



Behind the Premium

A former underwriter's guide to what your health plan really costs

By Dom Aiello, Founder, Trinity Risk Partners

Introduction: Why a former underwriter wrote this book

I used to be the person on the other side of your renewal.

I took an unconventional path to becoming a broker. I started out as a math major in college, then spent a few years as an underwriter at Cigna. My job was to look at a group's census, its claims, and its history, and decide what it was going to cost. I sat in the meetings where we decided which groups to get aggressive on and which ones to leave alone. From there I made an internal move into existing business sales, then worked at one of the largest national brokerages in the country before starting Trinity Risk Partners.

What kept pushing me closer to the employer's side of the table was how far the advice employers were getting sat from what their data actually said. I would see fully insured groups with excellent claims get hit with a big renewal, and the advice they got was to shop more fully insured plans and pick the cheapest one. They would leave, and a year or two later I would see them requesting a quote again, because the new carrier hit them with another increase their loss ratio never justified. Nobody explained that fully insured renewals are driven heavily by a large, generally unhealthy risk pool, or that they could keep the same carrier and plan, change how it is funded on the back end, and keep the profit from their own good claims. They were stuck riding the carrier carousel.

What I learned in both seats is simple. Most employers are making one of the biggest decisions on their P&L with less information than everyone else at the table. The carrier knows the numbers. The PBM knows the numbers. In a lot of cases the broker knows how they get paid and you do not. The CFO who signs off on the renewal is often the only person in the room who is guessing.

That is not because CFOs and HR directors are not sharp. It is because the system was not built to be understood. Discounts are quoted off prices nobody actually pays. Rebates are renamed so they are not called rebates anymore. Commissions get tucked into stop loss premiums where nobody thinks to look. None of it is complicated once someone lays it out. Nobody has much incentive to lay it out.

So that is what this book does. Each chapter takes one piece of the machine, explains how it actually works, and gives you the good and the bad of each option. I am not going to tell you there is one right answer for everyone, because there is not. A 60 person engineering firm and a 450 person PE-backed manufacturer need different things. What I can do is hand you the strategy, so you can make the call yourself.

Every chapter ends with a short list of questions to ask. Whether you ever work with me or not, if you ask those questions at your next renewal, you will get a better result. Underwriters, PBMs, and brokers all behave differently when they know the person across the table understands the game.

Let's get into it.

Chapter 1: How insurance networks really work

The discount is not the deal

Every carrier proposal you have ever seen brags about network discounts. 50 percent. 55 percent. 60 percent off. It sounds great until you ask the obvious question: 60 percent off of what?

The answer is billed charges, the hospital's list price, sometimes called the chargemaster. Almost nobody pays billed charges. Hospitals set them high on purpose, because a bigger starting number makes a bigger discount look impressive. A carrier can show you a 60 percent discount on a \$40,000 charge and still be paying \$16,000 for something Medicare pays \$5,000 for.

That is why the discount percentage on a proposal tells you very little. Two carriers can both claim 55 percent and be paying wildly different prices for the same MRI at the same hospital. What matters is the actual dollars paid, and the way to measure that is against a fixed yardstick.

Medicare is the yardstick

Medicare publishes what it pays for nearly every procedure. That makes it the closest thing healthcare has to a sticker price, and it is how sophisticated employers and their advisors compare networks today.

Commercial plans pay a lot more than Medicare. RAND's most recent national study found employer plans paid hospitals about 2.5 times what Medicare would have paid in 2022, with outpatient hospital services averaging 279 percent of Medicare and several states above 300 percent [1]. That is why more employers now price care as a percent of Medicare instead of a discount off billed charges. Instead of starting at an inflated list price and negotiating down, you start at a published number. There are two very different ways to do it, and they get confused all the time.

Direct contracts. The plan, or its TPA, signs an agreement with a hospital or physician group to pay a set rate, for example 150 percent of Medicare. The provider agreed to that price in advance, so it accepts the payment and cannot balance bill your employee beyond their normal deductible and copays.

Reference-based pricing (RBP). The plan pays a set percent of Medicare with no contract in place. Because the provider never agreed to that price, it can refuse the payment and send the difference to your employee as a balance bill. That is the real risk of RBP, and a

good RBP program comes with member advocacy and legal support to handle those bills when they show up.

Neither approach is free. RBP can save real money, but it can put employees in the middle of a billing dispute. A traditional PPO costs more, but your people almost never hear the word "no" at the front desk. I will always lay out both sides, because the cheapest plan on the spreadsheet is not worth it if your employees are getting collection letters.

How contracts actually get negotiated

Carrier and hospital contracts are negotiated system by system, usually every few years, and the leverage goes to whoever the other side cannot live without. A big carrier with half the commercial lives in a market has leverage over a small hospital. A dominant health system in a city where it owns most of the beds has leverage over everybody.

This is why network strength looks so different from one zip code to the next. In DFW, one carrier may have the best contract with one system while a competitor wins at another. When I put a group out to market, I look at where your employees actually live and where they actually go for care, not just the headline discount.

Federal Transparency in Coverage rules now require health plans to publish their negotiated rates in machine-readable files, and regulators finalized updates in October 2026 that add context to those files and move a separate prescription drug file forward [2]. The files are enormous and messy, but for the first time an employer can actually see what its plan is paying.

Site of care: same procedure, different building

Here is the one most employers have never heard of. The exact same MRI, colonoscopy, or infusion can cost two or three times more depending on where it happens. A procedure done in a hospital outpatient department is usually billed with a facility fee that the same procedure at an independent imaging center or ambulatory surgery center does not carry.

Your employee has no idea. Their doctor sends them to the hospital down the street because that is where the doctor has privileges, or because the hospital owns the practice. The plan pays the hospital rate, and the employee often pays more out of pocket too.

Steering care to the right site is one of the fastest ways to cut spend without cutting benefits, and Chapter 9 is all about how to do it.

If you have ever been told that claims are claims and there is nothing you can do, it is time to get granular and double check that assumption before you sign another big increase.

Questions to ask

- What are we paying as a percent of Medicare, by hospital system, not just as a discount off billed charges?
- Which systems drive most of our claims dollars, and how strong is this carrier's contract with each one?
- How much of our outpatient spend happens in hospital-owned facilities?
- If we change networks, what is our employee disruption, and how was it measured?

Chapter 2: How PBMs work

The middleman you never hired

If you have a health plan, you have a pharmacy benefit manager, even if you have never heard its name. The PBM decides which drugs your plan covers, negotiates with drug manufacturers, contracts with pharmacies, and processes every prescription your employees fill. Pharmacy now accounts for about a quarter of employers' total health spending, and employer drug costs are projected to rise 12 percent in 2026, faster than medical [3].

Three PBMs processed 80 percent of all prescription claims in this country in 2025: Express Scripts (31 percent), CVS Caremark (26 percent), and OptumRx (23 percent) [4]. Each one is owned by a company that also owns a major insurance carrier. Keep that in mind for the rest of this chapter.

Rebates: where the money goes

Drug manufacturers pay rebates to PBMs in exchange for favorable placement on the formulary. On paper, those rebates are supposed to come back to the plan and lower your cost.

Here is the catch. Most rebate contracts guarantee you a fixed dollar amount per brand prescription, not a percentage of what the PBM actually collects. If the PBM collects \$500 on a script and guarantees you \$200, the difference is theirs. And because the guarantee is per brand script, the system quietly rewards putting more expensive brand drugs on the formulary, not fewer.

GPOs: the rebate that stopped being called a rebate

A few years ago the big three PBMs each set up a separate rebate aggregator, sometimes called a group purchasing organization: Zinc (CVS Caremark, founded 2020), Ascent Health Services (Express Scripts, founded 2019), and Emisar Pharma Services (OptumRx) [5]. Ascent is based in Switzerland and Emisar in Ireland [6]. In 2024 the FTC sued all three PBMs and their GPOs over rebating practices it says inflated insulin list prices [5].

The aggregator negotiates with manufacturers and collects fees. Some of what used to be called rebates now shows up as "administrative fees" or "service fees" paid to the aggregator. If your contract says you get 100 percent of rebates, but the money is no longer called a rebate, you may not be getting 100 percent of anything. When I audit a PBM contract, the definition of "rebate" is the first page I read.

Formularies: preferred is not the same as cheapest

A formulary is the list of covered drugs and the tier each one sits on. You would expect the preferred drug to be the lowest-cost option. Often it is the one with the biggest rebate attached.

A classic example is a brand drug preferred over its own generic or biosimilar because the brand pays a large rebate. The plan pays more at the counter, the PBM collects more behind the scenes, and your employee pays a higher copay. Everyone loses except the middleman.

Not all PBMs are built the same

- **Big three, traditional model:** biggest networks and deepest manufacturer relationships, but the least visibility into how they make money.
- **Mid-market PBMs:** often more flexible and service-friendly for groups our size, with mixed transparency.
- **Transparent or pass-through PBMs:** charge a flat admin fee per script or per member and pass through actual pharmacy costs and 100 percent of manufacturer revenue. You see everything, and you carry more of the swings.

There is no automatic winner. A transparent PBM in a fully insured plan does not help you much, because the carrier keeps the savings. In a self-funded or captive plan, the right PBM can be the single biggest lever you have.

Alternative sourcing

For high-cost specialty drugs, smart plans now source outside the normal PBM channel: cost-plus pharmacies that charge acquisition cost plus a flat markup, manufacturer patient assistance programs, and in some cases international sourcing programs. These need to be set up carefully, with a reputable vendor and clear communication to the employee, but the savings on a single specialty member can be six figures a year.

Questions to ask

- Are our rebates guaranteed per script, or do we receive a percentage of everything collected, including aggregator fees?
- How does the contract define "rebate," and does it include fees paid to the PBM's GPO?
- Is there spread pricing at retail or mail, and do we have audit rights?
- When a generic or biosimilar is available, why is the brand preferred?
- What specialty drug sourcing options do we have outside the PBM's own specialty pharmacy?

Chapter 3: Traditional carriers vs TPAs

When most employers think "insurance company," they picture one of the big carriers. But in a self-funded plan, the company processing your claims does not have to be the company that owns the network, the PBM, and the care management program. A third party administrator, or TPA, lets you unbundle those pieces and pick the best of each. The right answer depends on whether you value simplicity or control more.

The bundled model: carrier ASO

When you self-fund with a big carrier, you buy administrative services only, or ASO. The carrier pays claims with your money and brings everything else with it: its own network, its own PBM, its own care management, often its own stop loss.

The upside is real. You get the carrier's network contracts, which are usually the strongest in the market. Your employees get one ID card, one phone number, and a name they recognize. There is one vendor to call when something goes wrong.

The downside is that everything is tied together. Want a different PBM? Many carriers will charge you more, or will not allow it. Want to see exactly what was paid on a claim? You will get what they choose to share. Want to shop stop loss? Some carriers price their ASO fees

higher if you do not buy their stop loss too.

Vertical integration changes the math

Today each of the biggest carriers also owns a PBM, and many own physician groups, clinics, specialty pharmacies, and even their own TPAs. UnitedHealthcare, for example, owns UMR, which calls itself the nation's largest TPA [7]. That means the company deciding where your employees get care often owns the place it is sending them. I do not think that makes them bad actors. I do think it means you should be the one checking whether the referral is the best value for your plan, not just the best value for the parent company.

The unbundled model: independent TPA

A TPA administers your plan and lets you plug in each piece separately: a rented PPO network or a reference-based pricing model, a PBM of your choosing, stop loss shopped across the whole market, and whatever navigation, clinic, or specialty drug programs fit your population.

You get full claims data, more flexible plan design, and the ability to swap out one piece without moving everything. The trade-off is more moving parts. TPA quality varies a lot, rental network discounts are not always as deep as a carrier's direct contracts, and when a claim goes wrong, the TPA, the network, and the PBM can each point at the other. A good broker earns their fee by making sure that does not happen.

How to choose

If your workforce is spread out, values a big-name card, and you want simplicity, a carrier ASO is usually the right fit. If you have a concentrated workforce, a few high-cost claimants, or a strong desire to see and manage your data, an independent TPA usually wins. Many employers start with a carrier and move to a TPA once they see what their data shows.

Questions to ask

- Can we choose our own PBM and stop loss carrier, and what happens to our admin fee if we do?
- What claims data do we receive, how often, and at what level of detail?
- What network fees, shared savings fees, or access fees are charged on top of the admin fee?

- When a claim is denied or delayed, who owns fixing it?

Chapter 4: How underwriters price your group

When I was an underwriter at Cigna, I had a budget to invest in rates, and I had to decide which groups were worth spending it on. Most employers think their renewal is a number the carrier calculates. It is actually a number the carrier decides. Understanding how that decision gets made is the single best way to change it.

The renewal formula

For a large, underwritten group, the renewal starts with a projection of what your claims will cost next year. The underwriter takes your recent claims, adjusts them for trend (medical and pharmacy inflation, which PwC projects at 8.5 percent for group plans in 2026 [8]), and blends that with a manual rate, which is what the carrier thinks a group of your size, age, and industry should cost.

How much weight your own claims get is called credibility. A 500 life group might be fully credible, meaning the renewal is mostly driven by its own experience. A 75 life group might be only partly credible, meaning the manual rate still drives a big piece of the price no matter how healthy the group was.

Then come pooling charges. Large claims above a set amount get pulled out of your experience and replaced with a pooling charge, so one cancer case does not single-handedly double your rates. Finally the carrier adds retention: admin costs, taxes, commissions, risk charge, and profit margin.

Where the judgment comes in

Every one of those inputs has a range. Trend can be set a point or two higher or lower. Credibility can be argued. The pooling point can move. The manual rate can be adjusted for "risk factors." That is where the underwriter's discretion lives, and it is why two carriers looking at the same data can come back 15 percent apart.

The market keeps score

Underwriters keep track of how often a group goes to market and how many brokers are shopping it. If a group gets shopped every year by three different brokers, the underwriter knows the odds of winning are low, so they quote high or do not quote at all.

When multiple brokers request quotes on the same group, carriers often refuse to sharpen their pencil until someone wins the broker of record. That is called blocking the market.

The opposite is also true. A group that shows up with clean data, a clear story about its claims, and one broker running a disciplined process gets the underwriter's attention. I always tell clients my job is to attack the market, create competition among the carriers, sell your risk to the underwriters, and drive them to their rock bottom price. That can only happen when one person controls the market for you.

What a good submission looks like

A strong submission includes a complete census, at least two years of monthly claims and enrollment, large claimant detail with current status (resolved, ongoing, or terminated), the current plan design and rates, and a short narrative explaining anything unusual. Underwriters price uncertainty high. The less they have to guess, the less they charge you for guessing.

Questions to ask

- What trend, credibility, and pooling level did the carrier use in our renewal?
- Which large claimants were included, and are any of them no longer active?
- How many times have we been marketed in the last three years, and by whom?
- What did our submission to the market actually include?

Chapter 5: Funding arrangements

Who holds the risk?

Every health plan answers one question: when an employee gets sick, whose money pays the claim? The answer to that question is your funding arrangement, and it shapes everything else, from what you pay to what you get to see.

There are four main options. Think of them as a ladder. Each step up gives you more control and more information, in exchange for taking on more of the risk.

Arrangement	Who pays claims	What you see	Surplus if claims run low	Typically fits
Fully insured	The carrier	Very little	Carrier keeps it	Smaller or high-risk groups
Level funded	You, with stop loss behind you	Some claims reporting	Often refunded or credited	Most common under 200 employees [9]
Self-funded	You, with stop loss behind you	Everything	You keep it	Roughly 100+ employees with stable cash flow
Group captive	You, sharing a middle layer with peers	Everything	You and the captive share it	Self-funded groups wanting stability

Fully insured: ACA vs underwritten

In a fully insured plan, you pay a fixed premium and the carrier takes the risk. Simple, predictable for the year, and the least transparent option on the ladder.

Small groups (in Texas, generally 2 to 50 employees) are ACA community-rated. The carrier cannot price you on your health, only on age, location, and tobacco use. That is great if your group is sicker than average, and not so great if you are a healthy group subsidizing everyone else in the pool.

Once you cross into large group, the carrier underwrites you. Now your claims history drives your renewal, but you still do not own the data, and if claims come in under what the carrier priced, the carrier keeps the difference. As a former underwriter, I can tell you that margin is built in on purpose.

Level funding

Level funding is self-funding with training wheels. You pay a fixed monthly amount that covers admin, stop loss, and a claims fund. If claims run high, stop loss catches it. If claims run low, many plans give back part of the surplus.

It is a great first step off fully insured for a healthy group. The watch-outs: the refund terms vary a lot between carriers, some plans can re-underwrite you hard at renewal, and the claims reporting is not always as complete as it should be. Read the surplus and

termination language before you sign.

Two level funded plans with the exact same monthly rate can produce very different results, purely because of how they are built. You want as much of your premium as possible going into the claims fund, because those are the only dollars eligible for a surplus refund. Some carriers quote with about 50 percent of premium in the claims fund; others put 60 to 70 percent there. Carriers also differ on how much unused surplus they give back: 50, 67, or 100 percent. Stack those two differences together and the gap can be hundreds of thousands of dollars, with no change to your rates, plan design, or carrier.

Self-funding

In a self-funded plan, you pay claims as they happen, through a carrier ASO or an independent TPA. You buy stop loss insurance to protect against large individual claims (specific) and an overall bad year (aggregate).

You get your data. You choose your PBM, your network, and your care programs. You avoid most state premium taxes and many state mandates under ERISA. And if you have a good year, the money stays in your bank account instead of the carrier's.

The trade-off is volatility. Your monthly costs move with your claims, and your stop loss contract becomes one of the most important documents you sign. Chapter 6 walks through exactly what to look for.

Group captives

A group captive lets a set of like-minded self-funded employers share a middle layer of risk together. Each employer pays its own smaller claims, the captive pools the mid-size claims across all members, and a reinsurer covers the catastrophic layer on top.

The result is self-funding with less volatility. One bad claimant does not wreck your year, because it is spread across the group. And when the captive performs well, members can share in the underwriting profit that a carrier would normally keep. Captives work best for employers who are committed to managing cost, because you are sharing risk with your peers and they are sharing it with you.

Questions to ask

- If our claims came in under what we paid last year, who kept the difference?
- Do we receive monthly claims and large-claimant reporting today? If not, why not?
- What would our last three years have cost under level funding or self-funding?

- If we moved to a captive, what is our retention, what does the pool cover, and how are dividends calculated?

Chapter 6: Stop loss, demystified

If you self-fund, your stop loss contract is the most important insurance policy you own, and most employers have never read it. Two contracts with the same premium can behave completely differently the year someone gets cancer. This chapter walks through what actually matters.

Specific and aggregate

Stop loss has two parts. Specific coverage protects you against any one person's claims going over a set amount, called the specific deductible. If your deductible is \$75,000 and an employee runs up \$400,000 in claims, you pay the first \$75,000 and the stop loss carrier reimburses the rest.

Aggregate coverage protects you against a bad year overall. The carrier sets an attachment point, usually 120 to 125 percent of expected claims [10], and if your total claims go past it, the carrier pays the excess. Specific protects you from one catastrophic claim. Aggregate protects you from a high volume of small and mid-sized claims that add up to a bad year.

Contract basis: when a claim counts

This is the detail that catches people. A stop loss contract only covers claims that are incurred and paid within certain windows.

- **12/12:** claims must be incurred and paid within the same 12 months. Cheapest, and the most dangerous, because claims incurred in month 11 and paid in month 13 are not covered.
- **12/15 or 12/18:** claims incurred in the 12 month year, paid within 15 or 18 months. Covers run-out.
- **24/12:** claims incurred over the prior 12 months plus the current 12, paid in the current year. Common at renewal to cover run-in.
- **Paid:** covers claims paid during the year regardless of when they were incurred, usually with a limit on how far back.

The question you need to answer is simple: if we leave self-funding, or switch stop loss carriers, which claims fall through the cracks?

Lasers

A laser is when the stop loss carrier gives one specific person a higher deductible than everyone else, because it already knows that person will be expensive. If your deductible is \$75,000 and an employee on dialysis is lasered at \$300,000, your plan absorbs that first \$300,000 for that person.

Lasers are not always bad. Sometimes accepting one laser saves more in premium than it costs. But you need to see the math, and you need to know they are coming before your renewal shows up.

No new laser and rate caps

A no new laser rider promises the carrier will not add new lasers at renewal. A rate cap limits how much the stop loss premium can increase. Together they protect you from the scenario where someone gets diagnosed mid-year, and the carrier responds by lasering them and raising your rates at renewal. These riders cost money. In my experience they are often worth it.

Terminal liability

If you ever move back to fully insured, you still owe the claims incurred before you left. Terminal liability coverage protects you during that run-out. Make sure you know how your plan would handle it before you ever need it.

Questions to ask

- What is our contract basis, and what happens to run-out claims if we leave?
- Do we have a no new laser rider and a rate cap? What did they cost?
- Were any lasers added or proposed, and what was the math on accepting vs buying them out?
- Is there any commission built into our stop loss premium?

Chapter 7: ICHRA and CHOICE strategies

An individual coverage HRA flips the traditional model. Instead of buying one group plan, you give each employee a tax-free allowance, and they pick their own plan on the individual market. For some employers it is the answer to runaway renewals and a workforce spread across several states. For others it means weaker networks and confused employees.

How it works

Federal rules finalized in 2019 have let employers of any size fund an ICHRA for plan years starting on or after January 1, 2020 [11]. You set a monthly allowance. Employees buy an individual market plan and submit proof, and you reimburse premiums up to the allowance, tax-free. Your cost is fixed and predictable no matter what claims look like.

You can set different allowances for different classes of employees: full-time vs part-time, salaried vs hourly, by location, and others. You can even offer a group plan to one class and an ICHRA to another, as long as you follow the rules on class sizes and do not offer both to the same class.

Why employers like it

- Fixed, budgetable cost. Renewal increases on the individual market are the employee's plan choice, not your bill.
- No participation minimums, which helps groups that struggle to get enough employees enrolled.
- Works across multiple states, where one group plan would have weak networks somewhere.
- Employees choose their own plan, network, and deductible.

The trade-offs

Individual market plans often have narrower networks than group PPOs, and in some counties there are only one or two carriers. Older employees can face much higher individual premiums than younger ones, which makes allowance design important. Employees also need real help picking a plan, or the benefit feels like a pay cut. And the affordability test under the ACA has to be checked for each class, or you can face penalties as an applicable large employer.

CHOICE arrangements

Lawmakers have also pushed to write the ICHRA concept into statute under the CHOICE Arrangement name, which would add permanence and some new flexibility. The Senate stripped those provisions from the 2025 One Big Beautiful Bill Act, and a December 2025 House bill that included them was not taken up by the Senate, so ICHRA still rests on regulation, not statute [12]. I plan around the rules that exist today.

Where it fits

ICHRA tends to work best for smaller employers, those with high part-time or hourly populations, multi-state workforces, and groups whose renewals have outgrown their budget. It is usually a weaker fit for employers whose workforce is older, concentrated in a county with a thin individual market, or who rely heavily on a rich group plan to recruit.

Questions to ask

- What would our allowance by class need to be to match current employee costs?
- How many carriers and what networks are available in the counties where our people live?
- How do we pass the affordability test for each class?
- Who helps employees choose and enroll, and what does that cost?

Chapter 8: Direct contracting and direct primary care

What if you skipped the middleman entirely? Direct contracting means your plan negotiates a price straight with a hospital, surgery center, or physician group. Direct primary care gives employees unlimited access to a primary care doctor for a flat monthly fee. Both work best in self-funded plans, and both can cut cost while giving employees a better experience.

Direct contracting

The most common version is a bundled case rate. Instead of paying a hospital line by line for a knee replacement, with separate bills from the surgeon, the anesthesiologist, the facility, and the imaging, the plan pays one fixed price for the whole episode, often including follow-up care. The price is known before the surgery, the employee's out-of-pocket is often waived, and the facility is chosen for quality as well as cost.

Some employers go further and contract directly with a local health system for most of their care, usually priced as a percent of Medicare. That takes real volume and a willing partner, but in the right market it can be the biggest single savings lever available.

Centers of excellence

For complex, expensive procedures like transplants, cancer treatment, and spine surgery, many plans route members to a short list of high-performing facilities, sometimes in another state, with travel paid. The research is consistent that better surgeons and better

facilities mean fewer complications and fewer repeat procedures, which is where the real money is.

Direct primary care

In a DPC model, the employer pays a flat monthly fee per member to a primary care practice. Employees get unlimited visits, same-day or next-day appointments, longer visits, texting access to their doctor, and often discounted labs and generic drugs, with no copay.

The value comes from what happens downstream. A primary care doctor who has time to actually manage a diabetic or catch something early keeps people out of the ER and the hospital. A good DPC partner also refers employees to high-value specialists and facilities, which ties right back to site of care.

What to watch for

DPC only pays off if employees use it, so location and communication matter. The HSA question has been settled: starting in 2026, DPC no longer disqualifies an employee from an HSA as long as fees stay at or below \$150 a month for an individual or \$300 for a family [13]. And direct contracts need clean language on quality, billing, and what happens when care falls outside the bundle.

Questions to ask

- Which procedures drive the most spend in our plan, and is there a bundled price available locally?
- Where do our employees live relative to DPC or near-site clinic options?
- How would a DPC fee interact with our HSA plan?
- How will we measure whether it worked?

Chapter 9: Site of care navigation programs

In Chapter 1 you saw that the same MRI can cost three times more depending on the building. One of the biggest levers left untouched in claims management is the site of care employees choose. Navigation programs fix that by guiding employees to high-quality, lower-cost providers before the claim happens.

How navigation works

When an employee needs a non-emergency procedure, imaging, or a specialist, they contact the navigation service (by app, phone, or chat) or are prompted by their doctor's referral. The navigator compares options in-network, factoring in price, quality data, and convenience, and helps book the appointment. The best programs reach out proactively when they see a referral or a prior authorization come through.

Incentives make it work

Employees do not change behavior for a brochure. They change it when it is easy and there is something in it for them. Common designs include cash rewards for choosing a lower-cost provider, waived copays or deductibles at preferred sites, and a lower out-of-pocket tier for preferred facilities built right into the plan design.

The math works because the savings are so large. If the plan saves \$2,000 on an MRI, paying the employee \$200 to choose the cheaper site is an easy decision.

Built in or bolted on

There are numerous standalone vendors that do this, and many TPAs now offer steerage programs built into their platform. Built-in programs are usually cheaper and integrate cleanly with claims. Standalone vendors can be more aggressive and more polished for employees. Both should be held to measured results, not anecdotes.

Measuring it

Ask for utilization (how many employees used it), the shift in site of care for targeted services, and savings calculated against what the claim would have cost at the employee's original choice. Be skeptical of savings reports that assume every navigated claim would have gone to the most expensive option.

Questions to ask

- What share of our imaging, labs, and outpatient surgery happens in hospital-owned facilities today?
- Does our TPA or carrier have a steerage program we are not using?
- What incentive design would actually move our employees?
- How will savings be measured, and who audits that number?

Chapter 10: Specialty drugs, GLP-1s, and gene therapy

A small number of claims now drive a huge share of plan cost. Specialty drugs are fewer than 5 percent of prescriptions but more than half of pharmacy spend, and their net cost rose 12.5 percent in 2025 [14][15]. GLP-1 drugs are forcing every employer to make a coverage decision. Gene therapies can carry a price tag in the millions for a single dose. You cannot manage a modern health plan without a strategy for all three.

Specialty drugs

Specialty drugs treat complex conditions like cancer, MS, rheumatoid arthritis, and Crohn's disease, and can cost tens of thousands of dollars a year per patient. The levers are formulary management, prior authorization done well, biosimilar adoption where a cheaper equivalent exists, site of care for infusions (a home or infusion center instead of a hospital outpatient department), and alternative sourcing like manufacturer assistance and cost-plus pharmacies.

The biggest mistake I see is a plan where the PBM's own specialty pharmacy is the only option, with no visibility into what is being paid. That is where the margin hides.

GLP-1s: the coverage decision

GLP-1 drugs are effective for diabetes and weight loss, and demand is enormous. Covering them for diabetes is standard. Covering them for weight loss is a real budget decision. The options I usually walk clients through:

- **Do not cover for weight loss.** Cheapest today, but expect employee pushback and recruiting questions.
- **Cover with guardrails.** BMI thresholds, prior authorization, required participation in a lifestyle program, and reauthorization based on results.
- **Carve out to a specialty program.** A separate vendor manages eligibility, coaching, and sourcing, sometimes at a negotiated price.
- **Cover broadly.** Best for employees, but the cost can be significant, and it needs to be budgeted honestly.

Whatever you choose, put it in writing and communicate it clearly. Pricing and coverage rules in this area are changing fast. Under late-2025 federal agreements, cash prices for injectable GLP-1s through TrumpRx start around \$350 a month, and Medicare coverage for weight loss was set to begin in mid-2026 [16]. At the same time, some employers plan to drop weight-loss coverage in 2027 as use keeps climbing [17].

Gene and cell therapy

Gene therapies can be curative, and they can cost more than a million dollars for one treatment. For a self-funded plan, one of these claims can be the year. Check how your stop loss treats them: some contracts exclude them, some laser known candidates, and some carriers now offer specific gene therapy riders or carve-out programs that cap your exposure. Read the fine print before a diagnosis, not after.

Questions to ask

- What share of our pharmacy spend is specialty, and who is dispensing it?
- Are we capturing biosimilar savings where they exist?
- What is our written GLP-1 coverage policy, and what does it cost us per month?
- How does our stop loss contract treat gene and cell therapies?

Chapter 11: Your claims data is an asset

In a fully insured plan, your data lives with the carrier, and they decide how much of it you see. Once you can see it, you can manage it. That is why every new client relationship I start begins with the same review, which I call the Risk Analysis Plan.

Your data is an asset

The most common reaction I get the first time an employer sees their own claims is surprise. Sometimes the surprise is good: the group is far healthier than its renewal suggested. Sometimes it is a handful of high-cost claimants nobody knew about, or a pharmacy line growing twice as fast as medical. Either way, decisions made with data beat decisions made with a renewal letter.

Even in a fully insured plan, larger groups can usually request claims experience and large claim reports. If your broker has never put that in front of you, ask for the last 24 months of premium vs claims and large claim data. It is the single fastest way to know where you stand.

The five pieces of the Risk Analysis Plan

1. **Underwriting review.** I rebuild your renewal the way an underwriter would, checking trend, credibility, pooling, and margin, so we know whether the increase is justified by your experience.

2. **Large claim review.** Every claimant over a threshold, with diagnosis category, status (ongoing, resolved, or terminated), and what can still be managed.
3. **Stop loss audit.** Contract basis, lasers, riders, run-out exposure, and whether the deductible level still makes sense for your size.
4. **PBM audit.** Rebate definitions, spread pricing, specialty pharmacy arrangements, formulary decisions, and audit rights.
5. **Actuarial plan design analysis.** How changes to deductibles, copays, tiers, and contributions would actually move cost and employee experience, before you make them.

What employers typically find

The patterns repeat. Groups paying a fully insured margin on claims that would have produced a surplus under a different funding arrangement. Large claimants who left the company still sitting in the renewal math. Pharmacy contracts where the rebate definition left money on the table. Stop loss contracts that would leave a gap if the plan ever changed. None of these show up on the summary page of a renewal.

Questions to ask

- Can we get the last 24 months of premium vs claims and large claim data?
- Who owns our claims data, and can we take it with us if we leave?
- When was the last time anyone independently audited our PBM or stop loss contract?
- Which of our large claimants are still active?

Chapter 12: Employee retention statistics and strategies

Replacing a good employee costs far more than most people think, and Gallup estimates replacing one employee costs one-half to two times their annual salary [18]. Recruiting, onboarding, lost productivity, and the work that piles up on everyone else all add up. Benefits are one of the few levers that touch every single employee, and one of the few they compare directly when another offer comes along.

What employees actually value

In MetLife's benefits research, 66 percent of employees called health benefits an important driver of their loyalty, while only 57 percent of employers thought so [19]. But what they value is not just a rich plan on paper. It is a plan they understand, with a network

that includes their doctors, and a paycheck deduction that does not feel like a punishment for covering their family.

That last point matters more than most employers realize. Plenty of companies offer a strong employee-only plan and then ask employees to pay most of the cost for dependents. To the employee with a spouse and two kids, that plan feels expensive no matter how good it is.

Building a plan that competes

Most employers are competing for talent with much bigger companies. You do not have to match them dollar for dollar. You do have to know where you stand. A good benchmarking exercise compares your plan design, employee contributions, and lines of coverage against your actual competitors for talent, not a national average.

The lines of coverage worth reviewing include medical, dental, vision, life and AD&D, short and long-term disability, EAP, telehealth, and increasingly fertility, mental health access, and financial wellness. Each one costs something, and each one sends a message.

Voluntary vs contributory

These terms get mixed up, so here is the plain version:

- **Noncontributory:** the employer pays the full cost. Common for basic life and long-term disability.
- **Contributory:** the employer and employee share the cost. Most medical plans work this way.
- **Voluntary:** the employee pays the full cost, but gets group pricing and payroll deduction. Accident, critical illness, hospital indemnity, and supplemental life are common examples.

Voluntary benefits let you expand the menu without expanding the budget. Done well, they fill real gaps, especially for employees on high deductible plans. Done poorly, they become a pile of policies nobody understands or claims on.

Executive benefits

The people you can least afford to lose often get the least out of a standard group plan, because group life and disability are capped well below their income. Executive benefits close that gap: supplemental medical reimbursement plans that cover deductibles and

out-of-pocket costs, individual disability insurance to replace income above the group cap, supplemental life, and nonqualified deferred compensation. These can be offered to a select group and are some of the most cost-effective retention tools available.

Questions to ask

- What does our plan look like next to the companies we actually lose people to?
- What does a family on our plan pay per paycheck, and how does that compare?
- Are our group life and disability benefits capped below what our leadership earns?
- Which voluntary benefits do employees actually use?

Chapter 13: Enrollment and communication

You can build the best plan in Texas and still have employees who think it is terrible, because nobody explained it to them. A benefit that is not understood is not valued, and a benefit that is not valued does nothing for retention.

Why enrollment usually falls flat

Most open enrollments look the same: a long PDF, a short meeting nobody can attend, and a deadline. Employees default to whatever they had last year, or pick the cheapest paycheck deduction without understanding the deductible behind it. Then they get surprised by a bill in March and blame the plan.

What works instead

- **Plain language.** "You pay the first \$3,000" beats "\$3,000 deductible, embedded, coinsurance applies."
- **Real examples.** Show what a family pays for a broken arm, a baby, and a year of a maintenance prescription under each plan option.
- **Total cost, not just paycheck cost.** Help employees compare premiums plus expected out-of-pocket, so the cheapest deduction is not mistaken for the cheapest plan.
- **Multiple formats.** A short video, a one-page summary, a decision tool, and a person they can call.
- **Spouses included.** Many health care decisions are made at the kitchen table, not at the office.

Year-round, not once a year

Enrollment is one week. Health care decisions happen all year. Short reminders tied to real moments (where to get an MRI, how to use telehealth, how the navigation program pays them) do more than any enrollment packet. This is where site of care programs, DPC, and every other strategy in this book either pay off or quietly fail.

Questions to ask

- What share of employees actively chose a plan last enrollment vs defaulted?
- Can a new hire explain their deductible and out-of-pocket max?
- Do employees know about every program we pay for?
- Who do employees call when something goes wrong?

Chapter 14: How your broker gets paid

Follow the money, including mine

I think every employer deserves to know exactly how their broker gets paid, so I am going to start with this: there is nothing wrong with a broker getting paid. Servicing a benefits plan is real work. Enrollments, file feeds, claim escalations, compliance notices, renewals. Someone has to own it, and carriers pay brokers because that service liability falls on us.

The problem is not that brokers get paid. The problem is when you cannot see how, because the way a broker is paid shapes the advice you get.

Model	How it works	What it rewards	Watch out for
Percent of premium	Commission built into your premium, roughly 2 to 7 percent depending on size [20]	Higher premiums	Broker earns more when your costs go up
PEPM	Flat dollars per employee per month	Headcount, not premium	Can still be stacked with other commissions
Flat service fee	A set annual fee you pay directly	Doing the work	Make sure commissions are actually removed from premium

Model	How it works	What it rewards	Watch out for
Hidden comp	Stop loss commissions, PBM per-script fees, carrier bonuses and overrides	Placing business with certain vendors	Often not on the proposal at all

Percent of premium

This is the traditional model, especially on fully insured plans. The commission is baked into your rate, so you never write a separate check. The issue is the incentive. If your premium goes up 12 percent, your broker's pay goes up 12 percent too, without doing any extra work. Most brokers are honest people, but you should not have to rely on that.

PEPM

A per employee per month fee ties compensation to your headcount instead of your premium. Your broker makes the same amount whether the renewal comes in at plus 3 or plus 15, which takes the conflict out of the renewal conversation. It is the most common model I see in self-funded plans.

Flat service fee

Some employers prefer to pay their broker a set annual fee directly, with commissions zeroed out of the premium. It is the cleanest model on paper. Just confirm in writing with each carrier and vendor that commissions really were removed, or you could be paying twice.

The commissions nobody mentions

This is where I see the most problems. In self-funded and level-funded plans, the stop loss premium can carry its own commission, sometimes a meaningful percentage of a large premium. Some PBMs pay brokers a fee on every prescription filled. Carriers run bonus programs that pay brokers more for placing a certain volume of business with them.

None of that is illegal. But if your broker is recommending one stop loss carrier or one PBM, you deserve to know whether that vendor is paying them to do it.

Since December 27, 2021, the Consolidated Appropriations Act has required brokers and consultants who expect \$1,000 or more in direct or indirect compensation from an ERISA group health plan to disclose it in writing [21]. If you have never received that disclosure,

ask for it. If your broker hesitates, that tells you something.

One question that keeps any broker honest

If you are worried your broker is not doing their due diligence but do not have time to interview other brokers yet, send them one line: "Please send me the last 24 months of premium vs claims and large claim data." A broker who is on top of your plan can send it the same day. If you feel like you have to ask, that tells you it is time to re-evaluate the relationship when your schedule allows.

Questions to ask

- How are you paid on our plan, in total dollars, across every line of coverage and every vendor?
- Do you receive any compensation from our stop loss carrier, PBM, TPA, or any point solution vendor?
- Are you in any carrier bonus or override program that our business counts toward?
- Can you send your CAA compensation disclosure for our plan?

Chapter 15: Your fiduciary duty

If you sponsor a health plan, you are a fiduciary under ERISA, whether anyone told you or not. That means you have a legal duty to run the plan in the best interest of the people on it, and to pay only reasonable fees for the services it buys. For years most employers treated the health plan as a purchase. The law treats it as a responsibility.

What changed

The Consolidated Appropriations Act added several new obligations for group health plans [22]:

- **Broker and consultant compensation disclosure.** Covered service providers must disclose direct and indirect compensation, so you can judge whether fees are reasonable.
- **Gag clause attestation.** Plans must attest each year that their contracts do not block access to cost, quality, and claims data.
- **Prescription drug reporting.** Plans report pharmacy and medical spending data to the federal government each year.

- **Mental health parity analyses.** Plans must be able to show that mental health benefits are not more restricted than medical benefits.

Why employers are getting sued

Employees have filed lawsuits against large employers claiming the company mismanaged the health plan, particularly by overpaying for prescription drugs through the PBM. The early cases against Johnson & Johnson and Wells Fargo were dismissed for lack of standing, but in 2026 a similar case against JPMorgan got past that hurdle and is proceeding [23]. Regardless of how individual cases resolve, the message to every plan sponsor is the same: you are expected to know what your plan pays and why.

What prudent looks like

You do not have to be perfect. You have to have a process. A prudent plan sponsor:

1. Reviews vendor contracts and fees on a regular schedule.
2. Collects and reads broker compensation disclosures.
3. Benchmarks major vendors, especially the PBM, every few years.
4. Keeps minutes or notes of how decisions were made and why.
5. Has written plan documents and SPDs that match how the plan actually works.

Documentation is your friend. If you ever have to defend a decision, "we reviewed three options and picked this one for these reasons" is a strong answer. "Our broker handled it" is not.

Questions to ask

- Who at our company is formally responsible for plan decisions?
- Have we filed our gag clause attestation and RxDC reporting?
- Do we have current compensation disclosures from every service provider?
- When did we last benchmark our PBM contract, and where is that documented?

Chapter 16: Running a renewal the right way

Most renewals fail because they start 60 days out. By then there is no time to gather data, build a strategy, or create real competition, so the employer signs whatever the incumbent sends. A good renewal starts five months or more before the effective date, with clean data, a clear strategy, and one broker controlling the market.

The 12-month calendar

Months before renewal	What happens
12 to 9	Post-renewal review: what worked, what did not, employee feedback
9 to 6	Strategy session: funding, plan design, PBM, and contribution goals for next year
6 to 4	Data gathering: census, claims, large claim detail, current contracts
5 to 4	Self-funded and captive groups: requests for quotes go out, if marketing is needed
4 to 3	Fully insured groups: requests for quotes go out, if marketing is needed
3 to 2	Quotes come back; negotiation, finalist rounds, and decision
2 to 1	Contribution modeling, employee communication, and open enrollment
1 to 0	Implementation, ID cards, file feeds, and compliance notices

Requests for quotes typically go out three to four months before renewal. Self-funded and captive groups go out earlier, four to five months ahead, because stop loss quotes and lasers depend on current large claim detail. If the strategy is to stay put, the marketing step is skipped and that time goes into negotiating the renewal instead.

One broker, one process

As I covered in Chapter 4, letting several brokers shop your group at once usually backfires. Carriers see the same group from multiple directions, decline to sharpen their pencils, and block the market until someone controls it. If you want a second opinion, the better move is to interview brokers early, pick the one you trust, and give them the market.

How the broker of record process works

A broker of record letter is a short document, signed by the employer, that tells a carrier or vendor which broker represents the account. Once the carrier accepts it, the new broker can request data, negotiate, and service the plan, and any commission typically moves to the new broker going forward, under each carrier's own rules.

Changing brokers is common and perfectly normal. Carriers allow it because the employer, not the broker, owns the relationship. A good transition is quiet: the new broker introduces themselves to each carrier, gathers data, and takes over service without the employees ever noticing.

Questions to ask

- When did our last renewal process actually start, and when did we see quotes?
- How many carriers and vendors were approached, and what did each one say?
- What is our strategy for next year, in writing?
- If we wanted a different broker, when would be the right time to make that change?

Chapter 17: PE-backed companies and M&A transitions

An acquisition is the moment benefits get messy. Two plans, two renewal dates, two sets of employees comparing what they had. It is also one of the best moments to restructure, because everyone already expects change, and a private equity sponsor is watching every line that touches EBITDA.

Before close: due diligence

Benefits diligence is often a checklist item handled at the last minute. It should not be. The questions that matter:

- How is the target's plan funded, and are there self-funded run-out liabilities or stop loss gaps that come with it?
- Who are the large claimants, and how will they affect the combined plan's renewal?
- Are plan documents, SPDs, and compliance filings current?
- Are there executive benefit promises, severance, or retiree commitments buried in employment agreements?
- What does the target's broker get paid, and is there anything in the contracts that triggers on a change of control?

A hidden liability found after close becomes the buyer's problem.

After close: harmonizing

Most buyers eventually move everyone to one plan. The questions are when and how. Moving too fast creates employee anger, especially if one group loses a richer plan. Moving too slow means running duplicate vendors, duplicate admin, and duplicate renewals. A good integration plan sets a target date, models cost and employee impact for each group, and communicates early about what is changing and why.

The funding opportunity

Combining two groups often creates enough size to consider self-funding or a captive for the first time. Larger, more credible groups get rated more on their own experience, can choose their own PBM, and keep their own surplus. For a sponsor focused on cost and predictability, that shift can be meaningful at the portfolio level.

Platform and add-on strategy

For sponsors doing a buy-and-build, the benefits plan should be built to absorb future add-ons: a funding structure that scales, contracts that allow new entities to join mid-year, and a broker who can onboard each new company quickly. Doing it right once saves rebuilding it with every deal.

Questions to ask

- What benefits liabilities did diligence uncover, and how were they priced into the deal?
- What is our target date and plan for moving everyone onto one plan?
- Does the combined group qualify for a better funding structure?
- Can our current contracts add new acquisitions without a new renewal?

Chapter 18: Cities, counties, schools, churches, and pooled plans

Many Texas cities, counties, school districts, and churches get their health coverage through pooled plans: TML IEBP for municipalities, TAC HEBP for counties, TRS-ActiveCare for public school districts, and denominational programs like GuideStone for churches. Pools offer stability, simplicity, and a familiar name. But they are not automatically the best deal, and few municipalities ever test them against the open market.

How pools work

A pool combines many public entities into one large risk group. Members pay contributions set by the pool. TML IEBP, for example, is a health risk pool formed under Chapter 172 of the Texas Local Government Code, which cities join through interlocal agreements, and it is governed by a board of trustees drawn largely from member cities [24][25]. The pool handles administration, network access, and often the PBM, and spreads large claims across all members.

For a small city with a few dozen employees, that sharing is valuable. One bad claim in a small group on its own could be devastating. In a pool, it is absorbed.

School districts and churches

TRS-ActiveCare is the statewide health plan for Texas public school employees. Every district is eligible to join, many larger districts run their own plans instead, and a district that does not participate still has to give employees access to health coverage [26]. Districts that leave and later rejoin must stay in for five years, so leaving deserves real analysis, not a one-year price comparison [27].

Churches play by different rules. A plan established and maintained by a church, or by a convention or association of churches, is a church plan and is exempt from Title I of ERISA. GuideStone, for example, operates as a nonprofit church plan serving Southern Baptist and other evangelical churches and ministries [28]. Being outside ERISA changes some of the compliance work, but not the basic math: a church plan should still be tested against the market at renewal.

Where pools fall short

The same sharing that protects small entities can work against larger or healthier ones. A healthy city may be subsidizing the pool year after year without knowing it. Plan design options can be limited, data access varies, and the pool's own renewal and rating decisions are not always easy to see into. Some entities stay in a pool for decades simply because nobody ever asked whether there was a better option.

What a municipality can and cannot change

Public entities have their own rules: procurement requirements, council approval, public meetings, budget cycles tied to a fiscal year, and their own purchasing rules, which should be confirmed with the city attorney before going to market. A good advisor works inside those rules, not around them.

Within those limits, a municipality can usually compare the pool against fully insured, level-funded, or self-funded alternatives, adjust plan design and contributions, and add programs like DPC or navigation that work alongside the pool or a new carrier.

Running a fair comparison

A fair comparison needs the city's own census and, where available, claims experience; plan designs matched as closely as possible; a realistic view of employee disruption; and a timeline that fits the budget and council calendar. Even when the answer is to stay in the pool, the city should know why, and have it documented.

Questions to ask

- How long have we been in the pool, and when did anyone last test it against the market?
- What claims or utilization data can we get from the pool?
- What procurement steps do we need to follow to make a change?
- What would our council need to see to make a confident decision either way?

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About the author

Dom Aiello is the founder of Trinity Risk Partners, an independent employee benefits brokerage based in Fort Worth, Texas. He works with CFOs, owners, and HR directors at companies of all sizes.

Dom took an unconventional path into the business. He started as a math major in college, then spent several years at Cigna as an underwriter, pricing groups and deciding which ones the carrier would get aggressive on. From there he made an internal move into existing business sales, then joined one of the largest national brokerages in the country before founding Trinity Risk Partners. Seeing renewals from both sides of the table convinced him that employers were making one of their biggest financial decisions with the least information in the room, and he built his firm to change that.

Today his work centers on self-funded, level-funded, and group captive plans, along with cities and counties on statewide pools and PE-backed companies working through acquisitions. His Risk Analysis Plan, a five-part review of underwriting, large claims, stop loss, pharmacy, and plan design, is how he starts every new client relationship.

Outside the office, Dom is a competitive bodybuilder, an avid fly fisherman, and a bulldog enthusiast. When he is not in the gym or on the water with a fly rod, he is at home with Petunia, his rescue bulldog.

Dom lives in Fort Worth. You can reach him at dom.aiello@trinity-risk-partners.com.