FROM REACTIVE TO READY:

A Practical Health Plan Renewal Guide

imagine360

For far too long, the annual health plan renewal process has relied on a single, flawed metric: the premium percentage increase. When a broker successfully negotiates a 20% rate hike down to 12%, the result is usually celebrated as a victory. However, for organizations that accept compounding, double-digit-percentage increases year after year, financial burdens that will eventually exceed what corporate operating budgets can absorb and what employees can afford to pay.

The fundamental economics driving this crisis are straightforward. From 2020 to 2025, an employer's average annual premium contribution for family coverage skyrocketed by 23% to more than $20,000 per family[1]; meanwhile, the healthcare cost burden for the average employee continues to outpace wage growth. From 2010 to 2025, an employee's portion of family premiums jumped by 27% while earnings grew by only 10%.[2]

Today rising deductibles and out-of-pocket limits have reached a breaking point. The financial burden of healthcare now exceeds most employees' savings, leaving workers with coverage they simply cannot afford to use.

As if unsustainable costs weren't enough, the evolving legal landscape is creating new employer fiduciary responsibilities that make renewals on autopilot risky. Recent federal transparency mandates have given employers greater access to health plan pricing and claims data, which is creating new opportunities to evaluate plan performance and purchasing decisions.

However, access alone does not make the data easy to interpret. The volume, complexity and format of much of this information can make it difficult for employers to identify meaningful insights without the right expertise. Working alongside knowledgeable brokers and advisers, employers can better understand what the data is revealing, can become equipped to ask more-informed questions during renewal discussions and can then make benefits decisions that align with both employees' needs and financial goals.

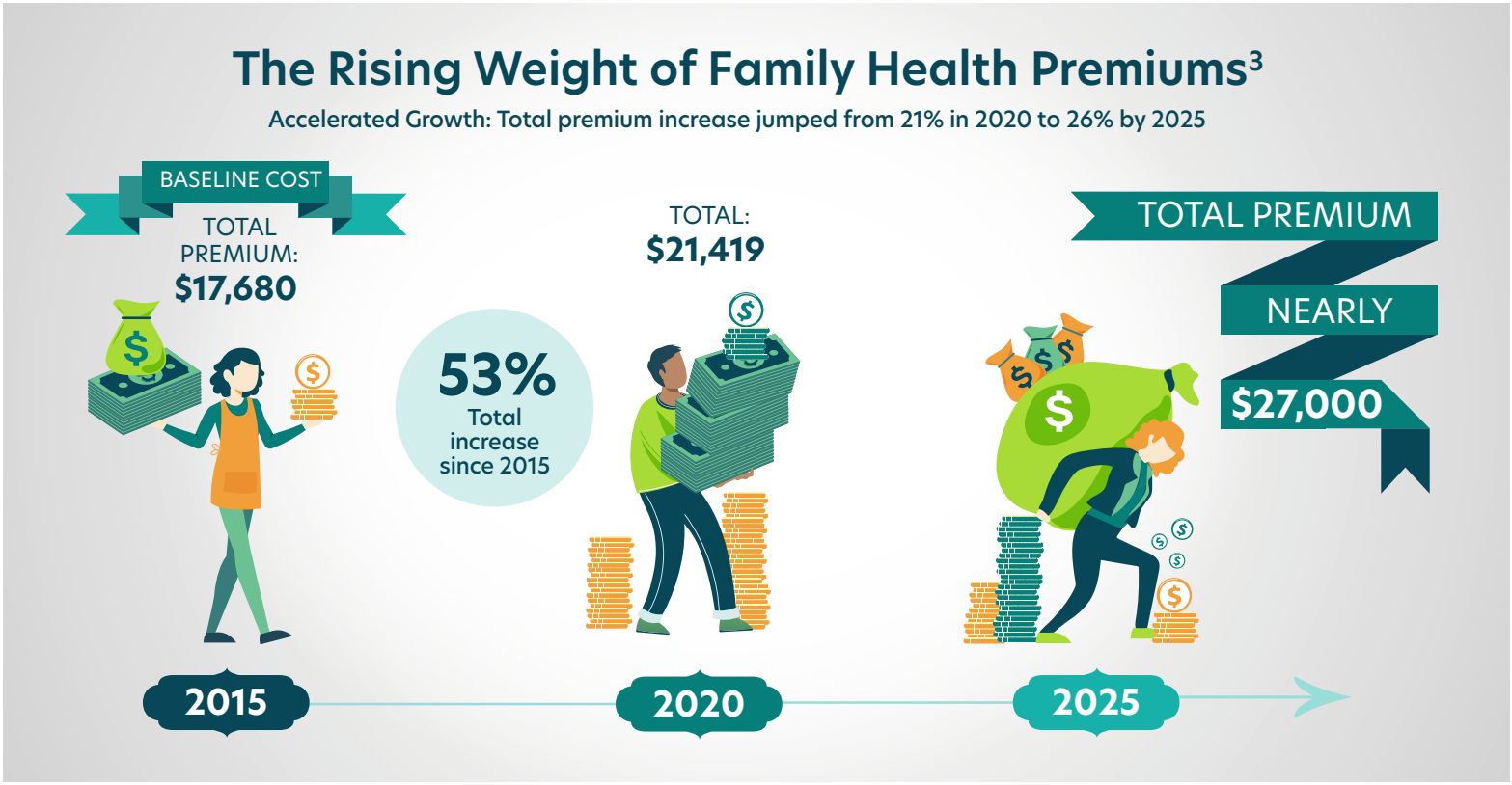
This shift aligns perfectly with a modern workforce seeking a higher standard of accountability by demanding high-value health plans that offer predictability, true transparency and clear guidance through the administrative complexities of traditional carrier models.

PREPARING FOR THE ANNUAL HEALTH PLAN RENEWAL

- Demand data transparency
- Analyze cost drivers
- Assess the cost burden on workers
- Consider fiduciary responsibilities during negotiations
- Determine readiness to move to a new health plan

With these converging trends, employers now have more leverage than they did even a few years ago. With support from their brokers and advisers, employers now possess the negotiating power to transform their annual health plan renewals into proactive, strategic exercises. The transformation gives organizations the opportunity to align healthcare spending with value and then either redirect savings toward business priorities or reinvest the savings directly back into the workforce.

Leadership must now shift the baseline renewal question from "How much more will this health plan cost this year?" to "Did this plan deliver true value for our spend?" The transition to this value-focused mindset requires an actionable framework that guides an organization through the questions it should ask in order to evaluate historical health plan performance, isolate cost drivers and develop a long-term healthcare strategy that aggressively protects both financial margins and the workforce.



Demand data transparency

You cannot manage what you cannot see and the first step in any meaningful renewal assessment is to obtain granular, actionable data. And even though traditional health plan carriers typically provide aggregated reports summarizing total billed versus paid amounts, such high-level overviews can artificially inflate perceived network discounts by incorporating completely denied claims, out-of-network leakages and experimental procedures that paid $0.

To move from reactive to ready, employers have an opportunity to partner with their advisers by requesting raw, line-by-line claims reports. Traditional health plan carriers often assert that line-by-line payment data is tied to so-called proprietary contracts and cannot be shared. However, the Consolidated Appropriations Act of 2021 explicitly prohibits these "gag clauses" for new contracts between providers and insurers. There are also ongoing regulatory efforts to make detailed disclosures to plan sponsors which allow trustees to better perform their fiduciary obligations.[4] As a plan sponsor, an employer has the legal authority to request and review the healthcare spending it ultimately funds.

Data collection checklist

- ☐ **Line-by-line claims data:** A meaningful assessment requires moving beyond aggregated summaries. Request raw, granular claims utilization reports that include the National Provider Identifier code, eligible billed charges and actual allowed amounts.
- ☐ **Independent benchmarks:** To accurately calculate baseline costs, organizations must evaluate claims data against objective, external metrics rather than rely on a carrier's internal reporting. Employers should work with brokers and advisers to collect third-party data.
- ☐ **Pharmacy and rebate costs:** Medical claims are only half the story. Employers should have access to a granular breakout of pharmacy spend — particularly for high-cost GLP-1s and specialty therapies. Most important is that pharmacy benefit manager (PBM) contract data will have to be verified to ensure (1) that the carrier is not retaining pharmaceutical rebates and (2) that those funds are being passed back to the plan.
- ☐ **Quarterly data reviews:** Data transparency is not a once-a-year exercise. Employers and their advisory teams should ensure they are securing the proper authorizations to access anonymized claims data year-round by conducting quarterly reviews that track cost trends long before the annual renewal cycle ever begins.

Conduct a deep-dive analysis to identify cost drivers and trends

With data in hand, organizations possess the leverage to identify exactly what is driving their top-line premium increases. High-level aggregate reports frequently mask the root causes of escalating costs. So, in order to make informed, strategic decisions, an employer must partner with its advisers to conduct a thorough analysis of the line-by-line data. Such a process of analysis helps identify recurring cost drivers, evaluate future risk and determine whether the current plan structure remains financially sustainable.

Data analysis checklist

- ☐ **Utilization review versus price variance:** Pinpointing the exact source or sources of cost trends is a strategy for uncovering savings. Evaluate whether recent increases are driven by employees' actively accessing more care or whether they stem from existing provider reimbursement structures.
- ☐ **Pharmacy and specialty drug drivers:** Analyze PBM contracts to ensure that pharmaceutical rebates are getting passed directly back to the organization and then explore alternative solutions like international drug sourcing or patient assistance programs to actively reduce spend.
- ☐ **Outlier claims:** Is an organization paying drastically different amounts for the exact same care? With line-by-line visibility, potential concerns can be exposed, such as extreme price variances wherein a routine procedure may cost significantly more at one local facility compared with the cost at another just miles away.
- ☐ **How the current plan compares with an alternative plan:** Has the organization objectively compared current costs against transparent, alternative health plan models? A repricing analysis can help model historical claims data against solutions like reference-based pricing (RBP).

Industry data reveals that traditional health plans frequently pay up to **254%**—and in some regions even more than **300%**—of Medicare rates for the exact same hospital services.[5]

Pharmacy benefits now represent **27%** of healthcare dollars, with specialty drugs such as GLP-1 medications and specialized therapies consuming more than **50%** of that total.[6]

Actively implementing alternative sourcing strategies has the potential to drive an additional **15 to 20%** in targeted pharmacy savings.[7]

Research demonstrates that evaluating transparent health plan models can help employers identify meaningful savings opportunities. An independent analysis found that Imagine360 reduced healthcare costs by nearly **20%** compared to commercial health plans.[8]

GETTING AHEAD OF THE NEXT RENEWAL CYCLE

Is data review an ongoing strategic priority or only a once-a-year scramble? Employers that want to get ahead of the scramble do not wait until the fourth quarter to discover what drove their costs up. Employers and brokers should work together to establish quarterly claims reviews so as to enable organizations to discover high-cost trends, leverage predictive data and course-correct well before the next renewal cycle begins.

Assess the cost burden on employees

A health plan is valuable only if employees can afford to use it. Research shows that high-deductible health plans can discourage the use of recommended care. In a study of more than 343,000 adults with chronic illness, HDHP enrollment was associated with lower use of recommended clinic visits, prescription drugs and laboratory testing.[9] With employees increasingly delaying or forgoing needed care because of cost, many workers are left with coverage that exists on paper but remains financially difficult to use, making employees "functionally uninsured."

Redesigning a health plan structure is not merely an exercise in reducing corporate expenses; it is a strategic opportunity to reinvest in the workforce, reverse the current trend of deferred care and transform the health plan into an engine for recruitment and retention.

Employee checklist

- ☐ **Measure employee access and deferred care:** Are high out-of-pocket limits inadvertently raising barriers to essential care?
- ☐ **Evaluate the true financial strain:** Evaluate whether current deductibles are misaligned with the average employee's savings. With 41% of individuals reporting they would have to take out a loan or go into debt to cover a $1,000 unexpected medical bill, maintaining an $8,000 family deductible leaves the workforce highly vulnerable.[11]
- ☐ **Assess healthcare as a potential retention strategy:** Healthcare affordability is increasingly shaping employees' perceptions of benefit value. When deductibles, out-of-pocket costs or drug prescription expenses become difficult to manage, employees are less likely to view their health plan as a meaningful part of their total compensation package.
- ☐ **Protect against price variability:** Does the health plan actively shield members from massive pricing inconsistencies within the same geographic area? Without transparent reimbursement mechanisms, employees are exposed to drastically different prices for the exact same procedure.
- ☐ **Request fairness in pharmacy benefits:** Pharmacy structures that incentivize higher list prices place unfair financial burdens on members who rely on daily or specialty medications.

Industry data shows that **44%** of employees postpone necessary care or medication because of cost, while research has found that high-deductible health plans can lead patients to delay or forgo needed care because of out-of-pocket expenses.[10]

Consider the organization's fiduciary responsibilities during negotiations

Fiduciary responsibility extends beyond regulatory compliance. As plan sponsors, plan fiduciaries are responsible for (1) monitoring how plan assets get spent, (2) evaluating vendor arrangements and (3) documenting decisions that affect plan costs and participant access to care. Those obligations form the basis for requesting data, reviewing contracts and questioning reimbursement arrangements that may not be serving the interests of the plan or its members.

By actively understanding and exercising those responsibilities, fiduciaries must transition from passive purchasers into empowered plan managers and set higher standards for accountability and value.

Fiduciary checklist

- ☐ Adopt a written fiduciary charter: Establish a formal health plan committee similar to a retirement plan committee, with clear procedures for reviewing plan data, assessing administrative vendor contracts and documenting meeting decisions.
- ☐ Remove contractual data restrictions: Audit agreements with third-party administrators (TPAs) and PBMs to ensure that all hidden gag clauses are removed so as to secure the organization's legal right to access line-by-line claims utilization data.
- ☐ Audit pharmacy benefit pass-through terms: Verify that PBM agreements are structured under a transparent, fixed administrative fee model whereby manufacturer rebates and price concessions get returned directly to the health plan.
- ☐ Perform regular fee and benchmark reviews: Evaluate paid provider claims quarterly against objective, independent market data — such as baseline Medicare rates or third-party cost transparency studies — in order to document that plan expenditures are reasonable.
- ☐ Secure documented compliance attestations: Ensure that an employer's administrative partners provide clear and ready-to-audit verification to meet legislative requirements, including mental health parity comparative analyses and annual gag clause compliance filings.

Assess readiness to move to an alternative health plan

A high-value health plan must do more than pay for care; it must also actively protect both the employer's bottom line and the employees' wallets. Organizations must be operationally, financially and culturally prepared to break away from legacy health plan structures. Then, before evaluating an alternative funding model, employers should determine whether leadership and internal stakeholders are prepared to support the operational and communication requirements associated with a plan change.

Organizational readiness checklist

- ☐ True executive alignment: Readiness begins when executive leadership is willing to evaluate alternatives to the current plan structure. Organizations are better positioned to evaluate alternative plan models when the CEO and chief financial officer participate in benefits strategy discussions.
- ☐ A new definition of health plan disruption for employees: A critical readiness indicator is shifting the internal narrative around what constitutes a disruptive change. Although human resources teams naturally want to protect employees from transition friction, leadership must recognize that absorbing, say, a 15% annual premium increase is already severely disruptive to the workforce. An unaffordable

deductible that exceeds an employee's savings is far more damaging to the employee's livelihood than simply having to learn to navigate an updated plan design without a traditional carrier logo.

- ☐ Willingness to establish direct access to solution experts: Are advisers facilitating direct conversations with the experts who actually administer alternative plans? If an employer is ready to evaluate a new plan type, it must work collaboratively with its broker to bring the solution providers directly to the table. Engaging directly with vendors alongside the advisory team ensures that all intricate plan details get clearly communicated and thoroughly vetted.

- ☐ Openness to a stepping-stone approach: Transitioning to a high-value health plan does not require an all-or-nothing leap. Readiness can mean establishing a tailored road map that eases the organization into alternative models. Options could include unbundling services to move to an independent TPA, carving out pharmacy benefits or offering a dual option. A dual option pairs a traditional network plan with a high-value, transparent model — like RBP to empower employees to actively choose the plan that puts more money back into their paychecks.

- ☐ A plan for strategic reinvestment: A truly ready organization views optimized healthcare savings not just as retained capital but also as a retention strategy. Evaluate how such captured dollars will be repurposed to actively support the workforce. Redirecting savings demonstrates to the workforce that structural changes are being designed with that workforce's best interests in mind, ultimately building a resilient and loyal team.

Conclusion: Moving forward with confidence

Moving forward by taking a new approach to health plan renewals requires leadership to evaluate healthcare spending with the same level of scrutiny applied to any other major operating expense. For instance, rather than focusing exclusively on the next premium increase, employers should examine whether the current plan is delivering measurable value, competitive provider pricing and affordable access to care to employees. That process starts with data, but it also requires a willingness to challenge long-standing assumptions about how healthcare should be purchased, funded and managed.

A dramatically different renewal process starts with broker advisers' bringing specialized experts directly to the table to ensure they are thoroughly evaluating the market options rather than focusing solely on negotiating a slightly lower rate increase. Achieving sustainable financial control means treating healthcare with the same rigorous, continuous oversight as any other major corporate expense.

Ultimately, transforming a health plan strategy means breaking free from the traditional, once-a-year-renewal mindset. Both effectively evaluating high-value alternatives and analyzing data take due diligence, which makes it critical to initiate strategic conversations months ahead of a standard renewal date.

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About Imagine360

Imagine360 is a leading healthcare solutions provider that helps self-funded employers take control of their healthcare costs while delivering better experiences for members. With more than 18 years of expertise in reference based pricing (RBP) and health plan administration, Imagine360 develops fully integrated solutions that combine deep industry knowledge, data-driven strategies and concierge-level support for employers.

The company partners with employers, brokers and consultants to design and manage customized health plans that lower costs, increase transparency and improve outcomes — without compromising quality or access.

Backed by dedicated advocacy, legal protection and proven results, Imagine360 is reimagining what smarter healthcare can look like for organizations and their employees.

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