Myth Busting:
A Strategic Approach to Employee Benefits Planning

How Companies Can Approach Benefits Renewal Planning with an Eye Towards Cost Containment

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Point of View: Understanding Our Role

Insurance is transacted in a marketplace where the broker controls everything - resulting in a lack of transparency at best. At ERA Group, our insurance specialists are licensed, but we don't replace your broker - instead, we are independent, objective marketplace facilitators, ensuring true and transparent competition and comprehensive consideration of your program among brokers and carriers. Our agreement is with you, not the carrier and it is contingent on how much money we save you. No savings? No compensation. We are truly independent of the system and 100% performance based.

Incumbent brokers don't like this because they are aware of the perverse incentives tied to direct commissions and indirect compensation they receive from the carriers that control the marketplace. Our goal with this whitepaper is to Bust the Top 10 Myths on benefits and the renewal process arming you with actionable information and insights which could save you several percentage points without diluting your plan while very likely strengthening it.

Executive Summary

For most mid-market organizations, not only are benefits renewals viewed as a dreaded annual task, but one that persistently results in cost increases. You may think that if your renewal increases aren't headed to the moon that you should count yourself amongst the lucky ones. This whitepaper provides insight to how you can approach the benefit renewal from a more strategic lens and will dispel some common myths along the way.

Myth #1 - Flat renewals means that we're performing great.

Truth - While a flat renewal one year can be a sign of low claims, being in a cycle of flat renewals over years can be a sign that you're a lucrative client to the insurance carrier.

But the ACA requires that carriers rebate clients when they spend less than 85% of premium on healthcare claims and quality improvement efforts, doesn't that protect us?

Not really - An MLR (Medical Loss Ratio) rebate is based on a - year average of an insurer's MLR performance within each state and market segment. Therefore, while your MLR could be great, if you're in a pool with other employers that have a high MLR, then you are subsidizing their claims.

Myth #2 - The premium goes up every year and there's nothing we can do about it!

Truth - In the US, Healthcare costs have outpaced overall inflation for the past 50 years. This has many impacts across the board from providers to payors to insureds. For employer health plans, this translates to 7-9% average annual increases. This does not mean that an employer has to be held hostage to rising costs, and there are many ways to establish controls over the plan.

Achieving a best-in-class result requires:

1

Understanding Plan Performance

Including population health dynamics, utilization and claims performance

2

Understanding Goals

Related to employee benefits relative to how the benefit plan fits within the overall talent attraction/retention strategy, relative to ease of use to their employees, and relative to cost

3

Work with the Right Partner

We have seen too many cases where a broker intentionally and unintentionally makes a decision or limits options for their clients. We believe that the right advisor should understand your goals and performance and identify all relevant options for you - presenting cost/benefit, pros and cons. Employers that offer benefit plans have a fiduciary responsibility to act in the best interest of plan participants. What better evidence of execution than a thorough, well thought out, well documented process to uncover and evaluate options.

Myth #3 - The only way to manage cost increases is to dilute plan benefits and/or increase employee contributions

Truth - Absolutely not true. Diluting plan benefits (e.g. raising deductibles and out of pocket maximums), and/or increasing employee contributions all result in shifting a greater financial burden onto employees. These are not plan cost management strategies.

There are many ways to design and structure a benefit plan to achieve the desired goals, including cost containment. It's not simply binary choices between the BUCAs vs. a Kaiser plan or fully-insured vs. self-funded. Your advisor should be providing you with benchmarking annually - showing you how your benefit plan stacks up vs. peers, providing insight to help you determine whether your plan is competitive and attractive to current and prospective employees. This incorporates an assessment of the benefits offered, benefit levels and structure, cost and contributions.

A good advisor will walk you through the spectrum of potential plan design and structures that could make sense for your organization. Establishing a plan's structure is not a 'once and done' exercise. It begins with a strategic view of your benefits - establishing a long term (3-5 year) benefit strategy, with annual decisions that iterate towards that strategy, with tweaks as needed. At ERA, our philosophy is that every client should be empowered with the information necessary to make a decision that is right for them, their business goals, and their employees. Establishing and maintaining benefit plans is a critical component of your business and culture - not only is the cost typically one of the top-costs annually, but it is an investment in employees.

Common Myths About Employee Benefits

Myth #4 - Changing networks is incredibly disruptive

Truth: Many are under the misconception that changing networks is always disruptive, and some within the industry are happy to promote this misconception.

The truth is that this is contingent on provider agreements - and it varies by region and plan type. Overlap among providers in some cases can be significantly high - at 95% or more. National PPO networks will have more overlap than an EPO network.

The utilization data available to you to assess the impact of a network change will depend on the size of your plan and the utilization reporting you have available to you. With provider-level utilization data, your broker can provide a disruption analysis to determine how much overlap there is between networks. Your broker can also provide a geo-access analysis indicating the concentration of providers - general and specialty, within the geographic location of your employees. If provider level utilization is not available, a more informal process can be used to identify currently used providers.

Myth #5 - The only way to save money is to go into a self-funded plan (or captive)

Truth: Not true, while a self-funded plan, or captive, can enhance control over benefits and plan elements, it's not the only way for companies to save money. In fact, depending on a group's claims experience, going self-funded may not even be a sensible first step. If you're not ready to entertain a self-funded plan, looking at network pricing efficiency, incorporating narrow networks, HRAs or an HRA wrap strategy can reduce overall healthcare costs, improve care coordination, and result in savings.

Myth #6 - Only large employers can have a self-funded plan

Truth: In reality, size does not determine whether a company should self-fund - rather it is a company's cash flow and appetite for expense variability that are leading factors. Although the term 'self-funded' is often used, the vast majority of companies that are self-funded are actually 'partially self-funded' - in that stop loss insurance is placed to limit a company's risk (and pay for claims over a certain amount). Some may think that self-funded plans are higher risk than fully-insured plans. However, over the long term, this isn't the case - the risk is generally limited to cash flow variability vs. actual risk.

A fully-insured plan builds in a pooling charge within its premium - which is what is used to cover claims over a certain threshold - essentially, it's built in stop loss. A fully-insured plan is often penalized for claims for years to come. Transitioning to a self-funded plan and buying stop-loss at the same deductible as the pooling point in your fully-insured plan, results in taking on no additional risk - as stop loss would kick in above the deductible (formerly the pooling point within the fully-insured plan). In addition, a self-funded plan, offers opportunities for more control, and potentially savings, but more on that later.

Myth #7 - The most efficient self-funded structure is in an ASO (Bundled) plan

Truth: An ASO (Administrative Services Only) or bundled self-funded plan is one where all aspects of the plan are purchased from a single provider - typically one of the BUCAs. That includes the Stop Loss, TPA (third party administrator), network, and PBM (Pharmacy Benefit Manager). While this may offer savings to a fully-insured plan, unbundling your self-funded plan has a greater likelihood to maximize savings. This is because an unbundled plan can incorporate the best-suited suppliers for your plan - giving you the freedom to choose your partners and potentially improve your results. As an example, in an unbundled plan, a company can contract with a transparent PBM to maximize the rebates, and additional partners can be added to efficiently source high-cost specialty drugs.

In an unbundled plan, you can also add 'point solutions' that can help you manage the cost of claims for specific conditions prevalent within your employee base. Examples of point solutions include diabetes management/drug programs, musculoskeletal programs, center of excellence programs, bundled procedure pricing, and even direct contracting of specific providers.

Unmasking Common Myths in Health Benefits Management

Myth #8 - As long as we work with a broker for our ERISA-covered plan, we've fulfilled our fiduciary duty to our employees, right?

Truth: Wrong. An employer that offers health benefits has a fiduciary responsibility to act in the best interest of the plan participants when managing and administering the plan. Using a broker does not abdicate an employer's fiduciary responsibility, and in fact, litigation of ERISA-covered plans has been on the rise.

Plan fiduciaries can demonstrate diligence by documenting the processes used to carry out their responsibility. This includes reviewing plan documents and existing contracts, monitoring plan performance and providers, and periodically evaluating your providers (including your broker) and potentially testing the market. In firms with 500-1000 employees or more, establishing a Benefits Committee comprised of employees can be a good component to add to the governance structure. Another opportunity to evidence diligence (and potentially save money) is through carrier reconciliations. Errors are found even when benefit administration has been automated and a manual reconciliation process is in place. Inaccurate carrier invoices can result in overpayments, hidden liabilities, and potential issues with coverage. An automated reconciliation process provides regular, ongoing validation, ensuring accuracy, and will avoid overpayments.

Myth #9 - All self-funding proposals are the same.

Truth: While the principles of self-funding are consistent from plan to plan, there are different configurations that can result in very different proposals for the same plan. We've seen proposals for a self- funded plan that made remaining in the fully-insured plan appear to be the only sensible option. However, when applying the appropriate Spec deductible and unbundling strategy the picture changes. What looked like it would cost hundreds of thousands more if self-funded, turned out to provide a half million in savings in the first year alone.

Carriers (and sometimes brokers) may be incentivized to keep you in the status quo & as the old adage goes - follow the money! More on that below. Don't be afraid to ask questions. Inexperience could just be your best asset - to initiate a conversation and drive understanding.

Myth #10 - Employer-sponsored medical plans are always the best option for employers to offer

Truth: While fulltime workers have become accustomed to purchasing medical benefits through employer sponsored plans, this isn't always the best option for employees or employers. In some cases, it may make sense for a company to offer an Individual Contribution HRA (ICHRA) or its equivalent for small employers - QSEHRA (Qualified Small Employer HRA.

These essentially replace a health plan with employer contributions that are used by employees to purchase plans directly from a carrier or healthcare exchange. QSEHRAs and ICHRAs are a newer healthcare 'vehicle' - created and offered to employers in 2020. They were designed to offer more flexible and personalized health benefits to employees. They don't work everywhere, but where they do, and for specific cases, they can offer a compelling alternative to traditional health insurance and can offer employees ultimate choice while removing employer liability related to claims-driven cost increases. We could write a whole article on ICHRAs alone.

> One last word - **Perverse Incentives** are everywhere in health care and in health insurance. Everything from the concept of an MLR (incentivizing carriers to spend more on healthcare to avoid rebates) to reimbursement models that incentivize providers to perform or prescribe treatments that are medically unnecessary, to PBM spread pricing and rebate structures, and even brokerage commission - and everything in between. While it's impossible to eliminate all perverse incentives, at least be aware of them and work to limit them. Working with the right partner goes a long way to helping you break through the marketplace myths to assist you in putting together a benefit strategy that best fits for your company.

Do you know how much your broker is compensated annually?

At face value, this appears to be a simple question, right? But in reality, the world of benefits can be fraught with pricing opacity and perverse incentives, and we've seen some pretty whacky compensation arrangements in place. Most typically, an agent is on commission - these are paid by the insurance carrier as a percentage of premium. Unlike fees in business insurance, where you would need to make a separate payment to your agent for services rendered under a fee arrangement, in benefits, it's possible that a broker's fee is bundled into the premium and remitted by the carrier.

Fees for benefits can be structured as a flat fee or on a per employee per month basis (PEPM) and may cover services pertaining to all coverages or may be limited to the medical plan only, with other lines on commission. If your broker is on a fee, someone at your company likely negotiated that fee, which may or may not include annual escalations. Do take note of how and when that fee is earned, and what happens with the fee in the event that the relationship is terminated. Also take note of the commission rates on ancillary lines - including disability and life coverages, sometimes these commissions are used to fund enrollment support, which can be helpful. On the other hand, we have seen cases where an agent charges high rates on ancillaries to 'make up' for less-than-desired compensation related to the medical plan. The bottom line is that you should ensure that you understand how and how much you are paying your broker.

In addition to direct compensation, many agents earn contingencies and commission overrides. These are additional amounts earned from carriers and other partners related to the entire portfolio of premiums and could include volume and/or profit-sharing arrangements. The forthrightness and transparency with which these types of arrangements are disclosed vary with each and every brokerage.

Commissions, or anything based on percentage of premium represents a perverse incentive. Not only is premium not a good measure of an agent's required effort, but should your agent effectively earn a raise when your costs increase? In addition, when it comes to contingencies and commission overrides, while many, larger agencies may claim that a 'Chinese wall' exists to separate the specific knowledge of compensation terms from those that work directly with clients, this isn't always the case, as has been proven in past industry scandals.

Best Practices

On behalf of our clients, ERA promotes aligning compensation with performance and full transparency and disclosure. This means negotiating a fee wherever possible. In a fee arrangement, carrier proposals are requested net of commission.

Negotiate Fee-Based Compensation

Request carrier proposals net of commission to ensure transparency

Tie Compensation to Performance

Align 10-25% of fees to pre-agreed performance guarantees

Demand Comprehensive Disclosure

Request annual disclosure of all compensation sources from your placement

The ERA Advantage: Strategy Meets Execution

ERA Group works with middle market organizations to transform how insurance and benefits are managed, not just priced. Because our compensation is 100% performance based, we are incentivized to improve outcomes through more disciplined renewals and rigorous evaluation of brokerage services.

What our clients have come to expect from us:

- Premium savings of 10-30%
- Improved broker accountability and alignment
- A better, highly vetted insurance program

We don't replace your broker - We manage the renewal marketing process and ensure a comprehensive review of your program.

About the Authors - Stephanie Scarola & Paula Kaeser

About Stephanie Scarola

Steph is a "recovering CFO" with nearly 30 years of experience in environments ranging from Fortune 250 to start ups. As a Fortune 250 divisional CFO, she's led delivery of various transformational restructuring initiatives resulting in nearly $100M of Savings, led a $650M operations team, and provided financial leadership to a multi-national $1.5B benefits consulting and brokerage business. Steph is co-founder and co-CEO of Clarity Management Consulting Services and is focused on delivering cost savings solutions to her clients. Prior to this, she was the CFO/COO of Mercer Health and Benefits, the largest global advisor and broker of health and benefit solutions.

About Paula Kaeser

Paula has 15 years' experience as a former agency owner and leading principal, bringing a deep understanding of the way insurance is bought and sold. Paula's skills, as a seasoned insurance professional, uniquely position her to help clients optimize their insurance costs with a focus on manufacturing, healthcare, transportation, education, retail, nonprofit, and hospitality sectors. By utilizing ERA's methodology, Paula assists clients in navigating the complexities of the insurance marketplace to deliver substantial savings through transparency and strategic industry placements. Paula prioritizes client needs, understands the larger risk management picture, and offers unbiased insights and recommendations.

About ERA Group

ERA Group is a global cost optimization and performance consultancy. Our insurance practice helps organizations uncover savings, reduce risk exposure, and build smarter, more sustainable programs for the long term.

Our risk-free model means a guaranteed **NO SAVINGS, NO FEE!**

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