EXECUTIVE Q&A

What a 19.8% Health Plan Renewal Increase Taught One CHRO About Healthcare Costs

imagine360

For many employers, renewal season has become an exercise in managing the impossible. Each year, leaders brace for another round of double-digit increases, another debate about what can be cut and another difficult conversation about how much more employees can reasonably be asked to absorb. At Duly Health and Care, that cycle had become unsustainable. Traditional approaches—adjusting plan design, shifting costs and accepting market explanations at face value—were no longer enough. The organization needed a different playbook.

This Q&A explores how Duly confronted a renewal environment defined by accelerating healthcare costs, uncovered deep misalignment in the traditional carrier model and chose a more transparent, employer-controlled path. It is a story of crisis, epiphany and action—but more importantly, it illustrates what becomes possible when an employer fully engages with its own healthcare spend instead of continuing to fund a system it cannot control.

Snapshot: Duly Health and Care

Organization: Duly Health and Care

Profile: The nation's largest independent, multi-specialty physician group

Footprint: 190 locations serving 1.5 million patients across the Midwest

Plan context: A long-standing self-insured employer responsible for funding the full cost of healthcare for its employee population

Renewal challenge: Healthcare trend climbed from manageable single digits to 13.6% and then 19.8%, making the traditional renewal approach untenable

Meet Paul Dumas

Paul Dumas serves as Chief Human Resources Officer at Duly Health and Care. A global human capital business and operations leader with more than 25 years of experience, he has led HR strategy in both publicly traded and privately held high-growth organizations. At Duly, he is responsible for aligning people strategy with business goals while helping ensure employees have access to high-quality, affordable benefits. In this conversation, he shares how Duly approached rising healthcare costs not as a routine renewal problem but as a strategic business issue that demanded a fundamentally different answer.

Q&A with Paul Dumas

Q: What made health plan renewal feel different—and more urgent—for Duly?

A: I have managed healthcare expense for years and traditionally the job was to understand your trend and try to meet or beat it. A good year meant staying below trend and limiting disruption. But over time, the numbers stopped behaving like a manageable benefits challenge and started looking like a business threat. What had once been 3% to 5% became 7% to 9%, then 11% to 12%. In 2024, our increase was 13.6%. Going into 2026, it had reached 19.8%. At that point, there is no amount of plan design creativity that can absorb a nearly 20% year-over-year increase without affecting the quality of the benefits you offer your employees.

> ***"No plan design creativity in the world is going to absorb a 20% year-over-year increase without impacting the quality of the benefits that you're offering to your employees."***

That was the turning point for me. I could see we were no longer dealing with ordinary inflation. We were dealing with a system that was pushing costs higher in ways that were unrealistic for employers and employees to continue absorbing. When you reach that point, renewal is no longer about negotiating harder. It's about deciding whether you're willing to continue participating in a model that is fundamentally misaligned with your interests.

Q: Why was this more than just a finance problem?

A: For me, affordability is never an abstract issue. Employees and families feel it every day. Healthcare has outpaced nearly every other household expense people are trying to manage. Years ago, most people would have thought about housing first, then transportation, then food and then healthcare. Today, healthcare is overtaking categories that once clearly came before it. That changes the lived reality of your workforce. It means employees are delaying care, skipping care or making impossible trade-offs between treatment and other essentials.

That is why I view healthcare strategy as both a fiduciary responsibility and a moral one. We have an obligation to provide access to high-quality care but also to ensure that care is affordable. When affordability spirals out of reach, the consequences go well beyond the balance sheet. In practical terms, families are having to make trade-offs of seeking the care they need or putting food on the table for their family, and that sounds pretty dire to me. Renewal decisions are often discussed in financial language, but at their core, they are decisions about what kind of pressure we are willing to place on employees and their families.

> ***"Families are having to make trade-offs of seeking the care they need or putting food on the table for their family."***

Q: Was there a specific moment when you realized the old approach was no longer workable?

A: Yes—very clearly. **I describe it as moving from crisis to epiphany to transformation.** The crisis came in the first week of February 2024, when I received our January loss ratio report. **We were already at 110% of budget for the year. We spend roughly $100 million annually on healthcare, so that meant we were $10 million over budget after the very first month.** There was no way to interpret that as a routine fluctuation. It was an immediate signal that something structural was wrong.

"The broker and the PBM and the drug manufacturer all had financial incentives to drive up the cost, and we were footing the bill for it."

When we dug into what was driving the spike, the issue was singular and obvious: GLP-1 utilization. At that point, we had not put restrictions on coverage for those medications. We knew we needed to make a midyear change—continue covering them where medically appropriate but restrict broader lifestyle use. What surprised me was not the decision itself; it was the resistance we encountered when we tried to act. Our broker and PBM pushed back immediately. We were told to slow down. We were warned that our rebates were at risk. And in that moment, the deeper issue became clear: the entities we assumed were helping manage our costs were financially aligned in ways that made higher costs beneficial to them. That was the epiphany.

Q: What did that epiphany reveal about the traditional carrier model?

A: It revealed just how little control employers often have, even when they are fully funding the plan. As a self-insured employer, we pay for healthcare. Our employees also contribute to that cost. Yet many people still assume the carrier is the insurer in the true economic sense, when in reality the employer is funding the benefit. Once we recognized that, we started asking a more basic question: if we are paying the bill, why are we not able to get the transparency, flexibility and data we need to manage it responsibly?

The more we examined our arrangements, the more disappointed we became. We had been passively renewing contracts year after year without fully appreciating how restrictive they were. We struggled to access our own data. We tried to conduct a more meaningful claims audit and discovered we were contractually limited to auditing just 300 claims out of a 10,000-member population. That is not real transparency. It is a tightly controlled system that leaves employers dependent on information they cannot freely access and decisions they cannot fully influence. For me, that was the point at which renewal strategy became inseparable from governance and accountability.

Q: Once you understood the problem differently, what did you decide to do?

A: We reset our expectations and rebuilt the strategy around control. We were not asking for anything unreasonable. We wanted transparency. We wanted the ability to tier and steer care to high-quality providers. And we wanted the flexibility to direct contract where it made sense. Those were the capabilities we believed any serious self-insured employer should be able to access.

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We conducted a broad RFP process across our partners and vendors. What we found was revealing: many carriers were willing to provide these types of capabilities to hospitals and health systems but not to us as an employer. That reinforced my view that the system was operating exactly as designed—for the financial advantage of carriers and health systems, not for the control or affordability needs of self-insured plan sponsors. Ultimately, that led us toward an independent model and a partnership structure that could support it.

Q: Why did reference-based pricing make sense to you in the context of renewals?

A: What appealed to me is that reference-based pricing starts from reality. It anchors payment to a market-based benchmark rather than to an arbitrary chargemaster rate that a facility sets without meaningful external constraint. In other words, it begins with a rational question: what should this procedure actually cost? That matters enormously in renewal planning, because if the baseline you are using is inflated, then every so-called discount built on top of it is misleading.

From my perspective as a provider leader, that logic is straightforward. We know what reasonable reimbursement looks like. We operate against market-based reimbursement every day, which is **what I love about reference-based pricing—it's based in market price**. To me, that is the right starting point. If you were buying a car, you would not begin with a fictional sticker price and then celebrate a discount off of it. You would ask what the car is worth in the market. Healthcare should be purchased with the same discipline.

Q: What have the results looked like so far?

A: Five months in, the most important point I can make is that the experience has tracked with what was presented to us during the evaluation process. That matters because there is a lot of noise in the market around alternatives to the traditional model. In our case, the transition performed as expected. Put simply, **things were going 100% as presented,** and every statistic and expectation we were shown about moving from a traditional carrier model to an independent reference-based pricing model has played out the way we understood it would.

> ***"Those are pretty compelling numbers when you overlay that with the amount that we're saving. We're talking tens of millions of dollars."***

Operationally, **97% of our claimants have had no issue.** Of the small percentage that encounter friction, most situations are administrative and are resolved with support. In practical terms, that means the overwhelming majority of members continue to access care without disruption, while the organization materially improves affordability. When you combine that experience profile with the savings opportunity, the case becomes compelling. We are talking about tens of millions of dollars in difference between what we had been paying under the prior model and what the services actually cost.

Q: How did you think about employee communication and change management during renewal?

A: Very intentionally—and very early. We began socializing the change months in advance, starting in August for a January implementation. That runway mattered. It gave us time to educate employees on something that many self-insured employers still struggle to explain clearly: the employer funds the plan, sets the plan design and determines the benefit structure. The name on the card does not change that reality. But employees often associate brand recognition with security, so there was understandable resistance when we introduced a model that did not carry one of the familiar logos.

We had to work through that directly. Some employees assumed that if they had not heard of the administrator or the model, it must be inferior. The real work was helping people understand that this was not about downgrading benefits. It was about regaining control over how those benefits were purchased and administered. For me, change management was not a side effort; it was central to a successful renewal. **The sooner you begin communicating and educating, the better positioned you are to bring people along in a thoughtful way.**

Q: How has this changed the way you think about your role as a CHRO during renewal season?

A: It has reinforced that healthcare strategy belongs squarely in the business conversation. Healthcare expense is the second largest line item on our P&L after wages. That means benefits leadership is not just an HR function; it is a business leadership responsibility. I take full accountability for that. My role is not only to help design competitive benefits but to ensure we are purchasing them in a way that is financially responsible and aligned with our values.

I often come back to the idea that leaders in my position have both a fiduciary and a moral obligation. I have both a fiduciary and a moral obligation to our employees to ensure that we're providing them access to high-quality healthcare and comprehensive, competitive benefits that are affordable. If renewal decisions fail on affordability, they fail where it matters most. That is why I encourage peers not to treat this as an issue to manage alone or in a silo. Engage your CFO. Engage your CEO. Bring the broader leadership team into the challenge because the impact is enterprise-wide and the solution must be as well.

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Closing thoughts

Q: What advice would you offer employers heading into their next renewal?

A: Start with your pain point. You do not have to boil the ocean. Identify the issue that is causing the greatest friction—cost trend, lack of data access, rebate dependence, employee disruption, limited contracting flexibility—and begin there. The important thing is to stop assuming the system will fix itself or that someone else is going to solve it for you. Employers are closer to the problem than anyone else, which also means they are closer to the solution.

My advice is to be explicit about what you expect from your partners, to examine where incentives are misaligned and to recognize that meaningful change requires leadership from inside the employer organization outward, because **employers are in the best position to directly affect change**. Renewal can remain a cycle of reacting to bad news or it can become an opportunity to take back control. For us, once we accepted that premise, the path forward became much clearer.

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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