:24-cv-03043-LMP-DLM

DECLARATION OF BONNIE S. ALBRITTON

I, Bonnie S. Albritton, hereby declare under penalty of perjury pursuant to 28 U.S.C. § 1746 as follows:

1. Attached hereto is a true and correct copy of my preliminary Expert Report in the above matter.

2. Everything stated in my Expert Report is true and correct to the best of my knowledge, information, and belief, and the Expert Report accurately reflects my opinions expressed therein.

Dated: May 8, 2025

Bonnie Albritton

Bonnie S. Albritton

NAVARRO V. WELLS FARGO & CO., NO 24-CV-3043 (D. MINN.)

EXPERT REPORT OF
BONNIE S. ALBRITTON

May 8, 2025

LEWIS & ELLIS
BONNIE S. ALBRITTON, FSA, MAAA

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I. EXECUTIVE SUMMARY

I, Bonnie S. Albritton, Vice President & Principal with the actuarial consulting firm of Lewis & Ellis, LLC, have been engaged by Fairmark Partners, LLP and Cohen Milstein Sellers & Toll PLLC ("Counsel"), as counsel for Plaintiffs, to provide expert services in connection with Navarro v. Wells Fargo & Co., No 24-cv-3043 (D. Minn.).

Specifically, I have been asked to offer my opinions, as an expert with relevant actuarial experience in the healthcare field, regarding cost projections and funding mechanisms for self-funded healthcare plans, and how they affect premium contributions for plan participants such as those in the Wells Fargo & Company Health Plan ("Plan"). Consistent with the scope of my assignment, I address:

1) The nature of self-funded plans and some of their unique attributes (including relating to costs);

2) Methods of calculating overall contributions needed to fund the plan;

3) Typical methods for determining the split between employer/employee contributions and the impact on employee premiums;

4) The overall effect of prescription drug costs on overall plan spending; and

5) The impact of prescription drug spending on employee premiums.

Based on my experience and the documents provided to me (identified in Section IV below), I have formed the following opinions.

1) Self-funded health plans allow employers to assume direct financial responsibility for employees' healthcare costs rather than purchasing a traditional insurance policy. In a self-funded plan, all healthcare costs must be funded by contributions from the sponsoring employer and participating employees.

2) While contributions for self-funded plans may be based on a number of factors, the largest factor by far is actual and anticipated claim costs.

3) The level of prescription drug spending directly affects total plan spending and claim costs and is an increasingly large driver of such costs. As such, prescription drug spending plays a significant role in the calculation of premium contributions.

4) In allocating premium contributions, most large employers target a set ratio of employer/employee contributions to total premiums. Consistent with this typical approach, Wells Fargo has historically set the employee contributions at approximately 25% of total contributions, without significant variation.

5) Due to (1) the significant impact of prescription drugs on overall costs, (2) the resulting impact on funding requirements for a self-insured plan like the Wells Fargo Plan, and (3) the set target

that Wells Fargo has used (consistent with other large employers) for allocating employer and employee contribution allocations, it is my opinion that reduced prescription drug spending would have resulted in reduced employee contributions.

II. QUALIFICATIONS AND EXPERIENCE

I am a Principal and Vice President of Lewis & Ellis, LLC ("L&E") in its Plano, Texas office.

I am a qualified actuary and became a member of the American Academy of Actuaries in 2001, a Fellow of the Society of Actuaries in 2004, and a Fellow of the Conference of Consulting Actuaries in 2014.

My primary practice since joining L&E in 2003 has been as an actuary and consultant in regards to health and welfare benefit plans on behalf of employers, brokers, and benefit consultants.

- I serve as the actuary for many self-funded health and welfare plans, providing actuarial analysis, including rate development, stop-loss projections, analysis of benefit changes, claim forecasting, and employee contribution strategy. This has included publicly traded firms, large national religious plans, and public-sector plans.
- On behalf of benefit consultants and brokers, I have provided self-funded feasibility analysis for employers considering a move to a self-funded arrangement.
- I work with several multiple employer welfare arrangement ("MEWA") plans providing, among other things, rate development, experience rating analysis for the member employers, and periodic monitoring of plan experience.

Since beginning work as an actuary in 1994 and prior to joining L&E, I worked in various actuarial positions at United Teacher Associates Insurance Company, TIAA-CREF, and Bankers Life Insurance Company of New York. A copy of my biography is appended to this Report.

III. COMPENSATION

L&E is being compensated for the time that I, and those working under my direction, work on this project. Hourly rates range from $225 to $1,000. Fees are not contingent upon the outcome of this litigation. My hourly rate is $700.

IV. MATERIALS REVIEWED

In developing my opinions and preparing this report, I received copies of the complaint as filed, the amended complaint, the exhibits from Wells Fargo's motion to dismiss, the order granting motion to dismiss, and the Form 5500 filings from plan years 2018 to 2023.

V. SELF-FUNDED HEALTH BENEFITS OVERVIEW

Self-funded health plans, also known as self-insured plans, allow employers to assume direct financial responsibility for employees' healthcare costs rather than purchasing a traditional insurance policy. These plans rely on a disciplined financial approach, integrating historical cost trends with actuarial projections to maintain stability.

Establishing a balanced employer/employee contribution structure for self-funded health plans requires financial assessment and strategic foresight. Employers weigh sustainability against affordability while ensuring compliance with regulatory standards and fostering equitable cost-sharing.

Prudent management of self-funded health plans includes proactive strategies to address evolving cost dynamics. Employers can strengthen financial resilience while maintaining affordability by leveraging actuarial expertise, refining plan design, and implementing targeted risk mitigation measures. Adaptive funding frameworks allow organizations to navigate financial fluctuations while optimizing healthcare benefits for employees.

Prescription drug expenditures, particularly unit pricing, exert significant influence on overall plan costs within self-funded health arrangements. Plans can employ a variety of comprehensive cost-control initiatives to mitigate financial exposure while preserving employee access to vital medications. Transparent pricing, formulary optimization, and strategic negotiations serve as essential components in sustaining affordability and ensuring long-term financial integrity.

VI. ADVANTAGES AND RISKS OF SELF-FUNDING

Employers choose self-funded health insurance for several strategic reasons:

- **Cost Control:** Self-funding allows large employers to avoid paying insurance carrier profit margins and some administrative fees, leading to potential savings of 8-10%.
- **Flexibility & Customization**: Employers can tailor benefits to their workforce rather than relying on standardized insurance plans.
- **Data Transparency:** Self-funded plans provide detailed claims data, enabling employers to identify cost drivers and implement wellness initiatives.
- **Cash Flow Advantages:** Instead of paying fixed premiums, employers pay claims as they arise, freeing up cash flow for other business needs.
- **Risk Management** – Large employers are often well-equipped to handle claims variability, and they can purchase stop-loss insurance to protect against catastrophic claims.

There are some risks associated with self-funding health benefits:

- **Unpredictable and Increased Risk of Losses:** Self-funding means the employer is responsible for paying all medical claims, up to stop-loss limits (if applicable). In addition, employers are exposed to the risk of high losses due to extraordinary claims.
- **Cash Flow Strains:** Unexpected high claims can strain an employer's cash flow, potentially creating financial difficulties.
- **Increased Administrative Work and Compliance Requirements:** Employers must manage claims, track spending, supervise vendors, and ensure compliance, even if they outsource some administrative tasks. Additionally, self-funded plans must comply with various federal regulations, including HIPAA and ERISA, which can be complex and time-consuming.

Self-funding is increasingly popular among large employers looking for long-term savings and greater control over their healthcare spending.

VII. SELF-FUNDED PLAN RATING METHODOLOGY

Given the unpredictable nature of healthcare expenses, effective rate calculations are essential to ensure sufficient funding while maintaining financial stability.

Self-funded plans are in a unique situation since future costs are not certain. For fully insured plans, the insurance company bears the risk of claims exceeding expectations and reward if claims are lower than expected (e.g., the employer/employee costs are fixed.) Rates in a self-funded plan are estimates and ultimately, the plan is responsible for costs that exceed those built into the rates. There are several types of rates within a self-funded plan.

1. **Premium Equivalent Rates**: These rates are used to estimate the cost of the self-funded plan as if it were a fully insured plan. They are calculated by taking the expected claims and administrative costs and dividing them by the number of plan participants. Premium equivalent rates help employers compare the cost of self-funding to the cost of purchasing traditional insurance.
2. **Funding Rates**: These are the rates used to determine the total amount of money needed to fund the health plan. They are calculated based on historical claims data and actuarial projections of future costs. Funding rates ensure that there is enough money to cover the expected healthcare expenses of the plan participants.
3. **Contribution Rates**: These rates determine how much money employees and employers contribute to the health plan. Contribution rates are typically based on the funding rates and are split between the employer and employees.

There is some overlap in the rates. For example, all three are typically based on historical claims data and actuarial projections. The funding rates may be increased or decreased based on asset levels.

The focus of this report is on contribution rates, which are typically based on premium equivalent rates that may be adjusted for various factors.

The following outlines the key methodologies used to determine total contributions needed for such plans, primarily based on historical claims data and actuarial projections of future costs.

COMPONENTS OF CONTRIBUTION CALCULATIONS

In a self-funded health insurance plan, contribution rates are calculated based on estimates of plan costs and determine the amount of funds needed to cover expected claims and expenses. These rates are calculated as if the plan were fully insured, though the employer – and ultimately its employees – assume the financial risk. The plan may make additional adjustments to the contribution rates. The main components of contribution rates include:

- **Claims Costs:** The projected medical and pharmacy claims that the plan will pay out, which are calculated based on factors like past claims history and anticipated changes (e.g., an aging workforce or increased utilization). There are usually adjustments for expected increases in healthcare costs (medical inflation) or demographic shifts within the covered population. Claims costs usually comprise more than 80% of contribution calculations and are typically closer to 85% to 95%.

- **Stop-Loss Insurance Premiums:** Employers often purchase stop-loss insurance to protect against unusually high claims. This premium is for coverage that caps the employer's financial exposure.
    - *Specific Stop-Loss:* Protects against high claims for a single individual.
    - *Aggregate Stop-Loss:* Protects against the total claims exceeding a set amount for the group.

- **Administrative Fees:** These cover the costs of third-party administrators (TPAs) or insurers managing the plan, which may include claims processing, customer service, and compliance, as well as any administrative fees paid to pharmacy benefit managers ("PBMs") or other vendors.

- **Network Access Fees:** Charges for accessing a provider network (e.g., doctors and hospitals) negotiated by the TPA or insurer.

- **Wellness Program Costs:** If the employer includes wellness initiatives, such as health coaching or biometric screenings, these may be factored into the rate.

The sum of these determines the total contribution amount. Essentially, contribution rates are designed to ensure the self-funded plan collects enough contributions from employees and the employer to cover all anticipated costs. By far the largest component of contribution rates is the expected claim costs.

EXPECTED CLAIM COST CALCULATION PROCESS

Expected claim costs are calculated using a mix of historical analysis, demographic insights, and future assumptions to ensure a self-funded health plan is adequately prepared to meet its financial obligations under the plan design.

Historical Incurred Claims

To estimate expected claim costs, the process begins with analyzing historical claims data over a period, usually 12 to 36 months. This involves evaluating the frequency of claims — the number of times members utilize healthcare services—and their severity, or the average cost per claim. Breaking this data into categories, such as medical or pharmacy claims, provides a clearer picture of trends in specific areas. The calculation process also includes reserves for incurred but not reported (IBNR) claims — those that have been incurred but not yet processed or paid.

Trend Factors

Projections for future trends are applied. Medical inflation and advancements in technology or treatment methods, which tend to increase costs over time, are factored into the calculations. Trend factors are usually derived from industry benchmarks or consulting actuaries.

Demographic Adjustments

Demographic changes within the plan's covered population must also be considered. A younger workforce might lead to lower costs, while an aging population could increase claims.

Large Claim Considerations

Large claims from high-cost events or catastrophic illnesses are analyzed separately to understand their potential recurrence, especially when paired with stop-loss insurance.

Utilization Changes

Economic conditions, like inflation, and healthcare trends, such as the rise in telemedicine or high-cost therapies, may also shape projections.

Plan Changes

If applicable, adjustments are made to account for changes in the plan design. For example, benefit changes, introducing new preauthorization requirements, modifying the types of excluded services, or modifying the provider network to change the number of providers available at in-network rates, can all impact overall costs.

Administration Changes

Changes in the administration of benefits and/or TPAs should be factored into the expected claims. There may be changes in administrative processes, provider networks, claim processing efficiency, drug formularies, negotiated drug prices and/or rebates, and utilization management, to name a few.

VIII. EMPLOYER/EMPLOYEE CONTRIBUTION ALLOCATION

A critical aspect of plan design is determining the split between employer and employee contributions.

METHODOLOGY FOR DETERMINING CONTRIBUTION SPLITS

Determining contribution splits usually involves two steps. First, the employer sets an overall aggregate spending target, which will be discussed in more detail below.

Once the overall employer/employee contribution level is set, employers typically use actuarial analysis and financial modeling to establish contribution levels at a more granular level. Employee contributions typically have a tiered structure which varies based on whether a spouse or children are covered. Further variation in contribution levels can be used to encourage/discourage benefit choices and lifestyle choices (e.g., tobacco use or wellness benefits). Employee contributions can also vary by income level and employment status (e.g., full-time or part-time). In addition, terminated employees electing COBRA coverage carry both the employer and employee contribution, plus a 2% administrative fee.

My focus in this report is on the overall employer/employee contribution.

For most large employers, the contribution split is based on a percentage of total expected costs. In this structure, employers target a fixed percentage for employee contributions (for example, 25% of total plan healthcare costs), ensuring predictable cost sharing.

As detailed above, as expected costs increase, the total contribution rates will increase, which in turn, result in proportionate changes in the employees' contributions.

Unless there are significant other changes[1], the total contribution rates will be based on prior year incurred claims, adjusted for expected unit cost and utilization trends.

[1] For example, changes to benefits, demographics, administration, or other anomalies (i.e., COVID).

X. IMPACT OF PRESCRIPTION DRUG COSTS

Prescription drug costs represent a significant portion of healthcare expenditures for self-funded health plans and has increased significantly over the recent past.

According to the Peterson-KFF Health System Tracker, inflation adjusted retail prescription drug spending per capita in the United States has almost doubled from 2000 to 2021 ($640 to $1,147).[2]

Unlike fully insured plans, self-funded employers and their employees bear the direct financial burden of prescription drug spending, making cost management a critical component of plan sustainability. The following considers the effect of prescription drug costs, particularly unit costs, on overall plan spending and explores strategies for mitigating financial impact.

THE ROLE OF UNIT COST IN PRESCRIPTION DRUG SPENDING

Unit cost refers to the price paid per unit of a prescription drug, whether per pill, injection, or treatment course. Several factors influence unit costs, including:

- **Brand vs. Generic Pricing:** Brand-name drugs typically have higher unit costs due to research and development expenses, while generics can offer cost-effective alternatives.
- **Specialty Medications:** Specialty drugs, used for complex conditions such as cancer and autoimmune diseases, have disproportionately high unit costs.
- **Pharmacy Benefit Manager (PBM) Negotiations:** PBMs set drug prices for self-funded plans, and a self-funded plan's contract terms with its PBM can lead to inflated unit costs if not properly managed.
- **Regulatory and Market Forces:** Patent protections, supply chain disruptions, and manufacturer pricing strategies contribute to rising unit costs.

IMPACT ON OVERALL PLAN SPENDING

Prescription drug costs significantly affect total healthcare expenditures in self-funded plans:

- **Increasing Total Claims Costs:** Rising unit costs drive up total claims expenses. This leads to higher costs during the year and, as outlined above, raises the required contributions in future years if cost-saving measures are not introduced.

[2] https://www.healthsystemtracker.org/chart-collection/u-s-spending-healthcare-changed-time/#Relative%20contributions%20to%20total%20national%20health%20expenditures,%20by%20service%20type,%202023

- **Impact on Employee Contributions**: For the vast majority of large employers who use percentage-based cost sharing for their employee contributions, changes in aggregate prescription costs are reflected proportionally in employee contributions the following years, as detailed above for plan spending in general.

PURCHASING POWER OF JUMBO EMPLOYERS

Prescription drug costs, particularly unit pricing, significantly impact self-funded health plan spending. Employers must adopt proactive cost-management strategies to ensure financial sustainability while maintaining access to essential medications for employees.

Jumbo employers – typically those with at least 5,000 employees – can leverage their size to gain more influence in contracting for self-funded health benefits.

- **Direct Contracting with PBMs**: Employers with bargaining power can negotiate more favorable and more transparent contracts with PBMs to eliminate hidden fees and maximize rebates.
- **Biosimilar Adoption:** Employers can push for biosimilars, which cost 15-35% less than brand name biologics, to reduce pharmacy spending.
- **PBM Transparency & Regulation:** Employers can demand clearer disclosure of fees, rebates, and spread pricing from PBMs, especially with increasing regulatory pressure.
- **Custom Formulary Design**: Instead of relying on standard PBM formularies, employers can customize drug lists to prioritize cost-effective medications.
- **Data-Driven Negotiations:** Self-funded employers have access to detailed claims data, allowing them to identify cost drivers and negotiate more effectively with providers and PBMs.

X. EVALUATION OF WELLS FARGO PLAN

BACKGROUND ON WELLS FARGO PLAN

Well Fargo established the Wells Fargo & Company Health Plan (for Eligible Active Employees and their Dependents) to provide medical, dental, and vision coverage to eligible active employees, their dependents and COBRA beneficiaries.

The Plan provides a combination of self-insured and insured health and welfare benefits. Pharmacy benefits are generally self-insured under the Plan.

Overall employee contributions have historically been approximately 25% of the total expected cost. Within the Plan, employee-specific contributions vary based on benefit option, employment classification, tobacco-use status, level of coverage, and compensation category.[3]

Based on information in the Form 5500 filings for plan years 2018 to 2023, the year-end participant counts are as follows.

Plan Year	Active Participants	Retired Participants	Total
2018	216,100	2,007	218,107
2019	214,116	1,882	215,998
2020	212,306	2,047	214,353
2021	186,090	2,708	188,798
2022	173,224	2,788	176,012
2023	160,873	6,190	167,063

HISTORY OF SPENDING AND EMPLOYEE CONTRIBUTIONS

The following table reflects the historical employer and employee contributions for each plan year as reported in the Form 5500 filings.

Plan Year	Employer Contributions	Employee Contributions	Total Contributions	Employee Percentage
2018	$1,906,738,522	$692,692,221	$2,599,430,743	26.6%
2019	$1,861,261,473	$682,155,159	$2,543,416,632	26.8%
2020	$1,917,011,660	$695,725,687	$2,612,737,347	26.6%
2021	$2,077,321,780	$692,507,948	$2,769,829,728	25.0%
2022	$1,931,456,732	$650,940,381	$2,582,397,113	25.2%
2023	$1,864,672,128	$676,330,949	$2,541,003,077	26.6%

The employee contribution percentage has varied slightly from year to year but shows a clear pattern of the overall split between employer and employee. The variation from year to year is likely due to differences between the expected and actual distribution of employees by the rating characteristics described in the prior subsection.

[3] Declaration of Clare Verplank In Support Of Defendant Wells Fargo & Company Motion to Dismiss the Class Action Complaint; Exhibit B.

LIKELY IMPACT OF HEALTH PLAN SPENDING ON EMPLOYEE CONTRIBUTIONS

I reviewed the average Plan expenses per participant and average contributions per participant.

Plan Year	Total Average Contributions Per Participant	Annual Change	Total Average Plan Expenses Per Participant	Annual Change
2018	$11,918		$11,947	
2019	$11,775	-1.2%	$11,880	-0.6%
2020	$12,189	3.5%	$12,193	2.6%
2021	$14,671	20.4%	$14,659	20.2%
2022	$14,672	0.0%	$14,641	-0.1%
2023	$15,210	3.7%	$15,373	5.0%

The comparison confirms that the total contributions per employee have changed at roughly the same rate as the total expenses, confirming that the expected costs impact contribution rates. This also confirms that, like most large employers, Wells Fargo uses percentage-based cost sharing for its employee contributions.

Based on my review of the pre-discovery information, it is my professional opinion that Wells Fargo employees' contributions were directly impacted by the plan costs, including prescription drug costs. As plan costs increased, so did the employee contributions. It is also my professional opinion that reduced prescription drug spending would have resulted in reduced employee contributions.

Bonnie Albritton, FSA, MAAA, FCA

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OVERVIEW

Built a successful health and welfare practice from the ground up.

Currently a Principal and Consulting Actuary with Lewis & Ellis since 2003, Ms. Albritton has 30 years of experience and offers a well-rounded background to her clients. Her primary practice is health and welfare benefits, but she also works with insurance companies and state insurance departments.

PROFESSIONAL CERTIFICATIONS

Fellow of Society of Actuaries

Member of American Academy of Actuaries

Fellow of Conference of Consulting Actuaries

EDUCATION

Bachelor of Arts, Mathematics
University of Texas at Austin
1990-1994

PAST EXPERIENCE

United Teacher Associates Insurance Company
Actuary
1994-1996, 2000-2003

TIAA-CREF
Actuarial Analyst
1999 - 2000

Bankers Life Insurance Company of New York
Actuarial Analyst
1996 - 1999

EXPERIENCE

- Serves as actuary for over 40 self-funded health and welfare plans, providing actuarial analysis, including reserve certifications, rate development, stop-loss projections, analysis of benefit changes, and claim forecasting.
- Serves as actuary for over 50 public and private employers, providing postemployment health benefit liability valuations in accordance with GASB Statements 74 and 75, ASC 715-60, and IASB 19.
- Serves as actuary for 5 association MEWA (multiple employer welfare arrangements) plans providing actuarial analysis, including reserve certifications, rate development (including individual employer underwriting), stop-loss projections, analysis of benefit changes, and claim forecasting.
- Serves as opining actuary for two health carriers, two health benefit captives, and two MEWAs.
- Served as the lead actuary on the audit of life and health insurance companies.
- For insurance companies, provide valuation of actuarial liabilities and financial reporting, product pricing, and rate and form filings with state insurance departments.

ARTICLES

Costs For Health Insurance Are Declining Nationwide

What Options Do People Have When They Lose Health Insurance?

Health Insurers See Roles Shift Amid Coronavirus Pandemic

Costs Keep Rising For Employer-Based Health Insurance

What Does Modern Health Insurance Cover, And Cost, For Most Consumers?

Financial Decision-Making Theory and the Small Employer Health Insurance Market in Texas