REZILIENT

2025 Healthcare Benefits Insights Report:

Charting the Future of Employer Health Plans

Unlocking a healthier, more sustainable future for employer health plans

The healthcare benefits landscape is at a crossroads. Costs are climbing at unsustainable rates, employees are demanding more meaningful solutions, and traditional approaches are leaving many employers and brokers feeling stuck.

We asked industry leaders about their changing role in the health benefits landscape, innovative plan design strategies, approaches and attitudes to using technology, and whether there's a willingness to challenge the status quo.

This year's *Healthcare Benefits Insights Report* reveals an industry on the brink of transformative change.

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Charting the Future of Employer Health Plans

Trends redefining health benefits

A movement to leave behind the status quo:
For decades, employers have relied on one-size-fits-all solutions that are simple to administer, but financially draining. Now, brokers and TPAs are stepping up as architects of customized plans, offering tools to lower costs and improve care without adding administrative headaches. Employers finally have the chance to reimagine benefits—not as a burden, but as a strategic advantage.

Employers are realizing that sticking with the status quo is like buying bigger pants to fit a growing problem. True change starts when we're willing to tackle the root issues.
Andrew Fondow

Putting control back in employers' hands:
Imagine being able to see exactly where your healthcare dollars are going and making smarter decisions for your people. Thanks to emerging price transparency tools and unbundled solutions, employers can finally start to do just that. These tools are delivering the power to design benefits like a master builder — mixing and matching solutions that meet the unique needs of their workforce while keeping budgets in check.

Transparency isn't just about data; it's about empowerment. With the right tools, employers can take control of their second-largest expense in ways they never thought possible.
Barbora Podzimkova Howell

Turning technology into a human-centered ally:
New technologies like AI and advanced analytics are doing more than crunching numbers — they're empowering people. Whether it's a chatbot answering benefits questions in seconds or algorithms identifying savings opportunities, these tools are turning complexity into clarity. The result? Employees and employers alike are experiencing healthcare as it should be: accessible, personalized, and supportive.

Technology is finally catching up to humanity's needs. By combining AI with real human empathy, we're creating healthcare experiences that are seamless, intuitive, and caring.
Nick Soman

The path ahead: predictions for 2025 and beyond

The role of brokers as change agents:
Brokers are no longer just advisors; they're becoming advocates for bold action. By challenging employers to step away from their comfort zones and embrace innovative solutions, brokers are driving a movement that puts people first and costs second. Their courage and creativity are reshaping the industry.

A great broker isn't just a guide — they're a Sherpa, helping employers climb the mountain of healthcare innovation with expertise and care.
Nick Soman

A movement toward affordability without compromise: Across the country, health plans are being rebuilt from the ground up. With intelligent, value-based models without deductibles and co-pays, employees don't have to choose between paying for care and meeting their basic needs. That world is becoming a reality as new models make it possible to deliver better care at lower costs.

Eliminating financial barriers is a game-changer. When employees can access care without hesitation, their health improves — and so does the employer's bottom line.
Josh Butler

The rise of Direct Primary Care:
Direct Primary Care (DPC) is transforming the way employees experience healthcare. By eliminating insurance barriers, employees gain unlimited, direct access to primary care providers who focus on prevention and long-term health. Employers, in turn, save on downstream costs like hospitalizations and specialist visits. With over 8,000 DPC clinicians leading the charge, this model offers a return to relationship-driven care where providers have the time to know patients deeply and proactively manage their health.

When primary care takes its rightful place at the center of healthcare, everyone wins. Employees get healthier, care gets simpler, and employers save money.
Adam Berkowitz

Q. How do you see the role of TPAs and independent brokers evolving?

Andrew Fondow: **Brokers can be highly influential.** However, the buyer is the biggest disruptor or the biggest blocker of the entire system. That begs the question, who's the buyer? I'm interested in understanding that individual at that employer, which is usually benefits and HR people. Are they a disruptor themselves or do they want to keep the status quo.

People often avoid change to make a situation better because it's easier to accept the situation. Like the dad bod: he accepted that he's getting bigger, and he just keeps buying bigger and bigger pants. The same thing happens in our benefit space. The real issue is not that we need new pants, the issue is the need to scale back on what we're eating and get some exercise because the status quo is not healthy. But it's much easier to stay within the status quo, like a BUCA plan, and deal with the incremental budget increases.

A broker's role is to put a mirror in front of buyers. We can see that there's a big problem and we can't sustain consistent increases of 9 to 9.5%. If your loss ratio was over a hundred, you're into double digits.

> My role is to get them to look at where they are: maybe they were at $700 per employee five years ago, but they're at $1200 now. That's not sustainable over time.

Your pants sizes can't continue to get that big, you're actually going to end up in the hospital and we're going to be forced into a major change. Can we get ahead of that?

We look at what we call the buyer's risk-adjusted ROI, and it sits with the individual buyer. Most buyers that we see are deflating the actual positive impact to the organization and inflating their workload and risk. Thus, that ROI goes way down. If they introduce something new, in their mind they're going to be on the hook for all the risk regardless of the savings that they are promising. If they miss that, they think they'll have egg on their face. And they have all the logistical and operational things that go along with setting up new benefits.

Where we find success is helping benefits teams ask what they're willing to put on the line to create real, sustainable change. The money is going to dry up if they don't change something. There's no way that the budget can sustain 50% over the next five years.

Beth Grellner: **TPAs and brokers will continue to lean on technology as a tool** and look at how to best incorporate AI into the work that we do. At WTW we have a global team dedicated to evaluating how AI might be able to improve the efficiency of our work and enhance our analytic capabilities. We're getting ready to launch an AI chatbot on our vendor profile database. What the chatbot will allow us to do is capitalize on consulting on the fly by being able to talk with a client about their approach to diabetes management, for instance, by asking the chatbot to find a diabetic management program that works with ExpressScripts as the PBM and has the ability to serve a client with 2,500 employees in these three states. Within seconds, we'll get that answer.

Then from a TPA standpoint, the big carriers have all acquired TPA capabilities over the last several years because, when you think about an insurance company, they designed their program to manage their fully insured programs that are filed with the state departments. The big carriers can't always adjust or have that flexibility that a majority of self-funded employers want, so the TPA really gives them that flexibility to put forward some different plan designs.

Nick Soman: **Good brokers are going out and saying, "I can help you find alternatives to what has been going on for the last five to 10 years."** Mainstream adoption of new approaches to health benefits is starting to happen faster than I expected.

The broker plays a critical role because they are the solution to the fact that many small businesses accidentally end up running a healthcare company when all they meant to run was their own company. Not many people want to become a true expert in that. So brokers will help you find a better option. I am a huge advocate for the brokers who are really trying to take care of people.

From our data, brokers drive or influence about 75% of small group health plan sales. A lot of people when they hear that number and they say I don't have a broker, I use Gusto, or Rippling. Guess what? Gusto's your broker. Rippling works as a broker. The good ones work hard and are valuable: you need a sherpa to get up a mountain, an expert who's motivated to help.

Barbora Podzimkova Howell: **I'm seeing two big trends.** There's a lot of private equity consolidation of the independent TPA market, and large insurance companies are acquiring independent TPAs. But there are also a lot of new TPAs. TrueClaim is not the only company seeing the opportunity in transparency and leveraging new technology to build something that traditionally is very non-transparent in a way that is helping the end consumer to lower costs and improve outcomes.

The amount at which healthcare expenditures have been increasing for companies per year continues to be close to 10%. Which, when you think about healthcare benefits being the second largest budget item for most companies, is just an incredible amount of money. This is coupled with employers historically not having a lot of access to data to understand where these expenses and increases are coming from, compared to salary compensation bands where CFOs can get into nuances that impact 0.1% of their payroll expenditures. Historically, it's impossible to do that for the second largest budget item.

> Independent TPAs have the opportunity to leverage new data sources such as price transparency data.

The government has made it very clear that medical claims data belong to the health plan not to the insurance company, so there's a lot of opportunity to leverage the data to start creating transparency around healthcare expenditures. With transparency comes power. And it turns out there are actually a lot of different ways in which benefits can be designed and costs can be managed by understanding specific population needs and addressing them in the most cost effective way.

If I was going to summarize the role of TPAs in a couple of words, it would be control and transparency, with the ability to mix and match like Legos. They can essentially bring together a variety of different solutions starting with the network and combine it with programs such as Rezilient to take some of the claims out of the system and provide better care at a lower total cost. They're then able to bundle that back together and show the comparison in terms of access to a variety of benefits.

Josh Butler: **Over the next year, we're going to see more brokers customizing programs** by putting together unbundled solutions and bundling them back up to where the TPA will execute the moving parts. We're seeing more brokers transitioning business over to independent TPAs to gain that level of flexibility and transparency.

There are hundreds of point solutions out there, and there are hundreds of companies and organizations that are providing tremendous value within the context of a plan design. There's not room for every single point solution that is available in the marketplace, so brokers and consultants are spending a good amount of time doing diligence on specific solutions to say

what best fits together. It's like building Mr. Potato Head: we start with a blank canvas and put the arms, legs, eyes, nose, mustache, and glasses. Brokers need to put something together that makes sense for their client in their specific marketplace. A TPA partner that can help bring that all together and consolidate it into high performing plans. It's easier said than done but I think we're going to see a big continuance of that.

Everything that we do without an employer who's willing to implement these types of plans and strategies or to custom build a plan is for naught. In order to get the sweetest, most ripe fruit, employers have to go out there on a limb to try to fix what's very, very broken in our industry. But they don't want more work. They're not in business to try to solve healthcare so they want a holistic solution.

What they like about the BUCA model is that it's plug-and-play. It's easy to administer and execute. But what they don't like about the BUCA model, it's not cost-effective: the costs keep rising and there's no transparency.

> Brokers are crucial in bringing employers the best of both worlds: ease and efficiency in execution, and the price controls and cost containment.

We're going to start seeing more people designing plans in conjunction with savvy TPA partners that can execute a holistic plan with all of these cost containment solutions that really work, but also make it just as easy to execute as the BUCA plans.

> Good brokers are going out and finding alternatives to what has been going on for the last five to 10 years.
>
> Nick Soman

Q. Do you anticipate any significant shifts in how employer-sponsored health benefits are designed?

Beth Grellner: **Our research shows that employers still see the value of offering a strong plan.** Behind salary, it's the number two reason for why people choose to work for the companies that they do. And quite frankly, there isn't another mechanism available today either in the industry or government that could manage that process. The government is paying Medicare claims, but they outsource to insurance companies because they don't have a function within the government to do that. We're not going to have a single payer system in my lifetime. We simply don't have the infrastructure to administer it.

We might see additional regulatory things come through. On the campaign trail, President-Elect Trump said he was going to require employer plans to cover IVF. It's kind of the issue of the day: the one that people are most interested in and are raising a lot of awareness around is typically what we see the regulatory bodies focus on. We'll probably see some results of that.

And how do you go through a day without saying GLP1? We see a tremendous amount of interest, excitement, concern, disbelief. It's such a controversial thing. It's got such duality associated with it that there I think we'll see something along those lines as well.

Tony Garavaglia: **Over the last several years, employers have been adding in point solutions** to solve for things like mental health or musculoskeletal issues. But there's more willingness to really disrupt the traditional system of a medical plan with BUCA or a standard high deductible health plan.

> I'm starting to feel a bubbling up hunger from my clients to take a "clean sheet of paper" approach and potentially move away from the traditional approaches of the BUCAs and the traditional PBMs like Optum, Express Scripts, and CVS Caremark to more progressive approaches.

People designing benefit programs are hearing the progressive employers that have already done this tell their story at conferences about cost savings, better employee experience, and the improvement in employee value proposition overall, so it's starting to catch on.

Employers getting point solution fatigue is becoming common. The traditional BUCAs might have been good at program X, but not program Y, so employers have had to piece together these point solutions where their carrier partners were falling short. Employees have point solution fatigue too. Where do I go for what? There are concierge models out there that help bundle it together to make it a little easier for the employee to navigate, and I've come across a relatively new solution recently that bundles it not only for the employee but for the employer. It seems to be easing some of the administrative burden on employers because they're not having to manage multiple point solution vendors and I thought it was a really interesting concept.

Nick Soman: **I anticipate significant shifts in how health benefits are designed and offered.** The current system is so deeply broken that becomes the underlying fact of any question about healthcare in this country.

The cost of employer sponsored health benefits has quadrupled since the year 2000. It now costs $24,000 a year for an average family to get health benefits, and

that number keeps going up every year.

> What we're starting to see is that employers are desperate for anything that can allow them to take good care of their team without just shifting costs onto their own employees through astronomically high deductibles.

So in a world where a lot of people are saying the right things about being able to keep costs under control and keep people healthy, that's really not what the data is showing us.

There will be more patience for alternatives to traditional ACA coverage. There's a role for it, but our country can't make its mind up about whether healthcare is a right or a privilege and as a result we're getting the worst of both worlds. We need to make better options available and they need to cost less money. One way to do that is to allow for a single payer environment, but that isn't the only way to do that.

The way that we seem to want to go is to unleash innovation in the context of healthcare, which comes with winners and losers. The winners are going to be companies that are willing to try something different from just buying from BUCA and taking an 8% increase, if not worse, every year. Insurance and health plans are a math problem, which is pooling. How do you take a bunch of people and make sure that you can cover them and their costs in a way that takes care of the sick ones without charging the healthy ones so much money that nobody can afford it? You have to find alternatives to being able to pool risk in different ways. I'm an advocate of a policy called association health plans or multiple employer welfare arrangements that offer more flexibility in which small employers can band together to offer coverage to their employees.

> The BUCAs are playing a shell game with America right now and that needs to stop.

You have to incentivize people to do the right thing, which is to find a high value health plan that costs less money for better coverage. At Decent we build health plans around direct primary care (DPC), which is a movement of about eight thousand primary care doctors and clinicians like my parents who got fed up working for big HMOs and decided to set out on their own and charge a capitated rate (typically $70 to $100 per month) for unlimited primary care. When you get more primary care, you stay healthier. You need fewer visits, you need less urgent care, you need less hospitalization, and that saves the plan a lot of money. The secret that not everybody knows yet is that if you combine direct primary care with a health plan, it seems like they will cost more but they actually cost less. Direct Primary Care is growing explosively, particularly with employers, and obviously that's the train that we are riding at Decent.

I love the direct primary care movement. As the child of two primary care doctors, I heard all of the things from my parents that I now hear people saying more loudly: "I used to love my job, but now I feel like I'm just dancing for the insurance companies," and, "How I can take good care of you if I only have 12 minutes before I'm legally incentivized to push you out to a specialist or, a prescription that frankly will overcharge you because that's how to make money". An increasing proportion of people are waking up to that and are willing to try something new. Nobody's saying, "Good thing I have my United plan and it only increased in cost by 10% this year on average." We are finding better ways.

Q. How do you think health plan affordability will change? Are there any emerging strategies to keep costs manageable?

Adam Berkowitz: **Every employee is feeling and seeing it and we're past a breaking point.** They can't afford their deductibles and companies can't continue to sustain cost increases every year.

This space is ripe for innovation. There's a significant tailwind to drive change right now, and a sense of urgency in the employer market to do something different. Change always comes with risk but I think the urgency has now outweighed that risk.

We're doing a lot of things to tackle the cost problem. We start by getting rid of a lot of the waste that is pervasive in health insurance and healthcare financing. There's a very long line of how the dollars flow between patient and provider and along that supply chain is where you get bloat and abuse, because there's a lot of hands in the pot and it's not very transparent. For a long time it's not been clear who's making what and how much.

The BUCAs have gone on an acquiring spree to the point that they own almost the entire vertical of healthcare financing and payment delivery, and a lot of the procurement and care delivery itself. United employs more doctors than the largest health systems combined and I think it's the fourth largest pharmacy in the country behind ExpressScripts, which is owned by Cigna. There's a lot of conflicts of interest.

When you add in transparency and apply rigorous ethics it's about paying fair prices for healthcare and aligning interest between providers and patients, a lot of which comes down to something as simple as how you pay for the care. For instance, in a subscription-based model it's not fee-for-service. Patients get better, and doctors can provide better levels of care. It's healthcare versus sick care. We're starting to focus on the things that people actually care about and driving value in the process. Everybody gains value in that equation when we're talking about something like Rezilient, and that's not often the case in healthcare. Usually, we're robbing someone to pay someone else.

It's an exciting time to be in this space because there is opportunity to benefit all parties. But we don't live in a perfect world and healthcare economics is flawed, so we view our job as agents of change and transformation.

> We're aligning all of these parties and putting them together to deliver a cohesive health plan to people, so there is inherent value there, but the only reason we exist is because the system is so broken. If we get to a point where we are our own demise because the industry rights itself, that would be a good thing. But I don't think we're going to get there anytime soon.

It's a four trillion dollar industry. The challenge is convincing an employer that it works before they've tried it. Employers have bought and consumed health insurance the same way for four or five decades, so telling them that it can be done differently is not such an easy thing to sell.

Andrew Fondow: **We're just continuing to see costs rise and the most promising ways of managing it are yet to bear out.** So we have to hang in there to watch some strategies that people are deploying around cost containment. The most immediate issue is to figure out how somebody at $20-$40,000 in spend stops there, and that is to surround them with the very best solutions possible.

We have to get beyond looking at something like Rezilient as acute urgent care and instead see it as a way to totally surround people with the right healthcare.

> We have to come together around Bill who has this heart issue from years of a bad lifestyle. That means bringing an entire care team together to help him, because depression has set in due to the health issues he has going on, his obesity is a problem and is made worse by his lack of motivation which comes with his depression, then the copious amounts of medications he might be on.

We've heard pitches for years on this from the carriers. The broker needs to know enough to see through the noise of what the insurance company just told them to work out whether it's another bill of goods that's not going to work versus a model that actually does work.

Where we are seeing this right now is in the folks that have quality data to use for steerage. Carriers say they have the quality data, but when we ask to look under the hood we get told that it's not possible. When we ask whether they do this by physician or just by system they tell us they do it by system because there's too much variation within the data. Next we ask them if they have any of their own hospital system customers that they have put in a lower tier? No. So, now I've peeled back the layers of the onion and it stinks. The carriers are simply placing their own hospital system clients at the top. So the broker needs to be smart enough to see through that and offer other solutions, because too many people have put in the carrier solution and that didn't work.

When we get to specialties, especially surgeons, there is a huge difference in quality and cost. We can look at the data points to show who does more conservative treatment patterns before they recommend surgery, like cortisone shots or sending people to PT.

When it comes to point solutions, they need to be strategic and foundational because a lot of these treatments need to be done in the doctor's office. HR probably isn't equipped to help you reverse your diabetes.

Beth Grellner: **There is a high degree of focus on this from our clients right now: the number one issue in our 2024 Best Practices survey was affordability.** There's high interest in the idea of co-pay only programs, so alternative plan designs will be helpful.

However, that does not bring down the unit cost of providing care in terms of the negotiations that happen between the insurance carriers and the hospitals, and we have seen a tremendous amount of uptick in some of those contentious negotiations on network participation over the last year or so. I think that, if we can't bring unit costs down, affordability is a problem.

I was struck by a stat that I heard recently that right now inside the hospital buildings, we have capacity. There are empty beds and floors that are not being utilized because so much care has been moved to outpatient. And so hospitals are needing to have increased costs and unit costs to cover the fact that they don't have people in the beds. So they're making the negotiations more controversial. I think we'll continue to see additional push to outpatient and additional virtual services. We see a tremendous amount of telemedicine for behavioral health and we can do so much now that we didn't have access to. How will hospitals respond, because that's where the largest costs come from.

Herb Catausan: **From my vantage point it will be less affordable.** Costs are always going up, and to some degree we can materially impact that. But things like inflation mean the cost of services in general go up, so in my opinion that would lead to less affordability.

I still think it will be more or less affordable for the small to middle market, which has been predominantly

a fully insured marketplace because of the presence of two very large integrated carriers that have bought providers and have been able to suppress rates. In fact, I've seen significant investment from Highmark specifically in this cycle to invest in that fully insured marketplace to at least provide another one to two years before this particular employer will seriously consider a move into a self-insured arrangement.

> But what we have seen over the past five to 10 years is the emergence of stop-loss solutions moving into that space and bringing more options for small to medium-sized businesses to enter into that self-funded dialogue.

A lot of the products and services are still evolving, so as they become creative with their underwriting mechanics it's worth considering these alternative financing arrangements.

The catch is, most small to medium sized businesses don't have the bandwidth or sophistication to really understand what this looks like. When they only had to buy one thing, it was easy and they were just managing premium costs. They got used to premiums being higher than expected and paying employees a specific way to account for it. The Health Rosetta movement is trying to create awareness from a grassroots level of employers saying they value their people but being unable to afford to pay them more, but if they had a million dollars more they would. Where does that million dollars come from? The health plan. The emergence of bundled solutions, like a Level Health plan, make it easy even on the brokerage side.

One of the problems we need to solve for the small to medium marketplace is the volatility of claims. That's the doorway to creativity to insert unique solutions like Rezilient or carved out PBM. Stop-loss is one of the areas in which we're seeing unique products that would help employers at least enter into the self-funded dialogue so that they can control costs and potentially make it more affordable.

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>
> Adam Berkowitz

Q. What role do you think government will play in incentivizing or regulating health benefits?

Adam Berkowitz: **We saw the Democratic attempt at healthcare reform through the ACA.** I would venture to say that was much more health insurance reform than it was healthcare reform, because all that law really did was force people into insurance products and put requirements on insurance companies to restrict declining coverage if you have pre-existing conditions or rating someone higher because they were pregnant, things like that. Nobody really agreed with those tactics so they solved for that, but they didn't really change the dynamics of healthcare.

What we pay for healthcare is still over-inflated. There's no transparency in the pharmacy side and the big got a lot bigger since the ACA passed. The uninsured rate went down, but you can't say that health insurance became more affordable as a result of it. We've seen minor iterations and bites around the edges since then.

> There's been really meaningful reform in price transparency, which is starting to make an impact in the market.

Unfortunately the amount of data in these transparency files is so massive that it requires third parties with big servers that can crunch this data to make it consumable and useful. Having transparency is good but what is its utility and how do consumers interact with it? And it's not really democratized data, you need to pay these third parties in order to access it in any meaningful way. But it's progress and I think it's going to continue to move in the right direction: consumers need to know what healthcare costs at every interaction. What is this visit with my doctor going to cost me? What is this X-ray going to cost me? And are there price differences between providers? That's really important to know.

We're going to see continued pressure on the PBM side. It seems that Congress is very interested in understanding these dynamics, which is long overdue, but I don't think the government is going to solve this. We're seeing the most meaningful impact at the grassroots level: when we're delivering a solution for a small company that saves them 30 or 40% of their premium and their employees now have amazing healthcare providers and health insurance. These are the things that are changing people's lives. We have to figure out how to scale and how to do more of it.

Herb Catausan: **On the federal level, we're going to have tax credits and subsidies,** plus the regulations of minimum requirements, which is not new. We're all still digesting what the election result means and trying to figure out what the new administration is planning.

While it's not ultra innovative, once folks start getting a handle on transferring risk to state and federal exchanges we might see problems.

Small to medium-sized groups want another way to handle large claims, like a $750,000 claim for a 200 life group that causes a 5% increase to become a 30% total increase on aggregate cost. These employers are potentially carving these claimants out saying, "we'll pay for your state, if you purchase individual coverage, we'll pay for everything with no out-of-pocket costs." Which means they're going to pay $30-40,000 annually, which is lower than their spec deductible and way lower than their $750,000 claim.

That risk is now being transferred over to the state exchange which can swallow a handful of these claims, but if everyone starts doing it, it may have financial impact on some of those exchanges and their financial viability over time.

Josh Butler: **Healthcare may be the only issue right now that is bipartisan:** Republicans and Democrats agree that health care costs are out of control and we need to do more to make health care more accessible and affordable for people all over this country, including pharmaceuticals. I think that we're going to continue to see a progression towards that.

The Trump administration is very pro-business, so they're going to continue to double down on some solutions and strategies that help American businesses thrive and keep health insurance privatized. If the Democrats had won, we may have seen a shift into more public options.

> If the past is any indicator of what this administration might do, I think we're going to see a very hard push into transparency and innovation, and also pro-business vehicles that empower American businesses to get creative.

On the state level — in September of 2023, Texas passed state legislation called House Bill 711 that allows employers to do what we call tier and steer: an employer can tier their benefit designs, even in the confines of a BUCA model, and steer people to high quality, low cost providers. High Plains Health Plan is a tier and steer model which we've been using since 2022. So House Bill 711 was vindication for the work that we're doing. I think it's going to have a ripple effect because I think other states might follow suit.

Another bill that passed in the Texas legislature allows patients to pay cash for a service, turn that receipt into their insurance carrier, and have that amount applied to their deductible and out of pocket maximum, even in fully insured plans. I think both those legislations are going to continue to empower businesses and consultants to build custom health plans to take advantage of cash pricing, direct to employer contracting, narrow network strategies, all of the things that are really driving down health care costs. The legislature is starting to put some wind in those sails.

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>
> Josh Butler

Q. How are compliance challenges changing, and what regulatory areas will require more focus?

Beth Grellner: **Employers are increasingly concerned about compliance,** which could lessen with a Trump administration. The Biden administration put a lot of resources towards regulatory compliance.

Mental health parity is probably top of mind for the employers that are aware of their obligations around it. We're fortunate to be uniquely positioned in that space because we have clinicians on staff as well as attorneys and individuals who are familiar with how to do claim audits. So, we do a tremendous number of mental health parity audits and reviews. We've been on the ground floor helping to guide the department of labor in terms of the most recent updated regulations.

> Nobody wants their name in the paper associated with something like that, so organizations are highly focused on it.

Compliance and transparency are becoming synonyms in some sense. When cost transparency data was first released, quite frankly, it was a mess and you couldn't make heads or tails out of it. It's getting much better and organizations like our competitors and insurance carriers are using that data to better understand positioning in the market. We have a tool that looks at discount arrangements with different hospital systems by zip code then overlays quality information, and we're bringing in cost transparency information too. We will be able to use all that data to understand that a specific facility is going to be the lowest cost for any given procedure and have the least likelihood for readmission. We'll be able to understand which places perform really well and which places might not do such a good job.

We're looking at how we can better use that information because when we talk with the leaders at insurance carriers, they're looking at that transparency cost information to ask whether their deal is better or worse than what we're seeing in the transparency data. In any of these contract negotiations, there are tradeoffs. They might get a rock bottom price on colonoscopies, but they might pay a premium on a procedure that is less frequent but more intensive. That transparency lets everybody see where they fit in the range and negotiate with and against each other.

Nick Soman: **We are increasingly going to be operating in a context where there are more options for patients** that are not straight down the middle, fully insured plans. Compliance is probably the single thing that matters most for new entrants who need to prove that somebody who chooses to use them over a BUCA isn't going to get fired for it. The approach that healthcare has taken to compliance is mirroring what I see in tech in a very healthy way, and more than it ever has before. Compliance used to be producing a report from a lawyer that shows that you're following every single rule that was largely written by the insurance companies themselves who are out there lobbying for what suits them.

> Compliance still includes following the rules, but now it's also about, can I trust you to do what you say you're going to do?

Can I trust you to disclose where my money is going, how much you're getting paid, whether you're taking kickbacks? There is a demand for transparency that I think is the absolute best thing that's happened for innovators. For us to be able to say, "Here's how we make money. If there's any other variability or another option, I'm going to give you both options. Here's the report that we're going to give you every month. Here's

what you'll see at the end of the year to determine whether it ended up being a right choice".

There's an increasing expectation that some of the things that have become accepted in healthcare are not okay anymore. Hiding the ball and not telling people how much it's going to cost, not charging people fees that they don't understand, and taking advantage of that fog of war is going to soon be unacceptable. Those are all things you'd want to have a better and more effectively regulated space, not just more rules.

Andrew Fondow: **It doesn't matter who the administration is when the country is so far in debt.** Auditing is going to pick up, and mental health parity regulations are going to have a big impact.

For instance, if diabetes management is the lowest cost you have, every mental health visit has to then match that piece. That's a huge problem. I am not criticizing mental health parity at all: the mental health crisis is real and we have to solve it. But when you start to handcuff plans to make it its lowest common denominator, you start to run into problems because there are big expenses in mental health areas.

The run at the fiduciary and trying to keep costs low: I don't know where that ends. Benefits teams are making decisions and putting together a board to review them. Some things might be a little bit more expensive upfront to get to a better outcome, but to a board that might not be acceptable.

> Compliance is probably the single thing that matters most for new entrants who need to prove that somebody who chooses to use them over a BUCA isn't going to get fired for it.
>
> Nick Soman

Q. What approaches are you seeing to control costs without compromising on plan quality?

Adam Berkowitz: **Driving health care hyper local is having an impact.** We're creating health plans around local providers, health systems, and communities, and by engaging in conversation directly with these providers we're driving down unit cost of care. We're saying we're not going to contract through the big insurance networks or lease a commercial PO, we want you to give us a fair price and help us lower our cost overall. In exchange for that, we're going to drive patient volume to you. In this environment employees no longer have deductibles or co-pays, so we've eliminated the financial barrier to accessing care, which is huge.

There was a study recently that found that 60% of working Americans don't have $1,000 saved and the average deductible in this country is north of that. So there's a huge financial barrier to care and a huge price sensitivity. A price change of $5 or $10 means that all of a sudden people stop taking their medications, that's how sensitive people are to price. Deductibles and co-pays are insurance carriers' answer to rising costs, they push more of that onto members through cost sharing mechanisms.

If costs keep going up, you see this trend towards higher and higher deductibles and higher and higher co-pays. That's a death spiral.

> So we're going in the opposite direction: we can get fair pricing that's 50% to 70% less than what we're typically paying and is still profitable to hospitals and providers. Then we don't need deductibles anymore. Everybody wins.

Barbora Podzimkova Howell: **With plan design, there's the top down approach and the bottom up approach.**

From the top down perspective, there's more choice in terms of point solutions or vendors that can be assembled into a health plan that's operated by an independent administrator. Because technology has advanced, we have the ability to operate more complex health plans in a way that still feels like one experience to the member and to the company.

We still have a long way to go, however. In the self-insured SMB employer market, you still see 30-page benefits guides that try to educate members by combining a page each from 17 different vendors. The member probably stopped reading on page number two, which happens to have 27 different phone numbers for each of the vendors and some of them have two phone numbers. Technologies already exist that can make a lot of this easier and cost effective.

The bottom up approach is day-by-day, condition-by-condition, bill-by-bill, which is where TrueClaim started. In our first ever pilot we retrieved medical claims from individual consumers with their consent and ran them through our technology to see if we can use those claims to identify savings opportunities. We were initially focused on payment integrity, so we looked for things like duplicate charges.

Eventually, we started seeing a lot more interest from members and employers to look at pharmacy and care navigation opportunities, like a prior authorization for knee surgery for a particular member.

> That's a great opportunity for our algorithms to automatically detect a chance to offer a second opinion to that member before they have surgery.

Similarly, on the pharmacy side, there could be a member who would save a lot of money if they were filling the exact same prescription at a different pharmacy or getting it mailed to them through a mail

order pharmacy. In both cases, the plan is saving money and the member is getting better experience and better care. This is something that hasn't been done at scale before, where the administrator recalculates opportunities in real time.

There is an opportunity for us to share information with the vendors in the health plan that we're administering and vice versa to enrich what goes into these algorithms.

> At the end of the day what matters is that it feels like one experience to the member, and the reason we believe in this so strongly is because if the member is not engaged we can't do anything.

It doesn't matter that we have 17 different vendors and 27 different phone numbers if the member doesn't know about it, which actually tends to be the biggest problem in the industry today.

Tony Garavaglia: **Advanced primary care or virtual primary care is a really hot topic.** It doesn't sound innovative at the surface because it's been around for a while, but when you dig deep into what virtual primary care and advanced primary care can do is bring concierge preventative care to the masses. We need people to get into the doctor before they're in a serious situation.

> You take your car in for maintenance and oil changes before it falls apart on the road but we don't do that with our bodies.

My clients ask: 'Why aren't people accessing primary care? Why are they not getting their preventive exam?" Because it takes so long to get an appointment for a physical: it could take six months unless you have a concierge doctor, even when they're partnering with one of the BUCAs. They have a lot of providers in their directories, but they're so overloaded with patients people struggle to get access. There's a ground swell of interest in getting access for their people to primary care.

Not only that, but access to specialty providers is also a concern. There's some specialties where there's a plethora of providers, but pediatric psychology, for example, has a big access problem. Kids coming out of the pandemic are struggling with their mental health. They had their social upbringing severely interrupted and a lot of them are feeling stress and anxiety, not to mention the influence of social media on that generational cohort. Some of the virtual solutions around mental health and well-being are interesting, and kids are very open to doing a physician's appointment virtually.

Older generations are more willing to do so too, because they had to during the pandemic and saw the convenience in it. They didn't have to drive to an appointment, pay for parking, and struggle with traffic, they were able to have their appointment via video and get on with their day. And men are especially reluctant to go to a mental health provider. When it's virtual, there's something that feels private about it so they seem to be more willing and not as embarrassed about doing it than if they were to go to an in-person provider.

Q. What changes do you expect to see in plan design to adapt to evolving employee health needs?

Josh Butler: **The elimination of deductibles and co-pays.** We went through this mass exodus into high deductible health plans and HSAs because we thought that if you give someone a $5,000 deductible, they're automatically going to become a savvy consumer and shop for high quality, low cost care. But that didn't happen.

> We're starting to prove that the actual way to improve clinical health in population health is to lower deductibles, lower co-pays, and lower financial barriers to good quality primary care.

Primary care can then take its appropriate place back in the relationship. Incentivizing people financially is powerful motivation, but it's the opposite of what we've done over the last few decades with high deductible health plans. We're scratching our heads saying, "Why aren't people getting healthier?" Because they don't want to pay $5,000.

That's how we have our plan designed. We offer $0 deductibles and $0 co-pays for thousands of medical services. All generic medication has a $0 co-pay. You have to incentivize the behavior you want people to adopt. If their deductible is $3,500 whether they go to a facility where their surgery is $50,000 versus a facility where the same surgery is $19,000, they're not going to care where they go. But if we eliminate their deductible where it's $19,000, but not for the facility that's $50,000, they'll choose the lower cost option.

The knowledge gap in the marketplace needs to shrink. People have to dig in and get educated on our industry because they don't understand capitation, like the Rezilient model. They don't understand that Rezilient is sharing in the risk. You're getting paid by the employer's plan or it's baked into their premium and in exchange you guys are doing a wonderful service at a $0 co-pay for the member. So employers can tell their employees to just go to a Rezilient clinic.

> We're going to see more and more models where the right partners are baked into a health plan and it's easy for members to access them.

If you compare it to the fee for service model, even in a co-pay or deductible model, the employer is still spending exponentially less. That's further proof that it's possible for an employer plan sponsor to pay less for health care services without pushing more financial burden onto employees with higher deductibles and higher co-pays. High Plains Healthcare's model is proof, and I think there are multiple other models that are proving this.

Tony Garavaglia: **There continues to be interest in offering high deductible health plans that have HSA compatibility** because of the savings vehicle and the triple tax protection of an HSA. There's no other vehicle like it in the IRS code where money goes in tax-free, it grows tax-free and it comes out tax-free as long as it's utilized for qualified expenses. Employees like it now.

A lot of my clients are struggling with what to do with GLP1s. Some of them cover it today, some of them don't and think maybe they should. But the studies on their impact just don't have enough data for clients to make the decision of whether they should add the offering or not. There are some potential benefits to GLP1s. If people are no longer obese and their hypertension is potentially going away, or their diabetic risks are going down and maybe they don't

have hyperlipidemia anymore, there could be a long-term positive impact of people utilizing these drugs. However, we don't know what the long-term side effects of these drugs are on anyone taking them for weight loss.

If you do cover GLP1s for weight loss, there should be some accountability and lifestyle management programs offered alongside them. This isn't some kind of magic injection where you just take it and be sedentary and eat poorly.

> There needs to be a lifestyle change while getting some really great results from the GLP1 so when they come off it, their new lifestyle has become their lifestyle.

Suicide rates and substance abuse are among the highest they've been in the US. The sandwich generation of people that are caring for their aging parents while raising kids and trying to have a career are particularly under pressure. It's estimated that a quarter of working adults are a family caregiver on both sides. Employers want to find personalization in their benefit offerings to be able to offer resources to people that are struggling with mental health and substance abuse, struggling with caregiving, and the pressures that come along with that, including financial pressure. If they're paying for their aging father's care while trying to save for their kids' college tuition, they're getting squeezed financially on both sides.

> Incentivizing people financially is powerful motivation, but it's the opposite of what we've done over the last few decades with high deductible health plans. We're scratching our heads saying, "Why aren't people getting healthier?" Because they don't want to pay $5,000.
>
> Josh Butler

Q. What role do you see technology playing in transforming health benefit administration and delivery?

Andrew Fondow: **The care and concern for people has to show through and above the technology.** We've had technology in this space for a long time and most people have ignored it because they want to get compassion from the person delivering care.

A lot of hospitals in the US come from a religious organization of care and compassion and that has stuck with people. It's not just somebody from San Francisco that built an app, it's somebody that built a solution out of love, care, and concern that will win the day. There's something magical still about seeing your therapist or your doctor at the grocery store, even in a big city, or seeing how nervous a patient is by their body language when they walk into an exam room.

> There might be a day in which a robotic arm comes and helps me get an exam but there does need to be some transitional period and a very qualified person on the other side. That's got to shine through.

Nick Soman: **Nobody wants to talk to their insurance carrier or their health plan,** so we don't have the ability to create delightful experiences the way that you could in the consumer space. It has to start by making it easier and faster and cheaper to do the things a healthcare consumer or a plan member wants to do.

This is very much where we're focused at Decent: we're a human first company. We are embracing AI, but we're using it to build ourselves Iron Man suits internally so that each person can do more with their time. Our members aren't interfacing with AI tools masquerading as humans. I think there is a risk of losing the humanity when you lean too hard into technology, and I would argue that loss of humanity is the single biggest thing that has destroyed healthcare in America. Robots aren't going to fix it, especially member-facing robots.

AI can scale the tedious and thankless work that has to happen to administer a health plan effectively, transparently, faster, and cheaper.

> Technology helps us do those tasks and allows humans to be more human.

You used to have the excuse that it was hard to create a report that shows you where every dollar goes, but AI means there's no excuse like that anymore. Sunlight is the best disinfectant. It is finally here for healthcare.

Barbora Podzimkova Howell: **The biggest one is in internal operations.** Internal data is generally unstructured, and includes multiple communications through multiple channels. If we use tech to enable internal teams to read or understand the context of the information faster and more accurately to respond faster, better, and more accurately, then that's a huge win.

I can resolve a problem on one call with a member because AI has ingested all the information and given me a concise and accurate summary, that's a much better experience for both sides than having to make seven different phone calls to gather information, or putting a call on hold to call another internal team member to retrieve that information, or reviewing an 80 page medical record.

There's an increasing value of technology — including generative AI — on the member experience side as well. Everybody's building a chatbot and I think that's great to answer questions on demand about people's

benefits, like what's covered or what's my deductible, without having to wait in a phone queue with your insurance company. No one wants to do that. Beyond that, interacting with healthcare and being able to find some context about what you need before you actually call, for example, your care navigator, I think is a real opportunity.

Herb Catausan: **Technology is and will continue to be a very big player as it relates to any sector of healthcare.** But I don't think you can ever divorce people from coming together. The hands-on, clinical people are going to be ultra valuable and they will be multi-talented, not just on the clinical side, but really on the people connection side, because they are our physical ties to the local community and local employer groups.

Technology can certainly aid them with a lot of the clinical pieces or driving data back to the mothership through machine learning and clever automation. There's going to be decision-making tools that are going to be pretty awesome to think through, but in my view always complemented with real people interaction.

> If benefits professionals are removed from the actual mechanics and we're completely relying on AI to facilitate, there's going to be something missing. And then when it breaks down, no one's going to know how to fix it.

Josh Butler: **Every TPA uses different technology for adjudication of claims, utilization management and disease management, and prior authorization requests.** The TPA of the future is going to have to wholeheartedly embrace newer technology — a lot of TPAs are operating with very antiquated technology. Blockbuster didn't just go out of business because they were stubborn. They ran figures on their internal processes and infrastructure. It was going to cost them so much money to overhaul it and catch up with the Netflixes of the world that they said "Look, we're losing so much market share. We'll never be able to catch up. We just need to ride this wave for as long as we can." I hope these TPAs aren't the same as Blockbuster and they start to make investments in technology upgrades.

We're going through a nostalgic period where people recognize that we have this big, brilliant evolution of technology, but I still see a whole lot of people that have a big appetite for personal service and being educated not by an AI bot, but by a human doctor.

> The companies that can figure out how to do that at scale with real people, maybe AI assisted, are going to do well.

Q. How are data analytics improving plan performance, and what advancements do you expect in the next year?

Tony Garavaglia: **I'm a data geek. Data should be at the core of everything everyone does.** You need to know where you are today so that you can develop a strategy on how to address what's driving your costs and what disease states your people have. That starts with data. It gives you the measurable components of whether the strategy is working and without that data it's just hearsay or an employee survey that says 'yes I love the benefit'. Data is key to understanding where you are starting from and what the things you need to focus on from managing a disease state, or a cost state, or access. Having that baseline means you can implement the right programs, then monitor and analyze that data to see if it's shifting the curve, then revisit and fix or get rid of the things that aren't working.

> When they have the data, they can dig deeper to see what is driving the cost and focus on that. We're going to dig into the claims data and find out where the money is going.

I have a client with MSK as their number one issue and I've told them, we need to look at an MSK solution or do some education or an ergonomic study. Why do you have so many MSK issues? Are your workstations not correct? Do the people on a line have the right shoes? You need to treat the cause as well as the symptoms.

Nick Soman: **The more our members tell us about themselves and the more we know about what provider options are available, the better we can match those two things up.** That's really at the heart of data analytics. I want to understand what people are dealing with. That becomes very human: this isn't about a computer reading through your medical history and making a bloodless recommendation for you.

> This is about trying to understand how we can help work with your DPC doctor who's going to build a good, trusting relationship with you and your family to figure out what you need.

I used to just go to the gym and I would crank out the worst form you've ever seen in your life. I was lucky I didn't walk out injured every time because I didn't feel like I had time to do it correctly. And this is what healthcare often feels like to people in this country. When you've got 12 minutes to sit down and see your primary care doctor, you're not going to get through everything that you want to get through. You're not even going to be known enough to have your needs be fully recognized.

A year ago I had my first experience with a personal trainer. It blew my mind that I could sit down with someone. They would take time with me, help me figure out what I'm doing that's not contributing to those goals, not just write a quick prescription for 50 bench presses. That's what DPC is. It's really a different model. So, you could call that data analytics, but I would just call it knowing our members well enough to help them.

Barbora Podzimkova Howell: **What we've been able to do with medical claims is actually pretty remarkable.** We can ingest the last two or three years worth of healthcare expenditures into our algorithm and essentially spit out a list of areas of savings opportunities for a particular client. Even there we're not working with the customer yet. We can have much more productive conversations about plan design based on real data.

A great example of this is leveraging price transparency data to show what the healthcare expenditures of a particular company would have had if they used a different network. We show a chart with two lines and prove to the customer that the same people paying the same bills would have been better off using carrier B instead of carrier A. Obviously this is not predictive, but you can have conversations with the customer about whether or not they're going to continue seeing the same trends in terms of expenditures for healthcare.

> A lot can be done by continuously reviewing medical plans then using AI to pre-digest information so that the human can do a better job solving for the right opportunity.

It could be a care navigator making a phone call to a member at the right time when they need help, or our team reaching out to the member about a billing issue that they haven't even noticed yet.

Adam Berkowitz: **In data is power, we can't fix what we can't see.** By knowing where our problem areas are in our claim spend, it allows us to tailor solutions to those areas, getting people better care and being smarter about those resources.

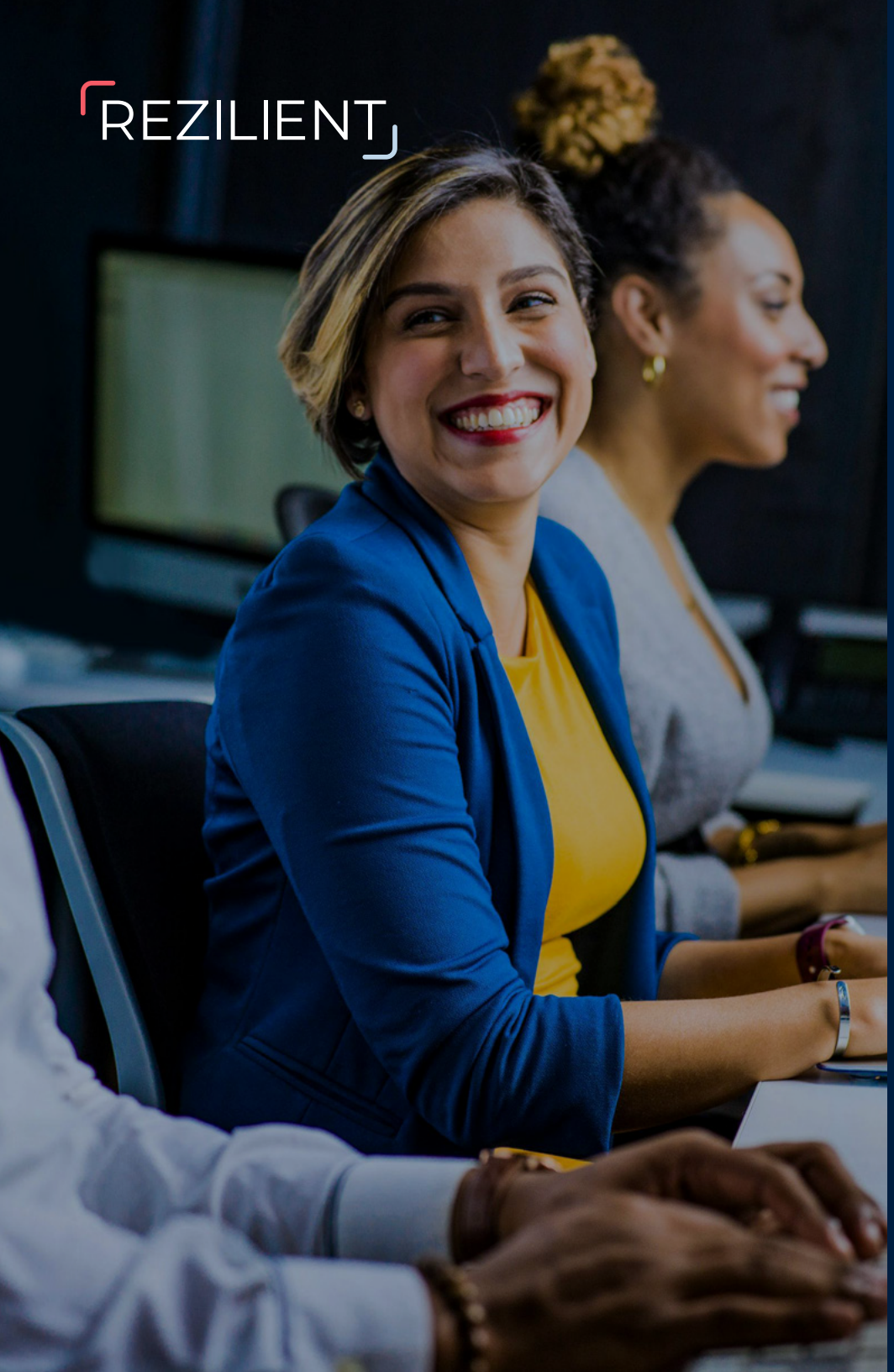
Where we see it going is getting actionable data at our and maybe also the consumer's fingertips. For instance, if I'm diabetic, what resources should I be seeking out and how does my plan or my care team support that and how do I engage better as a consumer to be responsible for my own health. Data is a tool to deliver actionable resources to the plan member.

If we go back to what Rezilient is doing, you're the patient's doctors. We're not just putting employees through a module, they're talking to their doctor. They're texting or emailing their care team and it's all being coordinated within the scope of their overall health plan. It's like the Kaiser model, it isn't just insurance, it's healthcare, and that's really exciting to me. It seems like such a minor thing, but it's so transformative. You're not calling a 1800 call center, you're calling your doctor. And there's no cost, there's no co-pay.

> We've had wool over our eyes for so long and we've become jaded for so long because of just how much we're spending it and how often we're just being taken advantage of in the system.

So, the skepticism is fair, but it also speaks to that transformation. It doesn't have to be a complex thing. It's really as simple as providing really good, honest health care. Let's have patients talk to their doctors. That's not complicated but it is transformational. That's how far away we've gotten from that.

> I want to understand what people are dealing with. That becomes very human: this isn't about a computer reading through your medical history and making a bloodless recommendation for you.
>
> Nick Soman



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