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The New Normal? It's all different.

Our first dive into design-build employee benefits reveals just how versatile brokers need to be.

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THE COUNCIL *foundation*

A New Approach to Benefits Brokerage

I have an optimistic outlook on healthcare reform. I was invited in 2014 by The Council of Insurance Agents & Brokers to speak to the employee benefits industry leadership at their annual meeting in Colorado. I spoke about the economic and dispassionate forces that compel us to do things differently. Together, we explored the new world we live in and the value proposition of benefits brokers. We talked about how brokers must demonstrate what they deliver and what it's worth, because the commission-based business model is going away. We discussed pricing and affordability, citing strategic imperatives such as provider collaboration, data analytics and a commitment to transparency. We also examined how collaboration will play a key role in the way markets influence the future of the Affordable Care Act.

The Council's benefits advisory board and its executive management team wanted to dig into more detail, so we met at The Council offices and discussed what I see as the seven key characteristics successful businesses will need. These don't apply just to health plans and hospitals but to any company looking to make a significant impact in the new healthcare value economy, including brokers.

7 Key Characteristics Successful Companies Will Need

- Capital
- The ability to manage risk
- The ability to aggregate lives
- A clinical footprint to serve a wide population
- The ability to change people's behavior
- A strong brand for consumer outreach
- A collaborative IQ to put this all together

Not all brokers will have the capacity to do this. Pressure on commissions and compensation models and the economic realities of expanded service offerings will be obstacles too great for some to overcome. Such headwinds drive consolidation, relying on volume to make up for the lost margins. However, among those brokerages that have taken a strategic, deeper dive into their benefits business and generated impressive organic growth, I see a common thread that is a foundation to their success.

A mission-critical attribute for brokers is the development of a collaborative IQ that recognizes the unique needs and expectations of clients, identifies other strategic partners in the local and national market with the same mindset, and can integrate these solutions for employers. The result is a new design-build consultancy approach to the employee benefits business model. I believe this should be the new normal for brokers who are focused on bringing value to middle- and large-market group benefits.

Michael Leavitt
Former Secretary of Health & Human Services
Former Utah Governor
Founder, Leavitt Partners

Leavitt Partners

When he left the Department of Health and Human Services, Secretary Mike Leavitt created a healthcare intelligence consultancy modeled after the national intelligence community to advise presidential decision making. He calls the result "healthcare tradecraft." His goal is to bring clarity and value to healthcare executives.

The company, Leavitt Partners,* works with many leading edge healthcare industry stakeholders to solve complex problems and uncover market and organizational opportunities.

* Leavitt Partners is not to be confused with commercial insurance brokerage The Leavitt Group.

What business are we in?

As the dynamics of market upheaval change over time, successful companies regularly evaluate the accuracy of their assumptions. It was this thinking that led The Council Foundation to work with Leavitt Partners on this study.

As we talked with Secretary Leavitt, it was easy to see how valuable it would be for a firm outside the insurance industry to analyze employer sentiment regarding health benefits offerings and the changing role of the broker.

More than five years into healthcare reform, the traditional employer-sponsored health benefits system has been disrupted. The implementation of the Affordable Care Act, innovative technologies, shifting demographics and the rise of consumers have forced a new way of doing business aimed at driving down employer healthcare costs and creating healthier, more productive workers.

As a result, I am often asked, "What business are brokers in now? What are their core competencies? What value do they bring to the shifting healthcare consumer paradigm?" Our goal with this study was simple—to see how today's market answers those questions.

And we found that the value brokers can bring in this new world is the ability to uncover employers' unique needs and pull together the resources to serve them. This is the design-build concept. In the construction world, design-build refers to one team working under a single contract to deliver both design and construction services. In brokerage, it works much the same. The broker can both design and build a unique plan for each employer.

This study has raised numerous questions and ideas about the future of employee benefits. And The Foundation will continue to investigate this evolving business. With this introduction, we aim to provide helpful business intelligence for brokers in their ongoing quest to evaluate their strategy in a tremendously complex employee benefits marketplace.

Ken Crerar
President & CEO, The Council of Insurance Agents & Brokers
Secretary, The Council Foundation

The Council Foundation

The Council Foundation is a 501(c)(3) charitable educational organization instituted by The Council of Insurance Agents & Brokers in 1994. The Foundation's mission is to secure the future of commercial insurance brokerage by attracting and developing tomorrow's talent and supporting forward-thinking research. The Foundation examines issues through the lens of the insurance broker and provides member firms with the tools, resources and knowledge to manage future business risks.

Until 2015, The Foundation's name was FAME, The Foundation for Agency Management Excellence.

Executive Summary

The U.S. healthcare system is still giving off strong signals that employment-based benefits will serve as the health insurance workhorse despite structural shifts forced by economic and policy pressures. Employers' attitudes and expectations are in flux. This climate has created opportunities in the healthcare benefits sector for brokerages that develop and market strengths in a handful of areas which employers have identified as crucial.

This study evaluates the needs and abilities of employers and the skills and service offerings of brokers. It then aims to identify the gap between them and how brokers can fill that gap.

We found five areas of opportunity for brokerages that want to build or consolidate their market share in health benefits:

1. Legal and regulatory compliance services
2. Ancillary services, including data analytics, actuarial services and industry benchmarking
3. Plan design
4. Wellness programs that support overall well-being and clinical outcomes
5. Integration of all of the above into a holistic employer-sponsored healthcare program.

▶ An estimated two out of every three non-elderly Americans are insured through their employer.

▶ In 2015, 57% of employers offered health benefits to at least some of their workers, statistically unchanged from 55% in 2014.

Source: 2015 Kaiser Family Foundation/Health Research and Educational Trust Employer Health Benefits Survey

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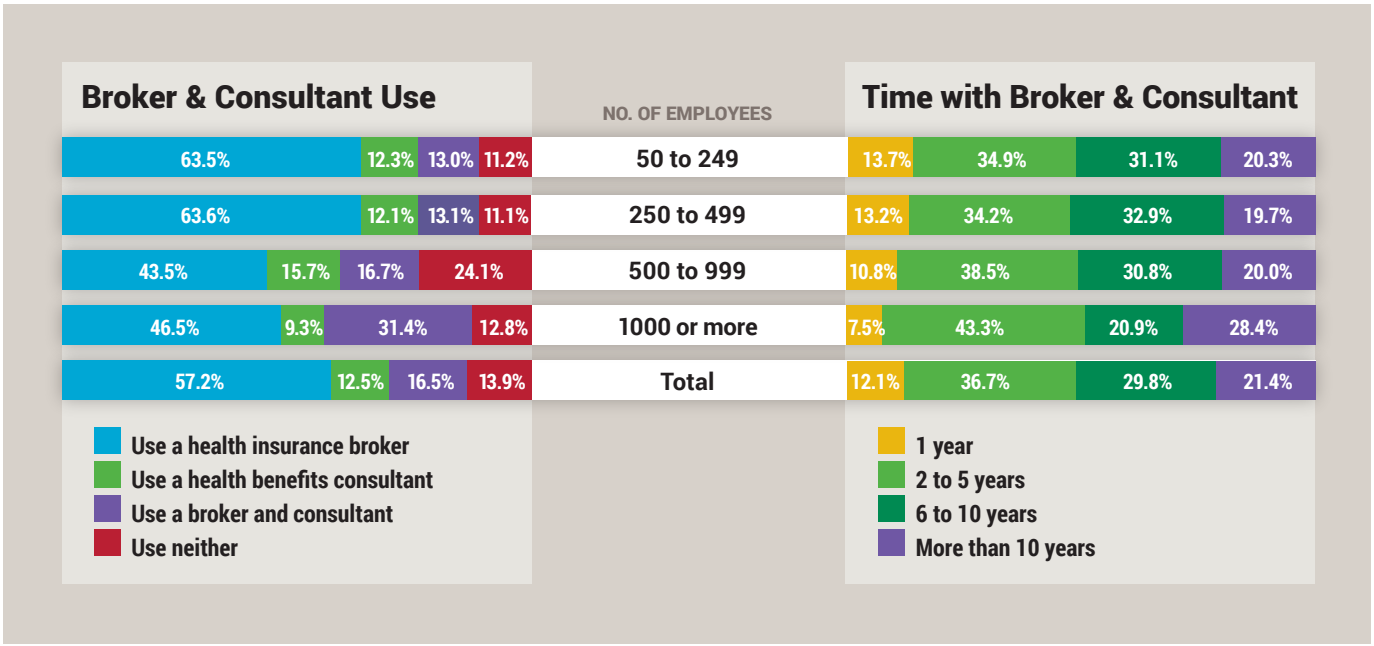
Key Takeaways

Of benefits decision makers, 84% indicate they are fully committed to providing benefits to employees for the foreseeable future. Employers continue to struggle to balance altruistic motivations with economic realities.

Employers remain confident brokers and consultants are best suited to navigate healthcare reform. Of all responding employers, more than 86% are using a broker, consultant or both. In addition, 85% of employers who considered switching to a private exchange consulted with their broker. And the majority of all employers surveyed believe a broker who sponsors an exchange can give objective advice on participating in a private exchange, demonstrating confidence in the relationship.

It is also noteworthy that certain employers have begun portioning out various functions to *both* brokers and benefits consultants. Throughout this research, employers conveyed an increasing interest in compartmentalizing certain benefits functions and procuring contracts through a competitive bidding process. This indicates employers may be looking for a more comprehensive or fully integrated solution than they feel a single broker or consultant can offer, and they may be willing to spend more to get it through multiple channels.

Brokers' traditional insurance distribution model is eroding in value. A design-build consultancy approach to employee benefits will become a necessity and will change the compensation model as well. Above all, employer clients and consumers want flexibility. Therefore, the era of "assign us as your broker and we'll do all of these things for free" is quickly going away. Employers want brokers to coordinate the myriad services needed to achieve employer benefits objectives. They expect their brokers to have a high "consultative IQ" and capacity to design the solutions required.



Designing the client's health benefits plan is the most important value a broker can bring to the table. Employers want brokers to be creative in plan design and to better integrate benefits administration, employee engagement, population health management initiatives, network development, and contracting and data analytics services.

Highlighted Findings

EMPLOYERS

Employers are aggressively foraging for the perfect blend of plan offerings that meet the broadest swath of employee needs while keeping costs down. Their goal is maintaining a healthy workforce to maximize productivity and attract and retain top talent.

- Employers with more than 49 employees want precision and flexibility based on their employees' needs.
- Employers are increasingly demanding plan designs that incorporate clinical programs and offer coverage models and distribution channels that all work together to better engage employees.
- Employers want ease of plan administration. They want a seamless system, not one that forces them to deal directly with multiple vendors or carriers. They want the brokerage to serve as their point of contact for all aspects of their health plans.
- Employers want brokers to continue handling regulatory compliance in core services, such as benefits administration. But they increasingly expect the brokerage to be a hub of market and policy tools and resources that help build models of their benefits options so they can make informed strategic decisions. The uncertain regulatory environment is driving employer anxiety over long-term plan design and stability. Brokers who build plan designs that reflect potential and probable regulatory outcomes give employers a sense that future regulatory risk is being managed.
- Employers are pursuing population health and wellness strategies with clinical attributes. Though brokerages are not expected to have these programs in-house, they are expected to pool such resources, vet providers and identify which programs would have the most meaningful economic and clinical results.

BROKERS

Brokers are no longer simply experts on placing health insurance. They now must understand employers' unique clinical and economic objectives, nuances of employee populations and uncertainties regarding the market. They must translate this intelligence into a focused design-build solution that is customized for the employer.

- Brokers are moving from a mindset of product sales to insight sales. Brokers who are holistic financial advisors that identify clients' needs and design the appropriate solutions will unlock new avenues to grow their business. Pushing products will not work with the next generation of benefits decision makers who demand a different level of experience and service.
- Brokers have access to captive populations, often representing a significant percentage of workers in a single zip code. This is a unique advantage and a powerful lever to improve consumers' health. Driving clinical wellness programs and population health management solutions represents a powerful opportunity for brokers to add value to benefits structures. Data services and analytic functions are the bedrock of integrated benefits solutions. Brokers must have the ability to use data analytics to assess prevention strategies, specific plan successes or failures, regulatory compliance and distribution models.
- Brokers' capacity to organize myriad legal, legislative and regulatory uncertainties into actionable intelligence will be a core differentiator.

Methodology

Research for this report was done in three phases in the first and second quarter of 2015.

INTERVIEWS: We conducted 10 in-depth interviews with select employers ranging in size, industry type and labor-market characteristics. We interviewed three employers with 50-100 employees, two with 100-500, three with 501-1,000 and two with 1,000+.

FOCUS GROUPS: The Midwest Business Group on Health assisted in recruiting five employers (one with 500 employees, four with 1,000+) with complex and varied health benefits operations. The employers participated in half-day focus groups. The first group investigated key organizational objectives and challenges employers experience. The second evaluated employers' interactions with benefits brokers and consultants, examining critical services they provide and current shortfalls in offerings.

NATIONAL SURVEY: We conducted a national survey of 600 health benefits decision makers from all employer sizes, types and industry segments. Proportional quota samples were taken from each Bureau of Labor Statistics (BLS) class above 49 employees in the Marketing Systems Group database of employers. In this study, 50-99 employees represents small group, 100-999 represents middle market and 1,000 or more represents large group. High turnover employers are defined as having a turnover rate of more than 15% (mining, gaming, entertainment, retail, etc.) while low turnover employers are defined as having a turnover rate of less than 15%. Of the 600 employers surveyed, 56% were fully insured and 44% were self-insured. The survey margin of error is ±4%.

We'll Take Some of Everything

Left to themselves, employers can't find the right blend of products and services. The top issues on their minds are premiums, plan design, workforce wellness, private exchanges and healthcare delivery. These factors are driving employers to continuously evaluate their benefits program.

Affordability Remains the Primary Concern

When it comes to health benefits, employers' two big concerns are culture and cost. The majority of survey participants feel they have a responsibility to provide for workforce healthcare, citing employee attraction and retention as their main business objective for this. Yet 54% say affordability is their primary worry. This is not surprising. The annual Kaiser Family Foundation/ Health Research and Educational Trust Employer Health Benefits Survey found in 2015 average annual premiums (employer and worker contributions combined) were $6,251 for single coverage and $17,545 for family coverage. Both rose 4% from 2014. Since 1999, premiums have increased 220% for single coverage and 203% for family coverage.

PLAN DESIGN: Cost-Shifting Is Slowly on the Rise

One of the most important trends in healthcare today is the shift toward high-deductible health plans. These are often paired with a tax-free spending account, such as a health savings account, that both employers and employees can contribute to. This trend is an attempt to drive cost-sharing and decision making to individual employees, increasing their engagement.

According to *Health Affairs*, just 8% of employees in 2009 were covered under a high-deductible health plan. And the 2015 Kaiser Survey shows the most common type of health plan is still a preferred provider organization (PPO), accounting for 52% of plans. But the high-deductible plan is now the second most common type, accounting for 24% of all plans offered.

Our figures tracked with that—18% of employers said 90% to 100% of their workers are enrolled in a high-deductible plan.

A widely publicized 2014 National Bureau of Economic Research study appears to justify the move toward high-deductible plans. According to the study, employers who offered high-deductible plans reduced healthcare costs over three years, compared to those who did not. There are growing concerns, however, people may be forgoing important care to save out-of-pocket costs. That behavior potentially raises healthcare costs in the long run.

The jury is out on the long-term effects of high-deductible plans, but everyone is keenly interested in studying them as an indicator of the potentially adverse consequences that come with cost-shifting to workers.

Self-insured plans are also becoming more popular. Of all employers surveyed, 44% self-insure their employees. Historically, larger employers have self-insured. But we expect to see an uptick in small and midsize businesses considering self-insurance, particularly in states such as California, Colorado, the District of Columbia, New York, North Carolina, Vermont and Virginia, which have expanded (and are anticipated to stick with) the definition of small group to 100 employees.

This is mostly just chatter right now, but it is easy to see how that could quickly change. The key advantages over fully insured plans are cost and utilization control, improved cash flow, flexible plan design, and access to data and benchmarking. By self-insuring, employers can obtain detailed claims and utilization data on their employees and dependents to identify the drivers of increased healthcare costs. They can then address those factors through health risk-management strategies.

Of survey participants who self-insure, 31% reported rising cost as the primary reason for moving to self-insurance, and 78% achieved savings. Although certainly a contributing factor, surprisingly, regulation at the state and federal level was not cited as one of the top reasons for moving to self-insurance.

WELLNESS: Employers Are Expanding Their View on Workplace Wellness

Multiple studies, including one in the *American Journal of Managed Care* and another in *Obesity Reviews*, note programs focused solely on behavioral wellness do little to sustain meaningful change. Instead, many in health research, including national leader AcademyHealth, say clinical wellness that furthers behavioral wellness has proven to have the most impact on employee

health outcomes. Taking this into account, we defined wellness programs as population health risk management with clinical attributes. (See glossary for more detail.) Our survey results in this area were higher than expected: 52% of employers have a wellness program, and 67% report some measurable return on investment.

Though most employer programs in the United States still focus on physical health at their core, employers are increasingly modifying them to address their employees' overall well-being. This generally encompasses an individual's physical, mental and/or emotional health, financial security, social connectivity and professional fulfillment. This approach requires measuring a wellness program by its value of overall investment, which accounts for its cost-effectiveness across all business operations, rather than its effect on aggregate healthcare costs.

Disability and workers compensation claims, employee absences, workforce turnover, productivity and jobsite safety performance are the most popular value-of-investment metrics used to measure wellness success, according to a February 2015 study by the International Foundation of Employee Benefit Plans.

DISTRIBUTION: Private Exchanges Are Down but Far from Out

Private exchanges have stolen most of the spotlight, but their growth has recently plateaued. For example, Accenture reeled in its 2015 and 2016 enrollment estimates, down to 6 million and 12 million respectively (from 9 million and 19 million). Employers say these models still need to prove their capacity to drive administrative efficiencies, facilitate economic decision making and engagement, reconcile consumers' e-commerce expectations with the complexities of the employee benefits transaction, and hasten innovation in the broader health insurance marketplace.

Private exchanges have seen a tremendous amount of investment and growth over the past five years. More than 188 unique private exchange entities are operated by benefits brokerages, carriers and technology companies. The idea that a private exchange could better facilitate a defined contribution financing scheme that would enhance predictability and stability of the employer's premium contribution drove initial interest.

However, costs can be defrayed to the employee for only so long before running afoul of the Affordable Care Act's employer requirement—an employee's share of the premium may not exceed 9.5% of household income. As such, defined contribution is indeed nothing more than a financing mechanism that simplifies buying decisions when an increased number of insurance products are in play.

Only 10% of employers surveyed offer benefits through a private exchange. And 84% said they do not expect to participate in a private exchange in the future.

Yet 41% of employers cited cost saving as the prime reason for using a private exchange, 27% cited increased choice and 21% saw the value in enhanced risk management. These numbers demonstrate that employers' reasons for using a private exchange may be changing. Don't count private exchanges out just yet.

HEALTHCARE DELIVERY: Employers Are Increasingly Involving Themselves at the Point of Care

We are seeing a closer affinity between healthcare providers and employers. Through population health initiatives, patient-centered medical home models, accountable care organizations and other forms of direct contracting, employers are increasingly involving themselves in the point of care for their employees. Of employers surveyed, 34% reported some type of direct contracting relationship with providers. Combined with brokers' increasing tendency to unbundle carrier products, this raises questions about the potential for either circumventing or disintermediating carriers' functional role as a third-party administrator.

The healthcare provider system is undergoing a period of profound change. Most notably, providers are increasingly accepting new forms of payment that are economically aligned with their ability to improve clinical outcomes, enhance the patient experience and generally bend the cost curve.

While most of these arrangements are simply shared savings or pay-for-performance agreements, a growing number include substantive risk-bearing by the provider. There was a strong increase in public and private programs in 2015, catalyzing enormous investment in the provider community. Some of the most relevant changes driving 2015's activity included:

- The Healthcare Transformation Task Force was formed in March 2015. It aims to have all private-sector members (including Caesars Entertainment, The Pacific Business Group on Health, Optum, Aetna, Blue Cross Blue Shield of Michigan, Blue Cross Blue Shield of Massachusetts, Blue Shield of California, New Mexico Health Connections and Health Care Service Corporation) assign 75% of their reimbursement to value-based contracts by 2018.
- The repeal of the sustainable growth rate formula, which was the basis for Medicare physician payments, ushered in two new programs that will become effective in 2019. Providers can choose to operate under either the Merit-Based Incentive Payment System or the Alternative Payment Model program.

  The first one calculates a composite score for performance under three sun-setting programs (meaningful use, patient quality reporting system, value-based purchasing). It rewards or penalizes providers based on this score. Incentives and penalties begin in 2019 at ±4% and will reach ±9% by 2023.

  The Alternative Payment Model program provides a 5% bonus to providers who can demonstrate 25% of their total reimbursement (including commercial payers, Medicaid contracts, etc.) is derived from value-based reimbursement contracts in 2019 and 2020. The number increases to 50% in 2021 and 2022 and 75% in 2023 through 2025. The 5% bonus target remains constant through this period.
- The Comprehensive Care for Joint Replacement model was established in November 2015 as a bundled payment initiative. It is intended to complement the Bundled Payment for Care Improvement program instituted in 2014. Comprehensive Care for Joint Replacement will mandate a retrospective payment to providers for two specific episodes (diagnosis-related groups) in 67 markets.

Payment Model	Description
Full Capitation	A single payment made to a provider organization to cover the cost of a predefined set of services delivered to a patient
Partial Capitation	A payment approach in which only certain types or categories of services are paid on a capitated basis; typical examples of this include capitation for primary care services, specialty care or other services such as mental health
Bundled Payment	A payment method in which a single payment is made to cover the cost of services delivered by multiple providers over a defined period of time to treat a given episode of care
Shared Savings	A payment approach whereby a provider organization shares in the savings (and, in some arrangements, losses) that accrue to a payer when actual spending for a defined population is less (or more) than a target amount

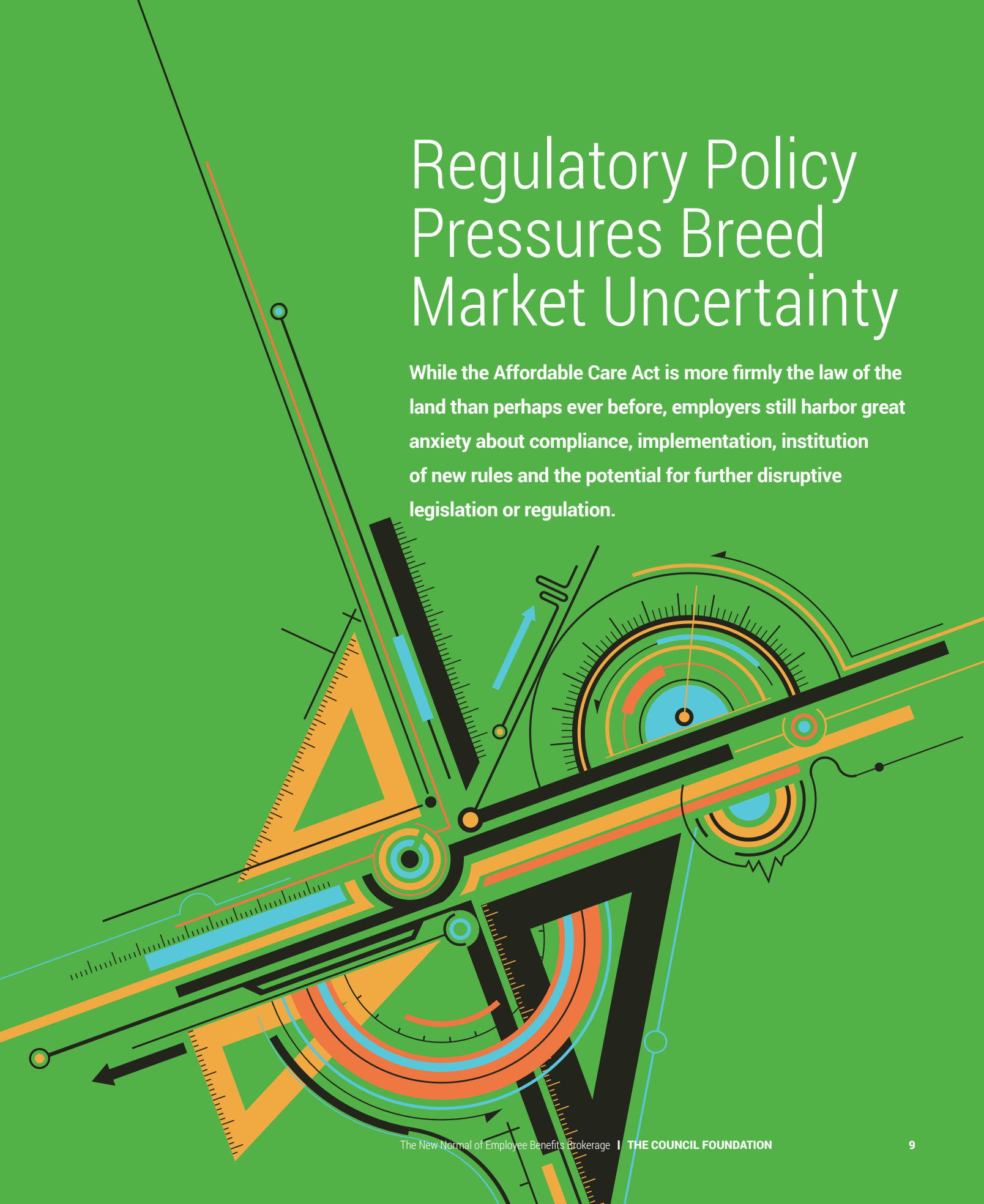
Source: Leavitt Partners, 2013

This activity matters a great deal. The shift away from fee-for-service and toward value-based payment and new benefit design is driving shared outcomes, which help move the health system toward successful collaborative care. This transition is guiding how carriers contract with providers to create high-performance networks and clinical services and introduce new product portfolios and options.

Employers can derive benefits from high-value arrangements, particularly when their footprint geographically aligns with a healthcare provider's. Geographic alignment allows employers and providers to explore integrating worksite healthcare services with community-based primary care, which creates a smoother patient (employee) experience.

Regulatory Policy Pressures Breed Market Uncertainty

While the Affordable Care Act is more firmly the law of the land than perhaps ever before, employers still harbor great anxiety about compliance, implementation, institution of new rules and the potential for further disruptive legislation or regulation.



Cadillac Tax Delayed, but Not Repealed

The Cadillac Tax is a game changer and a primary focus of this study. If the Cadillac Tax stands as is, it very well could be a tipping point for employer-sponsored healthcare coverage.

The 40% excise tax will be imposed in 2020 on health insurance plans exceeding premium payments of $10,200 for individuals or $27,500 for families. During the healthcare debate, the Cadillac Tax was described as affecting only a small minority of "overly generous" plans. It would raise revenue while reducing healthcare costs by addressing overconsumption of medical care and encouraging employers to control costs.

However, the 40% tax will apply to modest plans too, and this hurts employers' ability to continue to offer quality and affordable employer-sponsored healthcare coverage.

A 2015 Towers Watson study noted nearly half of employers in the United States would trigger the excise tax when it takes effect, and 82% would trigger the tax five years later if nothing changes. There are many factors affecting companies' tax liability, thus causing plans to hit the tax threshold earlier than expected. The tax applies to the total cost of employer-sponsored coverage, which means it includes the employer plus employee insurance premium, health savings accounts, health reimbursement arrangements, flexible spending arrangements, on-site medical clinics, certain wellness and employee assistance plans and other pre-tax health benefits. The bottom line is, as structured, this tax will significantly affect most workers, employers and health plans, which is why the results of our survey were interesting.

Not surprising, our survey found 53% of employers opposed the tax. What is surprising is the 34% of employers who "don't know" or were "undecided" in their support of or opposition to the tax, indicating an extraordinary degree of confusion. Just 19% of employers reported changing their benefits in 2015 in preparation for the Cadillac Tax. This indicates employers are waiting to see if the tax will stick.

In late 2015, Congress delayed implementation of the tax until 2020. This provides short-term cover for employers and the opportunity for a full repeal if the next administration is more amenable to it.

The biggest obstacle to Cadillac Tax repeal is paying for the lost revenue the tax is supposed to generate. The Congressional Budget Office predicted the tax would generate $87.5 billion over 10 years. The Congressional Budget Office anticipated 25% of the revenue would come from companies triggering and paying the tax. The other 75% was expected to come from newly taxable income.

The Congressional Budget Office expected companies to increase employee participant salaries as they decreased benefits. Our figures indicate otherwise. Companies will not automatically, dollar for dollar, increase taxable wages to compensate for cost increases passed on to employees. For those employers that did change their benefits, 73% did not increase other forms of compensation to their employees, 47% subjected their employees to higher premiums and 14% decreased health savings and flexible spending contributions. Of the employers who oppose the tax but have not changed their plans (yet), 64% are opposed to other forms of compensation and 57% favor greater cost sharing by employees.

Spotting Broker Opportunities

Identifying the gap between what employers want and what they can do.

The Match Game

Brokers must match their skillset to new client demands.

To understand where opportunities lie for brokers to add value to benefits-related services, we looked at what employers do in-house, what their biggest challenges are and what broker functions they most value.

Employee-facing functions including decision support, payroll services, and employee education and communication lead the areas employers fulfill with in-house resources. Of those surveyed, 83% fill decision support in-house, 81% fill payroll in-house, and 73% fill employee education in-house.

Legal/regulatory compliance services, wellness programs and plan administration repeatedly pop up as employers' most important desires and the areas they find most difficult to handle. Although legal/regulatory compliance is inherent in benefits administration, employers and focus group participants approached it as separate—an interesting insight into how employers think.

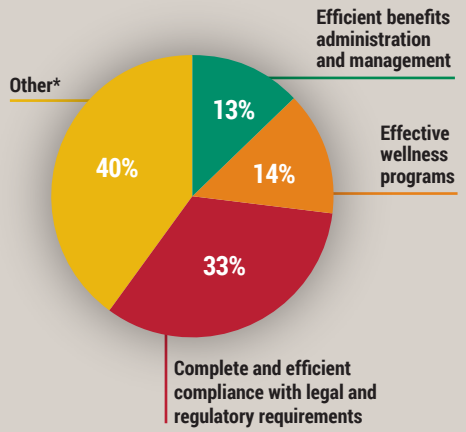
BROKER SERVICES TODAY

As shown in employers' ranking of broker services, the higher technical functions lead the areas in which employers are currently leveraging brokers. When we compare these results to functions employers fill in-house, we find employers have largely assumed the employee-facing role and function. This does not presuppose brokers have no role in management-based employee-facing functions. Instead, employers do not seem to place a high premium on these services.

KEY GAPS TO FILL

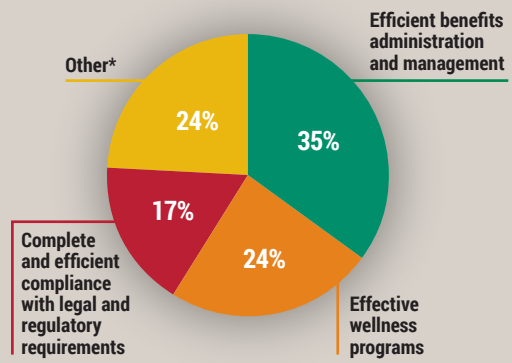
Just as important as understanding employer needs is evaluating current broker strengths—and finding opportunities to fill gaps. As the competency chart on page 13 demonstrates, brokers have a higher level of competency than employers in certain areas. While employers are already leveraging brokers in some of these areas, there is room for opportunity in others.

Most Difficult Functions for Employers to Accomplish In-house
(ranked by employers)



* Other includes vendor management, access to global healthcare data and analysis, and access to labor market competitive intelligence and benchmarking

Most Important Functions for a Successful Benefits Program
(ranked by employers)



* Other includes vendor management, access to global healthcare data and analysis, and access to labor market competitive intelligence and benchmarking

Five critical areas of opportunity: legal/ regulatory compliance, data analytics services, plan design, wellness programs and integration.

Brokers' capacity to organize myriad legal, legislative and regulatory uncertainties into actionable intelligence will be a core differentiator.

Employers describe legal and regulatory compliance as the most difficult function to accomplish in-house, and many (51%) use brokers to fulfill this function. Thus, this as an ongoing area of need.

There is a lot of regulatory compliance in general benefits administration, which is compounded by Affordable Care Act compliance. We don't think this compliance burden is holding employers back from making substantive positive changes to benefits plans.

Instead, we believe big-picture policy uncertainties are creating a low appetite among employers to change up their benefits strategy. In this study, we've mentioned certain key policy matters. Many more abound and will continue to emerge in the months and years ahead as policymakers and regulators continue to institute various reforms in the marketplace. This environment precludes employers from committing to offerings over the long term. The absence of clarity clouds the future and inhibits the kind of investment and innovation that might make for a more productive and well-rounded set of offerings in the employer community. As one large Chicago employer said, "Losing the tax treatment would be a game changer for my organization in fully funding going forward." To this end, employers are

Competency by Function

	LOCUS OF COMPETENCY	BROKER / CONSULTANT	IN-HOUSE (EMPLOYER)	CARRIER	OTHER VENDOR
Plan Design	BROKER	●	◕	◑	◔
Technology and Administration	BROKER	●	◑	◕	◔
Actuarial Services and Underwriting	BROKER	●	◔	◕	◑
Data Analytics	BROKER	●	◕	◑	◔
Industry Benchmarking	BROKER	●	◑	◔	◔
Regulatory Compliance	BROKER	●	◕	◔	◔
Population Health and Wellness	EMPLOYER	◕	●	◑	◔
Employee Education and Communication	EMPLOYER	◑	●	◔	◔
Vendor Management	CARRIER	◕	○	●	◔
Decision Support	EMPLOYER	◑	●	◔	○
Negotiations	BROKER	●	◕	◔	◑

Note: Full circles do not necessarily denote superiority in a function. Instead, they indicate the entity fulfills most of the needs of the function and therefore can reasonably be considered competent in that area.

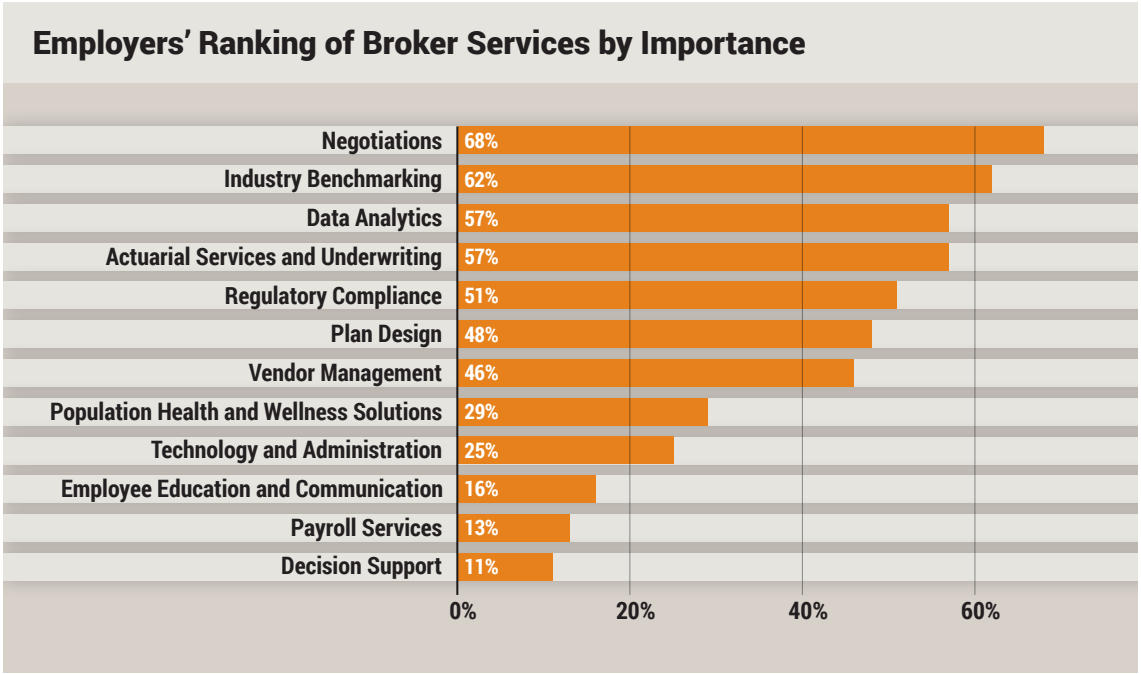
not seeking legal advice or tax counsel to the same extent they are pursuing resources that help with strategic assumptions in the face of the complex regulatory environment.

To support employers, brokers must monitor the landscape, apply the context of the local market (or the specific book of business) and render an assumption and/or policy position on the topics at hand. To accomplish these tasks, brokers can hire a full-time public policy or legal expert (or mulitple depending on the market need and demand), contract with a third party that can scale such intelligence over a broader swath of employers or use some combination of the two. The amalgamation of this intelligence should be readily available to employers.

Data services and analytic functions are the bedrock of integrated benefits solutions.

Employers will continue to expect brokers to be an objective, technically competent third party when it comes to data analytics, actuary services and industry benchmarking (small, midsize, and large employers leverage carriers for this 11%, 21% and 8% of the time, respectively). While health plans have traditionally employed analytic firepower, brokers who can provide new services supported by data analytics will have a comparatively unique offering. Data analytics can support plan designs and justify preventive services and coverage for different types of models. Analytics can determine the efficacy of certain coverage models and initiatives, allowing for adjustments and recommendations to streamline and enhance offerings over time. Further, analytics can be used to stratify at-risk employees or identify opportunities to intervene in population health, should certain clinical protocols be triggered.

A critical element to establishing and sustaining such services is having access to claims, clinical (when practical) and pharmacy data. Even if contracting for a network and developing plans in-house, brokers would do well to continue leveraging a third party for claims adjudication (though there is a growing prevalence of SaaS solutions that offer certain of these functions). Wherever data analytics services reside, brokers will gain a distinct advantage through claims feeds that allow them to scrutinize employee activity.



A rapidly changing delivery system, the rise of consumer choice and diffuse distribution channels necessitate a consultative approach to plan design.

Employers will continue to heavily leverage brokers' expertise in plan design, with the common goal of better managing healthcare spending through data, consumer engagement tools and incentives that change individual behavior.

In recent years, there have been many employer-driven innovations in health benefit design, such as health reimbursement arrangements, value-based benefit design, medical homes and wellness programs. And—though premiums by plan type can be compared and the use of preventive services can be tracked—reliable, unbiased information regarding the true impact of these programs is scarce. Despite that fact, these are broker and employer innovations, and plan design is the most important area in which brokers can develop enhanced services over time.

There are several dimensions to this, including plan diversification, network development and contracting, and distribution.

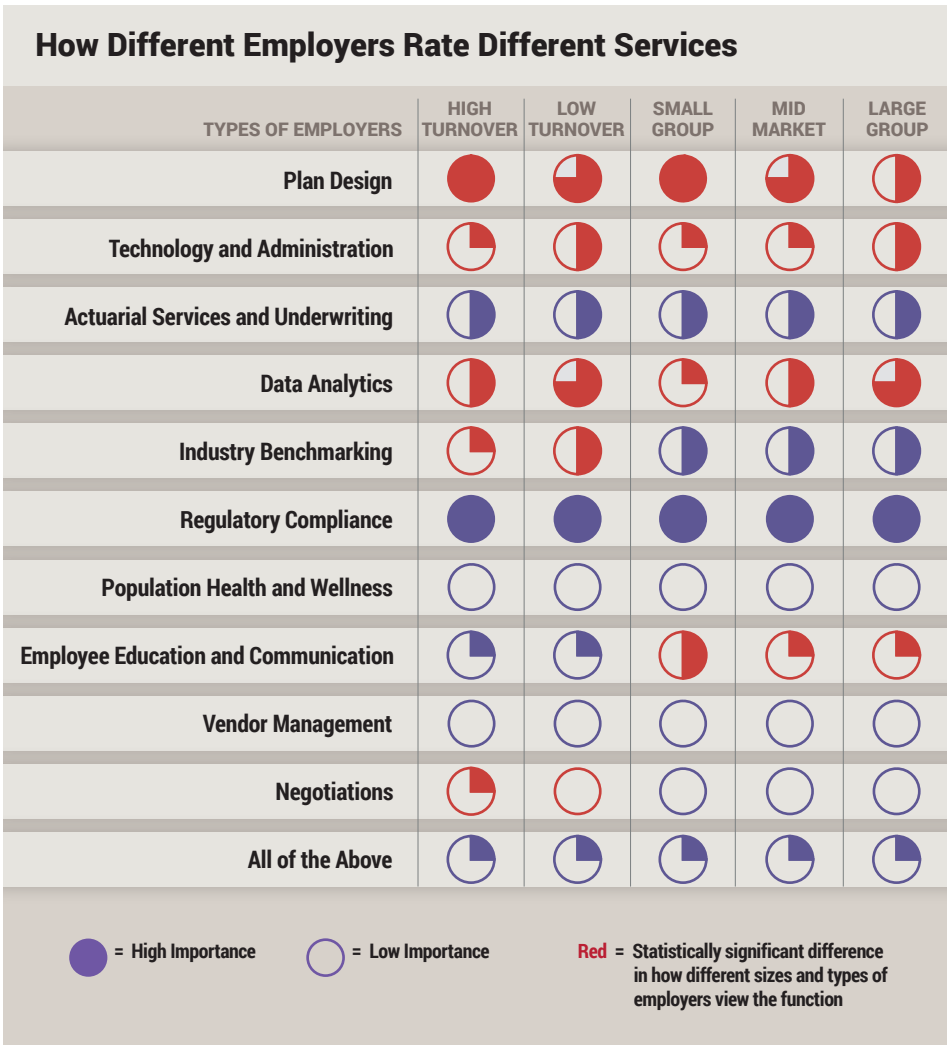
Wellness and population health management programs offer a good example of plan diversification. Brokers should consider unique designs and coverage options (preventive and otherwise) tailored to employees' needs. Employees should have options to ensure they can select a plan with the clinical and economic configurations that address their personal health portfolio. They should institute actuarially appropriate cost-sharing attributes to drive employees to properly use the network and the associated services, such as purchasing prescriptions.

The objective should be quality over quantity, and that includes meeting employers and employees where they are.

To that end, we are seeing an end to the days of a simple choice between a broad-based preferred provider organization and high-deductible plan. Instead, brokers are best positioned to consultatively determine the specific objectives of the employer, survey the third-party administrator and provider landscape, and put together the precise products and services that best match employer needs.

As noted earlier, the ultimate success of private exchanges is still questionable. We recommend brokers use them only as technology tools. Employers' expectations of these models lie in the administration, management and enhanced employee experience they offer over time. They should be used in conjunction with broker services and support.

How Different Employers Rate Different Services



Wellness and population health management solutions offer a powerful opportunity for brokers to add value to benefits structures.

As we've discussed, roughly a quarter of employers believe wellness is the single-most critical function of their benefits offering. Of employers who have yet to develop a population health initiative, 43% intend to in the future, and 67% report a positive and measurable return from these programs. This leads us to conclude there is indeed merit to these programs.

However, only 38% of employers fulfill the function in-house. It is more often implemented by a broker/consultant, other vendors or carriers. This is a great area of opportunity for brokers, even though employers have less confidence in brokers' ability to add value in this area. Brokers are in a unique position to pool resources, vet programs and identify which ones will have meaningful economic and clinical results.

The brokerage community is in a position to establish wellness standards, and individual brokers can integrate proven solutions into employer-sponsored insurance programs. By integrating such programs into plan designs and provider contracts, brokers can drive the right programs to the right employees at the right time.

Employers will increasingly expect brokers to integrate services into a seamless solution that meets the organization's unique needs.

Employers are not interested in carriers, vendors or employers themselves integrating the myriad services outlined above. They expect brokers not only to provide these competencies, but also to have the capacity to design the required solutions.

On the ground, integration is about asking practical questions—finding out who needs which services, what steps it will take to deliver them and how to organize the process. This does not mean everything has to be a single package. The aim is to provide a service menu users can seamlessly navigate.

Spearheading change in this way requires a sustained commitment to consultative services. Brokers with these attributes can set themselves apart by working to understand employers' unique clinical and economic objectives, nuances of the employee population and uncertainties in the market. Brokers must then translate this intelligence into a focused, design-build solution customized for the employer.

The Small-Group Broker Opportunity

Brokers in the small-group market are remodeling their approach in design-build fashion. The Affordable Care Act's underwriting and risk pool reforms aimed at businesses with fewer than 50 employees prompted many brokers to reevaluate this segment. Some opted to sell their book, others have partnered with a small-group specialist and others decided to double down—not only keeping the business but investing in it to increase returns.

The ability to use technology factors heavily into this decision. It allows brokers to increase efficiency in serving this segment, which is critical for profitability.

At the same time, a mashup of tech startups, benefits administration providers, human resources information systems and private exchanges came out of the woodwork. They seized on the opportunity to address a historic pain point for small-business owners, who just want a simple way to administer all human resources functions, including health insurance.

For brokers rethinking their strategy, the timing could not have been better to demonstrate their unique value. Brokers are marrying their trusted advice with client-facing technology and dedicating a full team to serve as a one-stop shop for small-business owners. Interestingly, some brokers are integrating small group employee benefits and property-casualty into one department. With cross-trained staff and one data system, brokers are giving employers the seamless solution they want while staying highly engaged in their clients' needs.

Design-Build Is The Way to Go

This break from the traditional model is perhaps the most important aspect of the brokerage model of the future.

Customizing Benefits to Meet Employers' Needs

Throughout this research, employers repeatedly expressed the need for brokers to reduce or eliminate two things: cost and complexity. Successful brokers will address these needs head on by simplifying health benefits for the consumer, which should then enhance employers' overall business performance.

Design-build is a building industry concept in which one team works under a single contract to deliver both design and construction services—traditionally separate entities. It answers employers' calls for a unified, integrated workflow (or benefits plan, in this case) and a trusted broker who will take disparate benefits options and combine them into a customized package.

Design-build brokers will

- Strategically partner with employers to balance affordability and paternalism
- Leverage emerging benefit models to design and execute health benefits
- Provide a suite of services to support employer goals

Design-build forces brokers to work in new ways to understand their clients on a different level. This is how brokers will differentiate, fend off competitors and grow their business while adding value to clients' businesses and charging a fee for it.

Strategic Design-Build Recommendations for Brokers

1. Assess and reconfigure the talent and infrastructure needed to achieve strategic benefits goals. Train brokerage staff to provide consultative services to employers. Enhance technical expertise in areas such as pharmacology, health information technology and data science. Identify a recruitment strategy.
2. Segment and build solutions that meet the needs of different sizes and types of employers.
3. Determine whether the brokerage can deliver functional competencies required by the marketplace and, if not, use partnerships, joint ventures or acquisitions to shore up absent capabilities.
4. Evaluate specific employer needs and develop a profile for the employee population that enables a network, clinically oriented wellness, preventive coverage, formulary and other cost-sharing features to work together.
5. Establish flexibile plan designs that meet employers' economic and clinical objectives.
6. Tap into or establish local, regional or national coalitions that facilitate clinical and cost-effective behavioral health and wellness programs.
7. Assess private exchange options and other benefits delivery tools.
8. Assess local delivery system dynamics and determine if there are opportunities through a third-party administrator or direct contracting to provide higher-value health services to employees.
9. Invest in building or accessing data services and analytics tools that give employers confidence in their benefits and facilitate contract performance management.
10. Establish a regulatory and policy intelligence hub that integrates with compliance efforts and promotes strategic assumptions that guide employers in long-term planning. Deploy intelligence assets through a centralized repository, regular "push" interactions, public forums and consultations.

Key Departures from the Traditional Model

In the traditional producer sales model, brokers lead both sales and relationship management with clients and prospects.

With few exceptions, most firms' producers have been benefits specialists versus brokerage generalists. In addition, firms vary on how much their producers are focused (if at all) on ongoing relationship management responsibilities. Many

firms expect the producer to be actively involved in leading the renewal process, though some allow the producer to lean heavily on account executives for driving renewal activity.

In general, producers are paid by base compensation, cash incentives and long-term incentives. Practices are somewhat mixed with respect to base compensation. Overall, most firms provide a draw with no salary. Not surprisingly, commissions are the most typical variable cash incentive.

In a design-build model, the client is being sold the brokerage's brand, not the personality of the producer or account manager. This mindset changes how the firm goes to market. A design-build consultancy model is very much a team sales model with a fee-based structure. The model leverages the brand and strengths of the entire organization, not just the relationship of a producer. It is based on strategic selling techniques and is focused on the business interests and issues facing clients and prospects. Fundamentally, this is about brokerages refocusing from the products to the experience the client has in working with the firm—and charging a fee for it.

One approach to this is to organize around high-performance, highly skilled, client-focused selling teams. This combines the elements of sales strategy, business/industry strategy and solution/delivery strategy to form a highly credible, value-oriented team focused on a set of clients and prospects. Smaller teams will typically consist of an experienced business development person, a benefits analyst or strategist and an account executive responsible for project or solution delivery.

Larger teams may also include market researchers, technology and plan design experts and financial specialists. These additional players can support the team in their own unique areas. For example, market researchers can provide specific industry insights to help the team understand the target opportunities and challenges.

A design-build consultancy model is very much a team sales model with a fee-based structure. The model leverages the brand and strengths of the entire organization, not just the relationship of a producer.

The size of the teams depends largely on the opportunity, the availability of resources and the sales budget. The primary responsibility of this design-build sales team is to open the door to a targeted strategic account. The ultimate goal is to provide such compelling value to the client that the team sustains project work and continues to discover new opportunities for the client.

Another key factor for design-build success is shared control. Unlike the traditional model in which the producer typically controls the relationship, in design-build, no one person owns or controls the relationship. Prospects and clients will come to expect different things from the different members of the team. And if team members do not effectively communicate with each other, the client and the rest of the firm, they will not be successful.

The operational heads of benefits firms certainly have their work cut out for them as they migrate to this new way of doing business. They must fight fragmentation by clearly defining roles and responsibilities, develop clear internal messaging, streamline communications, offer robust training and use technology to cultivate this new model—and it's not easy. However, risk and innovation are partners, and those who realign themselves with the client at the heart of what they do won't lose.

How do you move from rhetoric to results? Not by paring and pruning.

In this report, we identified five key areas in which brokers can satisfy employers' unmet needs, and we outlined a new model for employee benefits: the design-build consultancy. The next step is to examine the specifics of *how* benefits brokerages can go about reinventing themselves. Aligning a brokerage's leadership and benefits teams is an essential starting point for moving from rhetoric to results. Both must be invested in and supportive of the new approach.

To begin this process, brokerage executives should be thinking about and discussing the following key questions.

What ultimate vision do you have for the growing benefits consultancy services your organization is offering? This question has important implications. Despite efforts in recent years to modernize and standardize the state laws that govern fee payment, they still vary from state to state and often do not address the issue specifically, making it particularly difficult to structure compensation. Nearly every state now allows insurance producers to charge fees in addition to receiving commissions, though differences remain among the types of services for which producers may charge fees. Most states place conditions on or completely prohibit charging fees in connection with the sale of insurance.

It is also critical to know the type of documentation or disclosure required when a producer is compensated by both fees and commissions. As of 2015, at least 14 states required additional licensing for licensed producers to charge fees.

These are just a few of the questions that arise when considering a fee-based consultancy model. Seeking legal advice on your specific plans is always best and better sooner rather than later.

What are the first steps in migrating to a compensation system that is flexible enough to reward excellent performance yet simple enough to be well understood? Growing a design-build, multi-solution business over a sustained period will not happen by tweaking the sales and service model around the edges. This is a comprehensive overhaul. Think about how to develop a simpler, more disciplined compensation framework that can work in one segment after another.

How are you exploring non-traditional partnerships and alliances that can potentially provide a competitive advantage? The carrier has traditionally been the primary supplier and partner, but these lines are blurring, with other alliances entering the mix. How many hours did your firm spend in 2015 vetting essential partners? Brokers must determine whether the brokerage can deliver functional competencies required by the marketplace and, if not, use partnerships, joint ventures or acquisitions to shore up absent capabilities. Do you have an established committee to explore and set the order of importance of such investments? And, if so, what is its rate of return?

Will the majority of your 2016 strategic benefits decisions drive longer-term investments that make continual value for clients a priority over short-term profitability? At great companies, profit is not the sole end; rather, it is a way of ensuring returns will continue. A company's value should be measured not by short-term profits but by its sustainability and the continual profitability it brings to clients. These corporate leaders deliver more than just financial returns; they build enduring institutions.

What is your strategy for helping to initiate and cultivate transparency for employers and consumers? Information has to be accessible and simple if it is to be actionable. The system has a long way to go in this realm, but great opportunity for more transparency exists and brokers can really contribute to this. What are you doing to educate consumers on the different roles of all involved (employers, brokers, medical carriers, voluntary carriers, private exchanges etc.)?

Glossary

For the purpose of this study, we define these terms as follows:

Actuarial Services and Underwriting—deriving the rate tables that reflect the general risk of a pool (informed by the plan design functions) and ascribing specific rates to individuals on the basis of certain predefined underwriting criteria

Benefits Plan Management and Administration—includes functions related to enrollment, eligibility determination, customer service and any other general management functions; does not include, nor necessarily imply, the use of technology platforms or solutions

Data Analytics—leveraging claims data (provided by consultant, third-party administrator or other third-party resources) along with clinical and pharmacy data (when accessible) and evaluating them for employee/patient intervention, focused plan design and employer-driven medical management (or corresponding utilization management, case management and condition and lifestyle management)

Decision Support for Employees' Plan Choice—maintaining personal or intuitive support as employees select major medical and ancillary products/services that best meet their needs

Employee Education and Communication—functionally, this includes the capacity to administer notifications, encourage participation in ancillary programs and support the use of benefits through the enrollment lifecycle

Industry Benchmarking—assessing the performance of employer benefits by comparing utilization, cost and other related parameters to a broader baseline (typically constituted by employers with similarly patterned benefits structures in commensurate industries and/or with commensurate sizes)

Legal and Regulatory Compliance—maintaining compliance with all legal and regulatory requirements, including plan composition, reporting, taxation and employee notifications, in addition to anticipating regulatory changes; although an inherent function of benefits administration, we broke this out separately since employers approached it this way in the in-depth interviews and focus groups

Negotiations with Carriers, Providers and Vendors (i.e., procurement)—directly engaging other parties to coordinate services needed to support the various functional areas required by the benefits offering

Plan Design—the establishment of plan coverage parameters, network formation and contracting, cost-sharing mechanisms, preventive coverage mechanisms and other plan attributes intended to influence consumers' behavior in engaging the delivery system

Technology and Administration—the technology tools and resources required to facilitate enrollment, eligibility determination, administrative functions (for the plan, broker or employer) and employee-facing resources

Vendor Management—facilitating and coordinating vendors that provide support services or are directly contracted to furnish services related to the benefits offering

Wellness Programs—population health risk management programs operated by the employer and intended to influence employees' behavior while also structuring medical management solutions that focus on clinical outcomes for the employee population

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