The CFO's Guide to Health Insurance Finance

How to make your plans sustainable for the long term

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Opinions expressed herein are my own.

Executive Summary – The CFO's Guide to Health Insurance Finance

Health insurance costs are at a dangerous tipping point. Monthly per employee premium costs will double and easily cross the $1000 mark this decade. That means almost $4000 for a family. For an average plan. This contrasts with 20 years ago when premiums were $150/$500 for the something that was likely better.

Current corporate processes for evaluating employee health insurance and benefits are weak at best. Most mid-market companies don't treat the process with the seriousness it deserves, leaving a stressful annual dance under time constraint each year as last-minute renewal decisions are made to "get it off our plates" as rapidly as possible, with the hope that next year won't be so bad.

Well, Hope Isn't a Strategy. In the next 7 years health insurance premiums will double from an already high number. To wit, assuming a 9% annual increase, a firm with only 250-employees (not counting family) with $2.5MM in health insurance premium today (if they're lucky) and will be looking at $5MM by 2030 with zero ROI. Or worse. What else could you (or your employees) do with that extra $2.5MM?

Human Resources historically owns benefit decision making processes, but they are swamped with so many other issues of the day and the economics and solutions are complex. It's time that the CEO, CFO, and finance team steps in to lend a strong assist or lead the benefits process. How?

- It starts with a 3-5 year strategic plan developed with the necessary stakeholders. You'll define the sacred cows, and then have the data to make the changes necessary to keep your health plan sustainable and not ruin your P&L.
- There are many innovative ways to flatten the cost curve. We know that wellness programs didn't do it. Moving to high deductible health plans didn't do it. Adding carrier choice didn't do it. It makes sense to consider other solutions like HRA's, partial self-funding, fully self-funding, captives, reference-based pricing, pharmacy carve outs etc.
- It's important to understand your employee population and not just buy them health insurance, but provide a plan customized for their needs and engage them on how to use it to make them real stakeholders.
- You also need to carefully vet your current broker to see if they have the real skills to help you or find one that does.

This white paper will lay out the knowledge you need to start an internal conversation and make good decisions. It will challenge you to question the status quo. It will educate you as to how you got here. It will make you scrutinize how you fund health care today and what options you have for the future. It will make the case to carefully evaluate the advice you receive, who you receive it from, and what you pay for it.

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Contents

Smell that?

It's your P&L burning because your health insurance costs go up 10% a year and no one knows how to control it.

It's a vicious circle. Your broker comes in to present a renewal, likely too late to make any meaningful change. The broker presents an impressive package of spreadsheets to HR of which they remember 5% because they're incredibly busy. Then HR comes to you, the CFO. A few scenarios ensue:

- If you're up mid-single digits, everyone pops bottles and is thankful they can stay status quo for another year. (Whew! No changes!)
- If the renewal is about 10%, everyone is still reasonably cool, as that's what you budgeted for anyway. You may tweak a thing or two to get it to high single digits, and you think you're OK. You're not.
- If the renewal is above 10%, everyone gets stressed out and something MUST change. New carrier, fire the broker, heads will roll.

Here's what happens then, no matter the outcome:

- If your broker is paid commission, they got a raise, no matter the scenario (as well as any time you add headcount).
- Once last-minute decisions are made, everyone breathes their own sigh of relief, gets through open enrollment and packs it all away for another year.
- In a few months, everyone forgets how it all went till the engine revs up next renewal cycle in maybe August for a January renewal.

Back about 20 years ago, a typical insurance premium for an employee on a typical plan from a typical insurer was about $150/month. The family rate was about $500. Benefits were (and still are) the bastion of human resources. Benefits costed around 10% of payroll and most CFO's put these costs in payroll and administration (where they remain today in many cases). Contributions were set, plans selected and since then most employers have been living Groundhog Day. (Best Practice: separate out benefits cost as a line item so it can be easily tracked year to year.)

Human Resources ran the show because benefits were/are a people problem. CFO's didn't engage because costs were manageable, and they were busy running the business. They focused on all the "important things". Banking, credit and cash flow, supply chain, budgeting, tax, business insurance, 401k plan, compliance and anything else under their purview.

But over the years, benefits have dramatically grown in cost, now over 40% of payroll. HR has been hit with a tsunami of new responsibilities like DEI, remote work, recruiting, retaining, workplace investigations, state and federal law compliance, learning and development and everything else that the C-Suite chooses to give to them. HR is swamped, overworked and underpaid. Turnover is high and now the average tenure of a senior HR leader or benefits manager is 2 years.

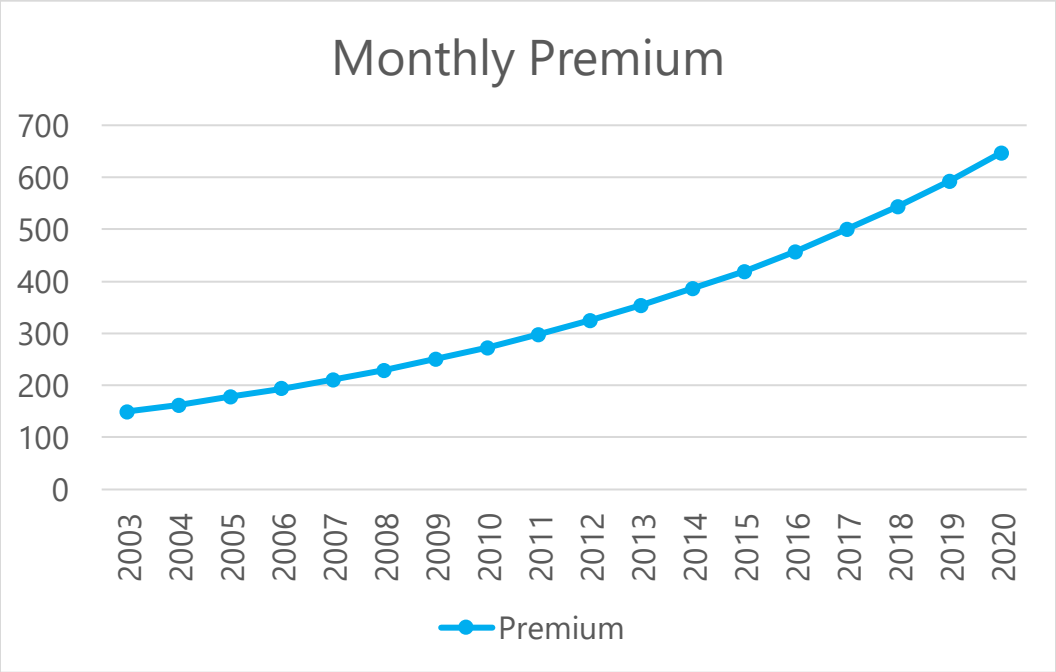
And HR professionals aren't trained in benefits strategy, finance or compound math. It's not their fault, it's been usually learned on the fly and not part of any formal curriculum. It didn't matter then, but it sure does today.

The second largest expense next to payroll is benefits and no one really knows how to control it. CFO's have been reticent to take over benefits because they don't want to step on HR's toes. But, if the house is burning out of control, and no one knows how to put the fire out, the finance side of a business needs to step in.

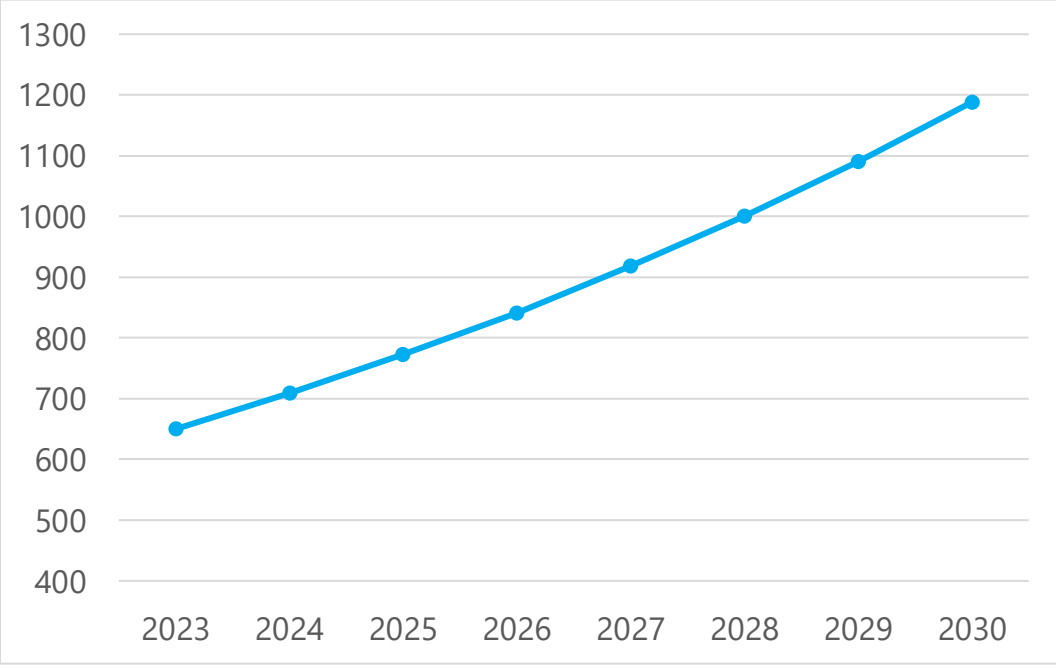
The purpose of this white paper is to educate CFO's on the challenge of benefits today and offer practical suggestions on how to be better stewards of your health insurance and benefits dollars.

How did we get here?

Remember that $150 single employee premium mentioned above? Here's what happened to it over the last 20 years. The graph below assumes a $150 start in 2003 growing compounded 9% a year to 2020. Notice how the curve keep getting steeper. 9% of 150 is much smaller than 9% of 600. **Premium doubled every 8 years.**



So, if you covered 250 employees (and paid zero for families), your annual cost in 2003 was $450,000. In 2020, your cost was $1,950,000. Over a 4X increase. Now, let's extend this trend forward. **Premium will double in 7 years:**



By 2028, you're now hitting $1000 per employee per month and near $1200 per employee/month by 2030. In real dollars, if you keep to the status quo, your costs for your 250 employees will go from $1,950,000 in 2023 to $3,600,000 by the end of the decade. And it's not just the employee only premium that is getting crushed. The monthly family premium at the end of the decade will near $4000. Even if you subsidize part of this, it's completely unaffordable for families. It's more than people's mortgage. And for what?

(Some of the above is a bit oversimplified, as some years are better, and some are worse. To keep the example straightforward, I kept the increases at 9%, but you may have experienced some flat years and some 15% years, but you get the point.)

So, why is this the way it is?

- Health care costs continue to increase at the provider level. Hospital systems are gaping maws for money and while they always complain they never have enough, they are the last industry to even think about lean processes (even though you have). Why is an MRI still $2000-4000 after all these years?
    - Name one healthcare executive that says they'll fight to lower costs. Good luck.
- Hospitals worry about "payer mix" or how much they receive from Medicare, Medi-Cal, ACA plans and commercial pay or how much they give out in charitable care. Let's just say that commercial pay unevenly bears the brunt of this mix and will continue to do so as hospital systems say they can't survive on Medicare alone and Medicare just capped certain payments.
- Insurers are not interested in really lowering costs as they make margin on the increases.
- Big pharma keeps the train moving with increasingly expensive treatments. New genetic treatments clock in at well over $1,000,000 for one curative dose. Talk about a gaping maw.
- Employers don't scream enough at all the above. (Who can they scream at?)
- Employers are unwilling to make difficult decisions to reset and get their programs on track.
- Your broker really isn't that interested in helping you as they are equally well compensated after every increase.

How can employers improve?

The first step in taking control of your benefits costs is recognizing that how you got here shouldn't dictate how you get out of here. While it will take making some difficult decisions, it is possible to not only flatten the cost curve but perhaps decrease it.

The next step is realizing that "hope isn't a strategy." Benefits planning needs to become a proper strategic process. It needs to include all stakeholders including the CEO, CFO, HR, and various department heads and employees. A benefits committee needs creating, much like an investments committee. This group will define "sacred cows" (the things that can't change), but beyond that allow anything else to be modified.

This means taking a hard look at how health insurance is funded, what networks employees can access, and building out a program that engages and trains employees on how to use benefits in a way that keeps costs in check. Open enrollment shouldn't be a "one and done" as far as employee education. Employees need year-round reminders, challenges, and reasons to engage. It's important to consider your employees as active participants in the benefits dance and not just passive users.

Any changes may affect everyone at every level. It will affect someone currently going through treatment, it might require people to talk to their doctors about new medications and maybe require people to find a new doctor. But hard decisions must be considered to take control of this beast.

How is health insurance funded and what are the options to do so?

California is the birthplace of the HMO. In the mid-80's, Foundation Health was founded on the premise that if we pay docs and hospitals a "capitation fee" or a monthly amount for all patients in a practice insured by the HMO, whether they saw the doctor or not, docs would be motivated to provide proactive care to keep patients healthy. The primary care doc was the "gatekeeper", funneling the patient through their same network to keep costs down.

It was also meant to keep premiums in check. And in the early years, it did. Insurance premiums plummeted. Until they didn't. Starting in the early 2000's, premiums have been increasing steadily. This was exacerbated by the Affordable Care Act (more on that later).

For the purposes of clarity, let's define a few terms:

- HMO – Health Maintenance Organization (as above).
- Staff Model HMO – Kaiser is the best example, a "one stop shop" for most outpatient and inpatient care required by a patient.
- PPO – Preferred provider organization. A very flexible model based on fee for service that allow patients to see docs in or out of a preferred network. They operate like two plans in parallel with different plan provisions whether you go in or out of network. Out of network benefits are significantly worse than in-network.
- EPO – A PPO that doesn't include out-of-network benefits and probably a narrower network than a full PPO.
- PBM – Pharmacy benefits manager.
- Network – An approved list of doctors that a patient can see that will be covered by insurance. These have gotten very confusing.
- Premium – What the insurance company receives monthly to cover a patient.
- Contribution – the percentage of the premium that an employer subsidizes on behalf of the employee or their family.
- Plan design – the features of a health plan that includes deductibles, copays, coinsurance, and annual out-of-pocket maximums.
- Deductible – the discounted amount a member pays before the insurance kicks in. The "you pay first".
- Copay – a flat fee for a service.
- Coinsurance – a percentage of contracted fees that make up the difference between the deductible and the out-of-pocket maximum.
- Out-of-pocket maximum – the amount after which an insurer will cover 100% of patient costs in a calendar or plan year.

How is your benefit plan set up today?

If you're a fairly typical employer, here's what I'd guess (if you're in California):

- You're fully insured (75% of CA businesses above 100 employees are, as are all small groups under 100).
- You offer choice that includes Kaiser.
- You offer a "base" plan and a buy up.
- You base your employer contribution as a percentage of the cost of the premium. (Meaning that if you offer Kaiser and they are lower, you charge your employees less for it.)
- Every year is a struggle to negotiate a few percentage points lower on renewal from initial offer.
- You pay your broker a commission vs. a fee. And you likely don't really know what that is.

Let's move on to the mechanisms of health insurance funding and why you should consider different things than you are doing now.

Fully insured

As mentioned above 75% of large groups and 100% of small groups in California are fully insured. This contrasts with the rest of the country where it's probably 75:25 in the other direction. Most companies above 50 employees are self-funded in some way in other parts of the US. Why? Because HMO's aren't as prevalent.

Fully insured is easy. You pay the same for each employee or family unit for the 12 months of the contract. HR and employees understand it. It allows you to offer choice. Networks are usually large and accommodating.

Here are a few reasons why alternates to fully insured health insurance should be considered:

- Data drives everything else in your business, why not your health plan?
- There is little or no claims transparency when you're fully insured. You have no idea where money is spent. Who are the frequent flyers? Who uses the ER egregiously? Who is taking that very expensive drug? Are your employees, seeing expensive doctors?
- You don't know the actual health of your populatio and how you can target various prevalent conditions like diabetes, asthma, heart disease and obesity.
- The insurers are not motivated to really engage with your employees. (Though they may try)
- Depending on your size, you are pooled with other companies of different risk.
- There is little flexibility in benefit plan structure as you must choose from off-the-shelf designs.

If you are operating with a single carrier like Aetna, Anthem, Blue Shield, Cigna, United Healthcare, or others, they do offer resources (many times underutilized) to improve population health. Your carrier account manager or broker needs to be proactive to make sure you are getting these services.

How are fully insured rates created?

A rate is created by combining all the anticipated costs (network charges, medical claims, pharmacy claims, taxes, administration, state mandated benefits, risk pooling & reserves) and modeling that to your employee census or demographics. This creates a "manual rate". Then the carriers always consider your current rates and recent years previous renewals to decide whether they can be competitive vs. the incumbent. If they decide to be competitive, they will offer a quote. They do have the option to decline.

They also consider your "credibility". The smaller you are the less credible you are, and this means that you are more likely to be pooled with other groups. The larger you get (depending on the carrier), you get to stand on your own, even as fully insured (so why not self-fund?). There is a sliding scale of credibility between 250-500 when you are partially credible depending on the carrier.

Recently, a client had a 10% increase from their incumbent carrier and asked us to go to market. Even though there were no outsized claims, they received mostly declinations. When pushed, the carriers said that due to the employees locations (all over the US), the best they could do was a 45% increase vs. current.

The Kaiser Death Spiral

Kaiser Permanente operates in CA, WA, OR, CO, GA, VA and DC.

The fully insured "death spiral" is real and this is how it affects you. What if you offer one of the above carriers next to Kaiser? There's a high likelihood you do. Most employers want to offer choice and many employees want Kaiser because they were born there. You either love it or you hate it. Kaiser also has 40% of the commercial market in CA. But, if we've seen it once, we've seen it a thousand times, here's what happens (and just know how you felt when you realized this was happening):

- An employer begins to offer Kaiser because it's cheaper than the other carrier. You probably added it after a high renewal from your current carrrier.
- The employer now charges less to employees who take Kaiser because the premium is lower.
- Employees begin to walk with their wallets such that over a few years the Kaiser population, once initially small, now makes up half of the group.
- The other carrier warns the group that they are now out of their underwriting guidelines (50% participation) and if the trend continues, they will non-renew the group. The reason for this is adverse selection. In most cases, the healthier employees choose Kaiser, leaving the higher risk employees with the other carrier.
    - A side note is that once the group hits this 50%-mark, other carriers become less interested in offering competitive bids at renewal and may very likely "no quote" because of adverse selection.
- Once the group drops below the 50% mark, the other carrier will begin to ramp up the increases (there's a lot behind this), because they can't take in enough premium to pay claims.
- The carrier ultimately non-renews the group and the employer has very little leverage in the market to go to other insurers.
- They may get taken on, but in a severely disadvantaged position.
- (It should be noted that in a market like Sacramento (and only a few others in CA), there are two other HMO competitors to Kaiser (Sutter Health Plus and Western Health Advantage) that have found a way to play well next to Kaiser and each other. But this three-carrier solution may not be for everyone depending on goals and employee locations. And it's all fully insured with all of those shortcomings.)

How do you not succumb to the death spiral and create a long-term sustainable plan while staying fully insured?

While it's been tempting to offer employees Kaiser at a lower cost because the premium actually is lower, the **best practice** is to look at health plan total spend and charge equal amounts to employees no matter

what carrier they choose. There is some population of employees that only picked Kaiser because it's less expensive. If you equalized the cost, then employees would choose based on preferred network vs cost, and an equilibrium would be created, and renewals would become more stable.

Some would say this isn't fair to those picking Kaiser, but you're responsible for stewarding the sustainability of the whole plan, not just one carrier or another.

I'm not "Kaiser bashing" here. One just needs to know how to work the system to their advantage. One may also consider going 100% Kaiser, which is a valid strategy depending on where employees are located.

How to reset existing your fully insured program?

Health reimbursement arrangements or HRA's have been around for a long time. They key to an HRA is moving from a richer plan to a leaner plan, taking the premium savings and then reimbursing employees the out-of-pocket cost via a third-party administrator. This move can represent a 10-25% lowering of premium costs while not costing the employer significantly in reimbursements.

It works because over a year the number of high-cost claimants tend to be low, and many employees just go for their annual physical or seek modest services.

Super charging the HRA

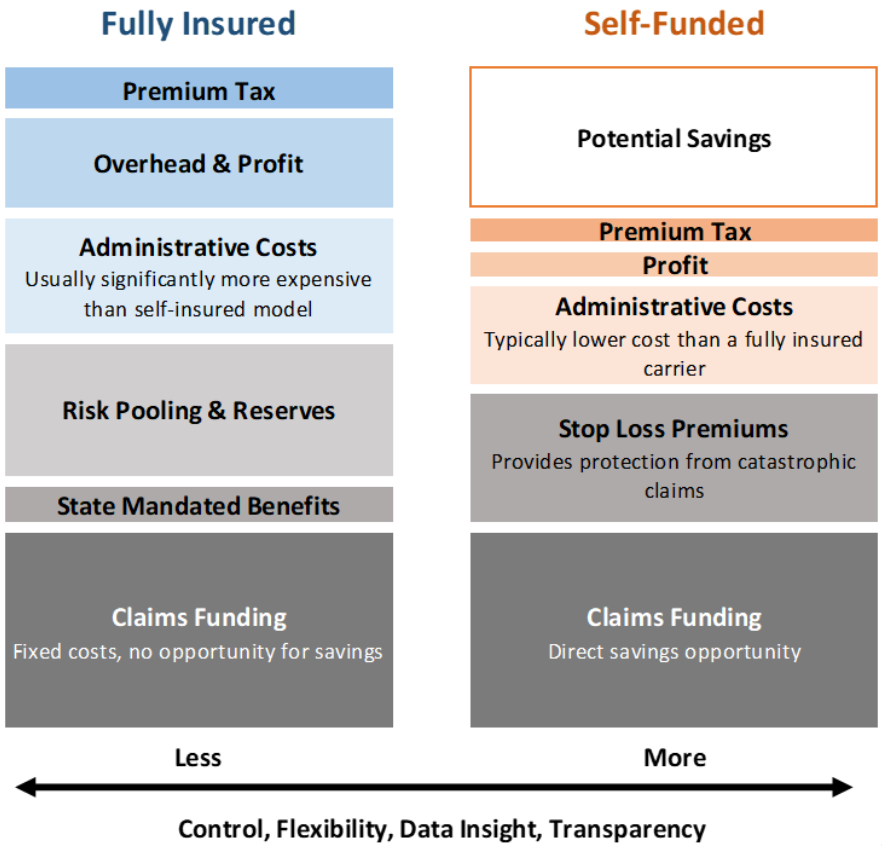
There are also ways to super charge the HRA, by encouraging high-cost claimants to choose high performance docs. One solution on the market sets up an HRA such that if an employee requires a high-cost procedure and then agrees to be seen by a doc of the solutions choosing, the employer will reimburse 100% of the out-of-pocket costs for the employee.

This particular solution has analyzed data across the US and knows what docs are of the highest quality and lowest cost for most expensive procedures within your health plan and geographies. Everyone wins in this scenario. The employer pays less in premium, the employee pays nothing in out-of-pocket costs and likely will have a better outcome.

It can work for fully insured or self-funded arrangements.

Non-Fully Insured Solutions

As mentioned previously, only 25% of groups over 100 in CA are self-insured or use some type of alternate funding mechanism. This section will cover some alternates to fully insured that should be considered. First, here's a high-level comparison of fully insured vs self-insured



Buy the Lamborghini or build a car that meets your needs on your own with the right consultant.

As you can see on the right above, there is a box called "potential savings". The savings can come in many forms:

- Lower premium tax as you'll only pay tax on the stop loss insurance and not the full fully insured premium.
- Transparency to claims so you can embed systems to address specific population health issues. Data, data, data!
- Lower profit paid to an insurer.
- The ability to opt out of state mandated benefits as self-insured programs are under Federal ERISA and not state laws.
- Ability to define what risk you choose to take on and full flexibility to design your plan.
- Tighter management of pharmacy costs.

Why aren't more plans self-funded?

- Many brokers, particularly smaller ones are not skilled at it.
- Fully insured is too easy.
- Too much Kaiser population, so groups may not have the right mix to self-fund.
- Companies have been discouraged about doing so for any of the above reasons. And no one on their staff has any experience with it.

The rule of thumb used to be that a group needed to have 500 or more employees to consider self-funding. Now, with some of the methods to follow, you can self-insure down to 50 employees.

Self-funding can be done on an insurance carriers chassis whereby they use much of their fully insured infrastructure to deliver the goods. It can also be done piecemeal using a third-party administrator where you pick:

- Your network
- Your pharmacy benefits manager
- Unique point solutions for telemedicine, condition specific issues and employee engagement
- Stop loss insurance
- What you cover and what you don't at what level

There are products ranging from shared risk to fully self-insured to more complex options like captives and reference-based pricing (RBP). These will be covered at a high level on the following pages.

Any choice of program should be considered carefully and meet with the risk tolerance of the employer and their employees. Don't chase the savings unless you fully understand the ramifications and how you can build a long-term sustainable program. This white paper does not endorse any particular solution but offers ideas as to things an employer can consider.

Level Funding – the least risky way to do self-funding

- The easiest way to dip your toe in the self-funded waters.
- Can be used alongside Kaiser, but carefully depending on mix.
- The group is rated manually based on census and renewal data or with previous claims data, if available. Annual claims are estimated.
- Group pays what looks like fully insured premium monthly with no variability. Premium is predictable.
- Group defines the health plan structure (deductibles, copays, etc.).
- Group chooses full or narrow network (or both).
- Plan can run on a calendar or plan year basis.
- Claims get trued up at end of year (actual vs estimated).
    - If groups claims are less than expected, the group and the insurer split the underage 50:50 and the employer receives this as a credit for the following plan year.
    - If the group claims exceed expected, insurer does not ask for reimbursement but then adjusts expected claims for the next year.
- Employer gets the data and understands what health conditions exist and understand how people access care creating an actionable program.

"Pure" Self-Funding

- Structure as above graphic.
- Group pays claims up to a set (attachment) point per person.
- Stop loss insurance exists for claims above set point for an individual and/or aggregate set point for group.
- Monthly costs will vary depending on claims. This is the point that causes employers the most discomfort.
- Reserves must be maintained.
- Various claim run out options exist if group might consider going back to fully insured in the future.
- Third party administrator handles claims & reporting.
- You choose network to rent.
- You add point solutions depending on your demographics are employee care needs such as telemedicine, etc.
- You choose a pharmacy benefits manager.
- Very high-cost claimants are typically "lasered", meaning that stop loss insurance won't cover them. This applies to multi-million-dollar chronic claimants.
- Upside:
  - You understand what's really under the hood. Data, data, data!
  - Employee engagement is higher.
  - You can customize based on your data.
  - Save on premium tax as you are only paying tax on the stop loss premium and not on the fully insured premium
- Downside:
  - Monthly costs will vary.
  - You'll need to monitor performance of the plan more carefully than you would have with a fully insured plan

Captives – self-funding with an additional layer of protection

- Operates similarly to purely self-funded.
- Captive layer consists of groups within an industry or created by a captive company
  - "Softens" risk if you held it all yourself
  - Captive layer pays after employer pays their specific deductible
- Stop loss insurance exists for claims above captive layer.
- Captive employer members can receive dividends if it performs well.
- Downside is there are a few members that always exceed their participation.
- Upside is that captive members get to know other members and work towards a common goal. There are usually annual meetings where all captive members get together.

Reference Based Pricing

RBP is a relatively new structure to California. And while this is so, it has been gaining traction in certain areas of the US. The companies that do this claim that you can reduce costs (usually facility charges and certain physician fees) by up to 30% or more because each large claim is negotiated individually. The term "reference" refers to Medicare reimbursement. The RBP company will offer a percentage above Medicare to settle a claim.

- No "network" necessary. Employees can go anywhere.
- Group pays "retail" for low hanging fruit like office visits, labs, imaging. Complex imaging is negotiated.
- Stop loss insurance exists for claims above an aggregate number for group vs. specific per person.
- Large claims are negotiated directly with hospital or provider by RBP company.
- Monthly costs will vary depending on claims.
- Third party administrator handles claims.
- You choose a pharmacy benefits manager.
- Upside:
  - You control costs especially facility fees
  - Employee engagement is higher
  - Runs like any other self-insured program
- Downside:

- It can take time to negotiate by RBP claims attorneys, and employees can get sent to collections affecting their credit rating (though this part is minimized by RBP companies claiming that they get this done quickly)
- Network and ID card may not be recognized by providers

What should you do?

First, get a second opinion. Speak to brokers about their actual competence in meeting your financial expectations. Beware the spreadsheet wrangler who shows up with current/renewal/options only. How can they help you develop a real corporate benefits strategy? Does your current broker really have the chops? Are they asking you the hard questions and challenging you?

This isn't about a broker talent show or rote RFP. This is digging into their real bona fides, successes, failures and if they can really help you with any of the above.

And while you're at it, ask for a compensation review with your broker. Most companies have never had one. The 5500 gets filled out every year, but no one really knows how to read it. In reviewing broker compensation in CA, the median fully insured contract pays the broker $400/employee/year depending on services. Some brokers are receiving 2X or 3X that amount. Perhaps, pivot compensation to a flat fee (which I do all the time). Commissions are negotiable across all lines in large group.

Next, commit to making benefits part of your corporate strategic plan. Begin working on this year's renewal in Q1, not August. If you do desire change, communicate it to your employees early and often.

Forecast financially good, neutral and bad benefit cost scenarios for the next 3-5 years. What can you live with budgetarily? What sacred cows are there in your current program? What can be jettisoned? Remember, "Hope is Not a Strategy". Be prepared for the worst and celebrate the best.

Build a benefits team that includes the CEO, CFO, CHRO or their analogues. Include your broker. Meet monthly or more to begin with in the first two years to get a decision making cadence in place.

Be serious about this. As benefit costs increase, profitability lags, raises stagnate, and employees can't afford coverage for their families.

Some random thoughts

- Why the ACA messed things up.
    - Once the ACA was implemented, it created a series of self-motivations across the board. Everyone (providers, insurers, states, drug companies) hoarded money because they didn't know how the law would affect them. Now, almost 10 years on, everyone realized that it's still OK to hoard money.
    - The most egregious part of the ACA was that it allows small group deductibles and out-of-pocket maximums to increase every year, whereby in 2023, some plans have an $8000/$16000 single/family out of pocket maximum. This is what a family pays for care beyond the premium. A travesty.
    - Large groups avoid this. But note, that CA is one of two states that a large group is defined at 100+. In every other state it's 51+. Why didn't employers with 51-100 employees scream? I still don't get that.
- Why not use High Deductible Health Plans?
    - You can, but they'll fail and create employee ill will without the employer contributing to the health savings accounts or HRA's.
    - Carriers also have figured out how to rate these such that they're not that much less expensive than traditional plans.
    - They've been around since 2006, but still only have 30% uptake nationally.
    - HRA's can accomplish this purpose more easily.
    - CA is one of the only states that does not allow tax deductibility of an HSA, only Federal deduction allowed. Why didn't employers scream?
- What does it take to replace a broker?
    - A broker of record change letter listing all policies and policy numbers signed by an executive of the firm and that's it.
    - If the new broker is professional and has a proactive transition process, then no worries.
    - But the ties tend to be more emotional:
        - Brokers know how to entertain and use this to stay sticky.
        - They're someone's brother-in-law.
        - HR teams get to know their account teams well and hate to part with that comfort.
    - So, what does it take to replace a broker? Political will and the realization that it's not about a better deal, but someone to help really steward your plans.
- What's a small group to do?
    - Consider a PEO that can consolidate many functions but also offer large group benefits.
    - Look at some self-funding options like level funding.
    - Wrap an HRA around your small group plan.
- The advent of point solutions
    - Since 2018 there have been hundreds of new, innovative solutions offered. Many are venture funded. Some will disappear but others will gain traction. They are in areas like telemedicine, mental health, well-being, employee engagement, primary care, HRA's , virtual musculo-skeletal treatment, high performance networks, and rent-a-chief medical officer amongst others.
    - The easiest way to access these is via a self-funded plan structure.