FOR LEADERS RESPONSIBLE FOR
PROFIT, RISK, AND PEOPLE.

THE EXECUTIVE PLAYBOOK

FIDUCIARY ALLY

A CEO's Guide to Cutting Health Plan Costs, Reducing Risk & Taking Control of Employee Benefits

GLENN FISHER

Dedication

To Liz, my incredible wife—your unwavering love, strength, and support inspire me every day. Thank you for believing in me and standing beside me on this journey.

To Reese and Rylan, my amazing boys—you are my greatest motivation. May you always chase your dreams, challenge the status quo, and never settle for less than what is right.

This book is for you.

And it is also dedicated to the leaders carrying the responsibility of protecting and guiding their organizations forward:

To **CEOs and Business Owners**—who refuse to accept rising costs as inevitable and are committed to protecting profitability while eliminating unnecessary expenses.

To **CFOs and Financial Executives**—who demand a strategic, disciplined approach to controlling one of the largest and most volatile line items on the income statement.

To **HR Leaders and Benefits Managers**—who balance care for people with the complexity of compliance, striving every day to deliver better outcomes for employees.

To **Board Members and Fiduciaries**—who understand that oversight is not optional, and who

are committed to safeguarding their organizations from financial and legal risk.

This book is for those willing to challenge the status quo, take ownership, and lead with clarity, courage, and conviction.

Acknowledgement

I’d like to take a moment to recognize trailblazing people and organizations who are real innovators—those shaking up the status quo and helping employers design high-performance health plans that prioritize cost-effectiveness, quality, and transparency. Here are some of the most influential people and organizations driving change in this space:

Innovative Individuals:

- **Dave Chase** – Co-founder of Health Rosetta, Chase has been a leading advocate for fixing the broken U.S. healthcare system by empowering employers to take control of their health plans. His work focuses on transparent, high-value healthcare solutions that prioritize patient outcomes over profit.
- **Marilyn Bartlett** – A healthcare cost transparency champion, she played a key role in Montana's state health plan reform by negotiating reference-based pricing with hospitals and lowering costs.

- **Dr. Marty Makary** – A Johns Hopkins surgeon and author of The Price We Pay, he has exposed the hidden costs and inefficiencies in the healthcare system, advocating for employer-driven healthcare reforms. Trump recently appointed him to lead the FDA.
- **Brian Klepper** – An outspoken critic of the traditional healthcare system, Klepper has worked to highlight the value of direct primary care (DPC), transparent pricing, and value-based contracting.
- **Tom Emerick** – A former Walmart VP of Benefits, Emerick has been a leader in direct contracting with high-performance healthcare providers and reducing waste in employer-sponsored health plans.
- **Lee Lewis** – A strategic consultant and benefits expert who has played a significant role in designing employer-driven healthcare models, advocating for cost control, transparency, and accountability.
- **Dr. Keith Smith** – Co-founder of the Surgery Center of Oklahoma, one of the first providers to offer fully transparent, bundled cash pricing for surgical procedures.

- **Chris Deacon and Julie Selesnick** – for your leadership, expertise, and unwavering commitment to transparency, accountability, and doing what is right for plan sponsors and their employees.

Game-Changing Organizations:

- **Health Rosetta** – Founded by Dave Chase, this organization provides a blueprint for

employers to design high-performance health plans using transparent pricing, direct contracting, and value-based care models.

- **The Leapfrog Group** – A nonprofit that pushes for transparency in hospital safety and quality, helping employers make better healthcare purchasing decisions.
- **The Free Market Medical Association** (FMMA) – Focuses on price transparency and direct payment models to drive down costs for employers and patients.
- **The Smarter Healthcare Coalition** – Advocates for value-based care and the smarter use of benefits like Health Savings Accounts (HSAs) and Direct Primary Care (DPC).
- **The Employers' Forum of Indiana** – A business coalition dedicated to increasing healthcare price transparency and reducing costs for employers.
- **Catalyst for Payment Reform** (CPR) – Works to improve how healthcare is paid for by advocating for value-based payment models and price transparency.
- **National Alliance of Healthcare Purchaser Coalitions** – Represents employer groups pushing for healthcare system changes that prioritize quality and cost-effectiveness.
- **Purchaser Business Group on Health** (PBGH) – An influential employer-led coalition driving direct contracting and value-based healthcare purchasing strategies.

- **True Captive** – founded by David Voorhees, the fastest-growing captive in America, driven

by a unique and innovative program redefining risk management and cost control.

- **Next-Gen Benefits** – led by Nelson Griswold, for pioneering a movement that equips advisors to think differently and act boldly.
- **YouPowered Collaborative** – led by Emma Fox, for building a community focused on empowering employers and advisors withsmarter, more transparent solutions.

- **True Network Advisors** – Scott Smith for building a powerful community of aligned advisors committed to transparency, innovation, and delivering better outcomes for employers.

These individuals and organizations are reshaping the way healthcare is purchased and delivered, helping employers escape the traditional, bloated insurance model and build high-performance health plans that work.

Their work is shifting the landscape, creating smarter, more effective health solutions for businesses and employees alike.

Table of Contents

Introduction

The Employer’s Burden: Rising Healthcare Costs & Fiduciary Responsibility

For decades, employer-sponsored health plans have been the backbone of healthcare access for American workers. Today, nearly 165 million Americans receive healthcare coverage through their employer-sponsored plans, making it the single largest source of health insurance in the country (KFF Employer Health Benefits Survey, 2023). Yet, the cost of providing these benefits has reached an unsustainable level, and employers are finding themselves at the center of a financial and legal crisis.

Over the past 20 years, total U.S. healthcare spending has **skyrocketed from $1.2 trillion to over $4.7 trillion** (CMS National Health Expenditure Data, 2023). This cost escalation has directly impacted employers. In 2000, the average annual premium for family coverage in an employer-sponsored plan was $6,438. By 2023, that cost had ballooned to $23,968, with employers covering a significant portion (KFF Health Benefits Survey, 2023).

Yet, despite these rising costs, outcomes have not significantly improved. The United States continues to spend more on healthcare per capita than any other developed nation while ranking last among high-income countries in healthcare efficiency, access, and outcomes (Commonwealth Fund, 2023).

But for employers, the challenge is more than just financial—it’s legal.

The Fiduciary Reckoning: Employers Are Getting Sued

Under the **Employee Retirement Income Security Act** (ERISA), employers offering health benefits act as fiduciaries, meaning they have a legal duty to act in the best interest of their employees when managing the health plan. If they fail to act prudently and solely in employees' interests, they can be held personally liable.

In recent years, employers have found themselves at the center of major class-action lawsuits for failing to fulfill their fiduciary responsibilities. Consider the case of **Johnson & Johnson**, where employees sued the company for allowing excessive fees in their health plan, ultimately settling the lawsuit for millions (Johnson & Johnson ERISA Lawsuit, 2023).

Similarly, **Duke University and Quest Diagnostics** were both sued by employees alleging that their employer-sponsored health plans were riddled with excessive costs and conflicts of interest, ultimately leading to settlements (Bloomberg Law, 2023).

The trend is clear: Employers can no longer afford to take a passive approach to managing their health plans. The cost of inaction is not just financial; it’s legal.

Why This Book? Protecting Your Business and Employees

As a business leader, you’ve worked hard to build your company. You’ve made strategic decisions to

improve profitability, enhance customer experience, and develop a high-performing workforce. But if you're like most employers, you've never been trained to manage a health plan—yet you are expected to oversee one of your company's largest expenses and comply with complex fiduciary requirements.

The reality is that the traditional healthcare system is not designed for employers to succeed. Insurance carriers, pharmacy benefit managers (PBMs), and hospital systems operate within a web of hidden incentives, all designed to maximize their profits at the expense of employers and employees alike.

This book exists to change the narrative—to give you the knowledge, tools, and strategies to take control of your health plan, reduce costs, and protect your business from unnecessary financial and legal risk.

Introducing the **FRAMEwork**: A Systematic Approach to Health Plan Management

Employers don't need more theory—they need a playbook.

That's why this book introduces the **FRAMEwork**, a structured approach that helps employers navigate the complexities of health plan management with confidence. **FRAME** stands for:

1. **Facilitate Transparent Benefit Advisory Services** – How to identify and work with a fiduciary-driven advisor who prioritizes your interests.

2. **Review Plan Documents and Design** – Understanding the fine print of your plan to eliminate waste, ensure compliance, and optimize benefits.
3. **Advance Value-Based Care Solutions** – Shifting from expensive fee-for-service models to outcomes-driven healthcare that lowers costs while improving care quality.
4. **Manage Independent PBM Strategies** – Breaking free from traditional PBMs and adopting transparent pharmacy pricing strategies to reduce drug costs.
5. **Eliminate PPO Network Constraints** – Moving beyond PPO networks to innovative direct contracting models that provide high-quality care at a lower price.

The **FRAMEwork** isn't just a theory—it's a proven methodology that has helped businesses **reduce healthcare costs by 20-40%** while improving employee benefits. For example:

Case Study: Rosen Hotels & Resorts
Rosen Hotels, a Florida-based hospitality company, **cut its healthcare costs by over 40%** by moving away from traditional PPO networks and implementing direct contracting with healthcare providers (Health Rosetta Case Study, 2023). The result? Higher-quality care, lower costs, and a healthier workforce.

Case Study: Self-Insured Employer Saves $5M
A manufacturing company with 5,000 employees **reduced its healthcare costs by $5 million annually** by shifting to an independent PBM

strategy and eliminating spread pricing (National Alliance of Healthcare Purchasers Coalition, 2023).

Who Is This Book For?

This playbook is designed for:

- **CEOs and Business Owners** looking to protect profitability and reduce unnecessary expenses.
- **CFOs and Financial Executives** who need a strategic plan to control healthcare costs.
- **HR Leaders and Benefits Managers** responsible for managing employee benefits while ensuring compliance.
- **Board Members and Fiduciaries** who want to safeguard the organization from legal and financial risks.

If you're tired of watching healthcare costs spiral out of control and want a proven system to regain control, this book is for you.

Your Next Steps

Each chapter of this Fiduciary Playbook will break down specific, actionable strategies that you can implement to take control of your health plan. By the end of this book, you'll have the knowledge, tools, and confidence to:

- Cut waste and unnecessary spending from your health plan
- Protect your company from fiduciary lawsuits
- Improve employee healthcare outcomes while reducing costs

- Align your benefits strategy with your company’s financial goals

The time to act is now. The cost of waiting is too high. Let’s get started.

1

The Healthcare Cost Explosion

The $4.7 Trillion Problem: A System Designed to Fail Employers

Imagine running a business where your largest cost outside of payroll rises unpredictably every year, yet you have little to no visibility into why it's happening. This is exactly the situation employers face with healthcare.

Over the past two decades, U.S. healthcare spending has increased from **$1.2 trillion in 2000 to more than $4.7 trillion in 2023** (Centers for Medicare & Medicaid Services, 2023). For employers, the impact has been devastating:

- The average annual premium for employer-sponsored family coverage has **risen from $6,438 in 2000 to $23,968 in 2023**—a 272% increase (KFF Employer Health Benefits Survey, 2023).
- Over the same period, **wages have only increased by 86%** and **inflation by 73%,** meaning healthcare costs have far outpaced economic growth (Bureau of Labor Statistics, 2023).
- In 2023, **83% of large employers reported that rising healthcare costs**

> **were unsustainable** and would negatively impact their business within the next five to ten years (Business Group on Health, 2023).

Employers aren't just struggling to keep up with costs—they're actively being drained by a system that offers little transparency, accountability, or value.

Why Are Healthcare Costs Rising So Fast?

Several structural problems have fueled the healthcare cost explosion, making it nearly impossible for employers to control spending.

1. The Fee-for-Service Model Drives Overutilization

In most employer-sponsored health plans, healthcare providers are paid based on the volume of services they provide, not the value of those services. This fee-for-service model incentivizes hospitals and doctors to maximize billing rather than deliver cost-effective, high-quality care.

Fact: Nearly 30% of all healthcare spending in the U.S.—roughly $1.4 trillion per year—is wasted on unnecessary services, excessive administrative costs, and fraud (National Academy of Medicine, 2023).

Example: A 2022 study found that one in four healthcare services billed to employer health plans was deemed unnecessary, yet employers still paid the full cost (JAMA Internal Medicine, 2022).

2. Insurance Carriers Profit from Rising Costs

Most employers assume that their health insurance carrier is working to negotiate lower prices on their behalf. In reality, carriers often have perverse incentives to let costs rise.

Fact: The largest health insurance carriers, including UnitedHealthcare, Cigna, and Aetna, collectively reported over $40 billion in profits in 2023, largely fueled by rising premiums and increased utilization (Public Company Filings, 2023).

Example: A 2021 lawsuit against Cigna revealed that the company automatically denied millions of medical claims in seconds, using an algorithm to avoid paying for necessary care while maximizing its own profits (ProPublica, 2023).

3. Pharmacy Benefit Managers (PBMs) Inflate Drug Costs

Prescription drugs account for nearly 25% of total employer healthcare spending—but many of these costs are artificially inflated by pharmacy benefit managers (PBMs), the middlemen who manage drug benefits on behalf of employers.

Fact: The three largest PBMs—CVS Caremark, OptumRx, and Express Scripts—control over 80% of the prescription drug market and generate billions

in hidden rebates and fees that drive up costs for employers (Drug Channels Institute, 2023).

Example: A self-insured employer that audited its PBM contract found it was paying 60% more for certain medications than the actual pharmacy acquisition cost due to hidden markups (National Alliance of Healthcare Purchasers, 2023).

4. PPO Networks Drive Prices Up, Not Down

Preferred Provider Organizations (PPOs) were designed to provide employers with access to a broad network of providers at “discounted” rates. However, the reality is that PPO networks often drive-up prices rather than reduce them.

Fact: Hospitals charge 250% to 500% more than Medicare rates for the same procedures within employer PPO plans (RAND Corporation, 2023).

Example: A knee replacement that costs $29,500 under a typical PPO is often available for $14,000 or less through direct contracting with providers (Health Rosetta, 2023).

5. Lack of Transparency Prevents Employers from Making Informed Decisions

One of the biggest challenges employers face is a complete lack of transparency in healthcare pricing. Most employers don’t know:

- The true cost of medical procedures or prescription drugs

- How much their insurance carrier or PBM is profiting off their plan
- Whether employees are being routed to high-quality, cost-effective providers

Without this data, employers are effectively flying blind, unable to make informed decisions about their health plan.

Fact: A 2023 employer survey found that 72% of businesses lacked access to detailed claims data, making it nearly impossible to identify cost drivers or negotiate better rates (National Business Group on Health, 2023).

Example: One employer that gained access to its claims data discovered over $500,000 in unnecessary spending on hospital-administered infusions, which could have been performed at half the cost in a standalone infusion center (Marathon Health, 2023).

The Bottom Line: Employers Are Paying More for Worse Outcomes

Despite all this spending, the U.S. healthcare system delivers some of the worst outcomes among developed nations:

- The **U.S. ranks last** among 11 high-income countries in healthcare efficiency, access, and outcomes (Commonwealth Fund, 2023).
- **Employer healthcare spending has risen 272%** since 2000, yet life expectancy in the U.S. has declined over the past five years (CDC, 2023).

- **Medical debt is the leading cause of personal bankruptcy**, even for those with employer-sponsored insurance (American Journal of Public Health, 2023).

This is not a sustainable model. Employers are paying more, getting less, and facing increasing fiduciary risk for failing to control costs.

What Employers Can Do About It?

If the traditional system is designed to work against employers, the logical solution is to stop playing by its rules. That's where the **FRAMEwork** comes in.

In the next chapters, we'll break down **five key strategies** employers can implement to reduce costs, improve care quality, and regain control of their health plan.

By the end of this book, you'll have a **clear roadmap** to eliminate waste, improve transparency, and build a cost-effective health plan that **protects both your business and your employees**.

The first step? Finding the right partners and advisors to guide you through the process.

The financial burden of rising healthcare costs is only part of the problem. Employers who fail to actively manage their health plans aren't just overpaying—they may also be exposing themselves to legal and fiduciary risks under ERISA.

Courts are increasingly holding employers accountable for failing to act as responsible fiduciaries, with lawsuits targeting companies that allow excessive fees, hidden markups, and mismanaged vendor contracts.

In the next chapter, we'll examine why employers are getting sued, the fiduciary responsibilities that come with managing a health plan, and how businesses can protect themselves from costly litigation while ensuring they act in the best interests of their employees.

2

Legal and Fiduciary Risks – Why Employers Are Getting Sued

Introduction: The Growing Legal Storm for Employers

Most employers assume their health plan is just another business expense—something to be managed but not necessarily scrutinized. However, under federal law, offering a health plan is not just a business decision—it's a fiduciary responsibility.

Under the Employee Retirement Income Security Act (ERISA), employers are legally required to act in the best interests of their employees when managing their health benefits. Failure to do so can result in lawsuits, regulatory fines, and even personal liability for company executives.

In the past, ERISA lawsuits were primarily filed against 401(k) and pension plan sponsors. But in recent years, a new wave of health plan-related ERISA lawsuits has emerged, and employers are increasingly being sued by their own employees for failing to act as responsible fiduciaries.

Fact: Since 2020, the number of ERISA lawsuits related to employer-sponsored health plans has skyrocketed, with dozens of large employers—including **Quest Diagnostics, Johnson & Johnson, and Duke University**—facing legal action (Bloomberg Law, 2023).

Fact: Employers **lose or settle most ERISA cases**, with settlements often exceeding $10 million (U.S. Department of Labor, 2023).

This chapter will break down why these lawsuits are happening, the fiduciary responsibilities employers must uphold, and the proactive steps businesses can take to protect themselves.

What Does It Mean to Be a Fiduciary?

Under ERISA, a fiduciary must:

1. Act solely in the best interest of plan participants and their beneficiaries.
2. Ensure that health plan costs are reasonable and necessary.
3. Monitor service providers (insurance carriers, PBMs, TPAs) and eliminate conflicts of interest.
4. Maintain transparency in plan expenses, contracts, and coverage decisions.

Failure to uphold these duties can result in severe financial penalties, including personal liability for company executives and HR professionals responsible for managing the plan.

Example: In 2022, a lawsuit was filed against **Johnson & Johnson**, alleging that the company's self-funded health plan paid excessive fees to its third-party administrator (TPA), resulting in millions in unnecessary costs (Johnson & Johnson ERISA Lawsuit, 2023).

If an employer is overpaying for health services, allowing conflicts of interest, or failing to monitor their vendors, they are violating their fiduciary duties—and employees are starting to take notice.

Case Study: The Quest Diagnostics ERISA Lawsuit

In 2023, employees of Quest Diagnostics filed a lawsuit alleging that the company mismanaged its self-funded health plan by:

- Failing to negotiate reasonable fees with its insurance carrier.
- Allowing its third-party administrator (TPA) to overcharge for routine procedures.
- Not disclosing hidden fees embedded in its health plan contracts.

The lawsuit claims that Quest Diagnostics breached its fiduciary duty under ERISA, resulting in millions of dollars in excessive costs passed on to employees and their families.

This case is part of a growing trend where employees are no longer accepting skyrocketing healthcare costs without scrutiny. If an employer is not actively managing its health plan, it could become the next target of a lawsuit.

The Most Common Fiduciary Violations in Employer Health Plans

Employers don't set out to violate their fiduciary duties, but the complexity and opacity of the healthcare system make it easy to fall into traps.

Here are the most common mistakes that lead to ERISA lawsuits:

1. Allowing Hidden Fees in Health Plan Contracts

Most employers assume that their insurance carrier or TPA is negotiating the best possible rates on their behalf. In reality, many contracts are riddled with hidden fees, inflated costs, and backdoor payments that benefit the vendor—not the employer or employees.

Fact: A 2023 audit of employer-sponsored health plans found that 94% of TPAs and PBMs included hidden fees that employers were unaware of (Health Plan Fiduciary Audit Report, 2023).

Example: A self-funded employer discovered that its TPA was charging a 10% markup on every hospital claim, resulting in $2.5 million in unnecessary fees annually (National Alliance of Healthcare Purchasers, 2023).

2. Failing to Monitor Pharmacy Benefit Managers (PBMs)

PBMs control which drugs are covered, how much they cost, and what pharmacies employees can use. Unfortunately, many PBMs engage in spread pricing, where they charge the employer significantly more than they reimburse the pharmacy—pocketing the difference.

Fact: Employers overpay for prescription drugs by an estimated $28 billion per year due to spread pricing and hidden rebates (Drug Channels Institute, 2023).

Example: A school district in Kentucky discovered it was being charged 800% more for generic drugs than their actual cost, leading to a $1.5 million overpayment (Kentucky State Audit, 2023).

ERISA lawsuits increasingly focus on whether employers conducted proper oversight of their PBM contracts.

3. Paying Excessive Hospital Prices Without Scrutiny

Many employers assume that because their health plan receives “network discounts,” they are getting a fair price. In reality, hospital pricing is wildly inflated within PPO networks.

Fact: RAND Corporation found that employers pay hospitals an average of 254% of Medicare rates,

with some hospitals charging more than 500% of what Medicare pays (RAND Hospital Price Transparency Report, 2023).

Example: A manufacturing company in the Midwest discovered it was paying $16,000 for an MRI, which was available for $700 at an independent imaging center (Employer Benefits Roundtable, 2023).

Employers who fail to question these costs can be held liable under ERISA for failing to manage plan expenses responsibly.

How Employers Can Protect Themselves?

ERISA violations are often the result of a lack of visibility into plan costs and contracts. Here's how employers can reduce their legal risk:

Conduct a Fiduciary Audit – Regularly review your plan's spending, contracts, and vendor fees.

Demand Transparent Contracts – Work with vendors who disclose all fees, rebates, and markups in writing.

Benchmark Costs Against Industry Standards – Compare your plan's pricing against Medicare rates, employer coalitions, and independent market reports.

Adopt an Independent Pharmacy Benefits Strategy – Avoid PBMs with spread pricing and hidden rebate agreements.

Leverage Direct Contracting & Value-Based Care – Negotiate fair pricing directly with hospitals and providers instead of relying on PPO network rates.

Conclusion: Employers Must Take Action Now

The legal and financial risks of mismanaging a health plan are greater than ever. Employers who fail to monitor costs, eliminate conflicts of interest, and act in employees' best interests face lawsuits, regulatory penalties, and significant financial losses.

The good news? Employers who take a proactive approach can dramatically reduce costs while improving benefits for their employees.

Understanding your fiduciary responsibilities is only the beginning. To truly protect your business and employees, you must recognize who is really driving healthcare costs—and why the system is designed to work against you.

Insurance carriers, pharmacy benefit managers (PBMs), hospital networks, and third-party administrators (TPAs) all profit from rising costs, often through hidden fees, inflated reimbursements, and complex contracts that limit employer control.

In the next chapter, we'll uncover how these players manipulate pricing, why traditional PPO networks don't actually save you money, and what steps you

can take to break free from a system that is designed to keep costs high.

3

The Broken System – Who’s Really Controlling Healthcare?

Introduction: Why Employers Have Lost Control

When employers negotiate contracts with vendors—whether it's for office supplies, software, or logistics—they expect clear pricing, transparency, and accountability. But in healthcare, those basic principles of business don't exist. Instead, employers operate in a system where:

- They don't know the actual cost of healthcare services until after they are billed.
- Insurance carriers, pharmacy benefit managers (PBMs), and hospital networks inflate costs behind the scenes while pretending to offer discounts.
- Third-party administrators (TPAs) and brokers often have financial incentives to keep costs high rather than reduce spending for employers.

The result? Employers are losing billions in unnecessary healthcare spending without even realizing it.

Fact: 82% of large employers report that they lack visibility into how their health plan dollars are spent (National Business Group on Health, 2023).

Fact: The healthcare industry wastes an estimated $1.4 trillion per year due to excessive pricing, administrative inefficiencies, and fraud (National Academy of Medicine, 2023).

This chapter will expose who is really controlling employer-sponsored healthcare, how they profit from rising costs, and why employers must reclaim control of their health plans.

1. The Illusion of Insurance Carrier Discounts

Employers assume that large insurance carriers like Blue Cross, UnitedHealthcare, Cigna, and Aetna negotiate lower rates on their behalf. However, these “discounts” are often misleading—because the starting prices are artificially inflated.

Example: A hospital may bill $50,000 for a procedure, but after the carrier’s “negotiated discount,” the employer still pays $25,000—even though the same procedure might cost $10,000 at an independent provider.

Fact: RAND Corporation found that hospitals charge employer health plans an average of 224% of Medicare rates, with some charging more than 500% of what Medicare pays (RAND Hospital Pricing Transparency Report, 2023).

The reason? Insurance carriers profit from higher prices because they collect administrative fees as a percentage of total spending—giving them a built-in incentive to let costs rise instead of driving them down.

Case Study: Marriott’s Wake-Up Call

Marriott International conducted an audit of its health plan spending and found that **hospitals were charging 300% to 400% of Medicare rates for routine procedures**. By implementing direct contracting with high-quality providers, the company cut costs by over 25% while improving employee satisfaction (Harvard Business Review, 2023).

2. Pharmacy Benefit Managers (PBMs): The Middlemen Driving Up Drug Costs

PBMs were originally created to help employers manage drug costs, but today, they often do the opposite. The three largest PBMs—**CVS Caremark, Express Scripts, and OptumRx—control 80%** of the prescription drug market and have been exposed for using hidden fees and spread pricing to maximize profits.

Fact: PBMs generate billions in revenue by marking up drug prices, steering patients to expensive brand-name drugs, and pocketing hidden rebates that employers never see (Drug Channels Institute, 2023).

Example: The Hidden PBM Markup on Insulin

A large employer discovered that its PBM was charging $340 per insulin prescription, even though the pharmacy's actual cost was $72. The employer was unknowingly paying a 372% markup due to spread pricing (Health Plan Fiduciary Audit Report, 2023).

Fact: An independent PBM audit found that employers could save 25-40% on prescription drug costs by switching to transparent, pass-through PBMs that eliminate hidden fees (National Alliance of Healthcare Purchasers, 2023).

Case Study: How Caterpillar Fixed Its PBM Problem

Caterpillar, the global construction equipment manufacturer, eliminated traditional PBMs and moved to a transparent, direct contracting model for prescription drugs. The result? **$20 million in annual savings and lower drug costs for employees** (Forbes, 2023).

3. PPO Networks: The "Preferred" Pricing Trap

Preferred Provider Organization (PPO) networks were originally designed to offer employers better pricing through network discounts. However, they often do the opposite by:

- Locking employers into overpriced contracts that prevent them from negotiating better rates.
- Requiring employees to use expensive hospital systems instead of lower-cost, high-quality providers.
- Discouraging price transparency, making it nearly impossible to compare costs across providers.
- Fact: A knee replacement that costs $29,500 under a PPO plan can often be purchased for $14,000 or less through direct contracting (Health Rosetta, 2023).

Case Study: A School District Saves $7 Million

A public school district in Indiana conducted a PPO claims analysis and found that it was paying 300% more for common procedures than independent providers were charging. By eliminating PPO network constraints and adopting reference-based

pricing, the district saved $7 million in healthcare costs in one year (State of Indiana Benefits Report, 2023).

4. Third-Party Administrators (TPAs): The Hidden Conflicts of Interest

For self-funded employers, third-party administrators (TPAs) manage claims and provider payments. However, many TPAs are owned by or financially linked to large insurance carriers—which means they often prioritize the carrier's financial interests over the employers.

Fact: A 2023 audit of TPA contracts found that 89% contained hidden administrative fees and undisclosed revenue-sharing agreements (Employer Health Plan Transparency Report, 2023).

Example: An employer discovered that its TPA was charging a 12% "network access fee" on every claim—adding up to $3 million in hidden costs annually (Health Plan Fiduciary Audit Report, 2023).

Employers who fail to monitor their TPAs can end up paying millions in excessive fees while assuming they are getting a fair deal.

Conclusion: Employers Must Take Back Control

The reality is employers have been locked into a broken system where insurance carriers, PBMs, PPO networks, and TPAs all profit from rising costs while offering little transparency.

But change is possible. Employers who **challenge the status quo** can:

- **Reduce healthcare costs by 20-40%** without cutting employee benefits.
- **Eliminate hidden fees, markups, and conflicts of interest** in their health plan.
- **Adopt direct contracting, transparent PBMs, and independent TPAs** to regain financial control.

In the next chapter, we'll begin breaking down the FRAMEwork, starting with how to identify and work with a truly transparent benefit advisor who has the employer's best interests in mind.

4

Facilitate Transparent Benefit Advisory Services

Introduction: The Problem with Traditional Benefit Advisors

Most employers rely on benefit advisors or brokers to help them design and manage their health plans. The expectation is that these advisors act in the employer's best interests, negotiating better rates and ensuring cost-effectiveness. However, the majority of benefit advisors are financially incentivized to keep costs high, not reduce them.

Fact: More than 80% of benefit advisors are paid through commissions, overrides, and bonuses from insurance carriers, creating an inherent conflict of interest (National Alliance of Healthcare Purchasers, 2023).

Fact: A 2023 survey found that only 22% of employers felt that their broker was proactively helping them reduce costs (KFF Employer Health Benefits Survey, 2023).

Instead of advocating for lower costs, many advisors steer employers into expensive plans that generate higher commissions for themselves. Employers who fail to question their advisor's financial incentives risk overspending by millions of dollars without realizing it.

1. How Traditional Benefit Advisors Make Money (And Why It Matters)

Most brokers and advisors don’t get paid directly by employers—they get paid by insurance carriers, PBMs, and TPAs. Here’s how they profit:

Commission-Based Compensation

Many advisors receive a percentage of the total premium paid by the employer, typically between 3-5%. The more the employer spends, the more the advisor earns.

Example: If a company spends $5 million on health benefits, and the advisor earns a 4% commission, they receive $200,000 per year—regardless of whether they control costs or add value.

Bonuses and Overrides from Carriers

Carriers often pay brokers undisclosed bonuses for renewing contracts at higher costs. These incentives are called:

Growth Bonuses – Advisors earn extra commissions when they increase an employer’s spending year over year.

Retention Bonuses – Advisors are rewarded for keeping employers locked into high-cost plans with the same carrier.

- **Fact**: A 2023 study found that large national brokers received over $500 million annually in undisclosed bonuses from carriers (Department of Labor Fiduciary Report, 2023).

Fiduciary Shockwave: The Lawsuits That Just Changed Healthcare Forever

On December 23, 2025, the healthcare benefits industry crossed a line it can't uncross.

The same law firm that fundamentally reshaped the retirement plan industry—forcing transparency, slashing fees, and redefining fiduciary responsibility—has now turned its attention to employer-sponsored health plans.

Schlichter Bogard LLC did not quietly enter the market. It filed class action lawsuits against major employers including **United Airlines, Laboratory Corporation of America, Community Health Systems, and Universal Services of America.** But the real signal wasn't just who they sued. It was how they sued.

For the first time, the lawsuits didn't stop with the employer.

They named the benefits consulting firms themselves—**Gallagher, Mercer, Lockton, and Willis Towers Watson**—as defendants, **alleging fiduciary breaches and prohibited transactions tied to compensation structures that, in some cases, reached as high as 40% of premiums.**

That changes everything.

This is not a technical legal dispute. It is a direct challenge to the economic engine that has powered the benefits industry for decades.

To understand the magnitude, you have to understand who is bringing these cases.

Schlichter Bogard is widely credited with transforming the 401(k) industry. Through relentless litigation and a strategy focused on precedent-setting cases, the firm forced a complete rethinking of fiduciary responsibility in retirement plans. Recordkeepers redesigned their business models. Fee compression became the norm. Employers were no longer allowed to operate passively.

Three unanimous Supreme Court decisions reinforced that shift, establishing an ongoing duty to monitor investments, remove imprudent options, and justify fees with rigor. What was once optional became mandatory. What was once hidden became exposed.

Now that same playbook is being applied to healthcare.

And the early message is clear.

This is not about a few bad actors. This is about systemic conflicts of interest embedded in how benefits are designed, sold, and managed.

When compensation is tied to premiums, higher costs can mean higher income for advisors. When consulting firms receive indirect payments, overrides, or revenue sharing, objectivity is called into question. And when employers rely on these structures without full transparency, fiduciary risk doesn’t disappear. It transfers.

Julie Selesnick, one of the most experienced plaintiff-side ERISA attorneys in the country, put it plainly: *"large consulting firms should be very worried."*

That may be an understatement.

Because this moment mirrors the early days of 401(k) litigation. At first, the industry dismissed it. Then came settlements. Then came structural change. And eventually, a new standard of care.

Healthcare is now on that same path.

The implications are far-reaching. Employers can no longer assume their advisors are simply service providers. They must evaluate whether those partners are acting as fiduciaries—or functioning within compensation models that create misalignment.

Advisors can no longer rely on legacy revenue structures without scrutiny. Transparency is no longer a differentiator. It is becoming a requirement.

And consultants who fail to adapt may find themselves not just losing business but defending it.

This is the beginning of a fiduciary reckoning in healthcare.

The question is no longer whether change is coming.

It's whether you're ahead of it—or about to be pulled into it.

PBM Revenue Sharing

PBMs often pay advisors a cut of the prescription drug rebates and spread pricing fees, further incentivizing them to steer employers into high-cost pharmacy contracts.

Case Study: How a Self-Insured Employer Uncovered $3M in Hidden Commissions

A **mid-sized manufacturing company in Ohio hired an independent consultant to audit its health plan**. The audit revealed that their broker:

- Had received over **$3 million in undisclosed commissions** from their insurance carrier over five years.
- Had **pushed the company into an expensive pharmacy contract with excessive spread pricing, generating additional bonuses.**

By switching to a fiduciary advisor model, the company cut its healthcare costs by 28% in one year (Self-Insured Employer Case Study, 2023).

2. What a Fiduciary Benefit Advisor Should Do

To avoid hidden fees, conflicts of interest, and misaligned incentives, employers should work with fiduciary benefit advisors—advisors who:

Are paid directly by the employer with transparent, fixed fees.

Refuse commissions, overrides, or bonuses from carriers and PBMs.

Have a legal obligation to act in the employer's best interests.

Key Traits of a Fiduciary Advisor:

- Provides full fee transparency, disclosing all sources of revenue.
- Negotiates direct contracting options for lower-cost healthcare services.
- Recommends transparent PBMs instead of traditional spread-pricing models.
- Regularly audits claims data to eliminate excessive spending.

Case Study: How a Fiduciary Advisor Helped an Employer Save 40%

A 1,500-employee tech company switched from a traditional broker to a fiduciary benefit advisor. Within 18 months, they:

- Reduced health plan costs by 40% through direct contracting with providers.
- Cut pharmacy spend by 32% by switching to a transparent PBM.
- Increased employee satisfaction with better access to care.

The total savings? Over $5 million per year—without reducing benefits (Employer Benefits Coalition Report, 2023).

3. How Employers Can Find a Transparent, Fiduciary Advisor

Most brokers won't voluntarily disclose their commissions and overrides—so employers must ask the right questions before hiring an advisor.

Key Questions to Ask a Potential Advisor:

1. How are you compensated? (If they earn commissions from carriers or PBMs, it's a red flag.)
2. Do you accept bonuses or overrides from insurance carriers? (If the answer is "yes," they have a conflict of interest.)
3. Will you provide a signed fiduciary agreement? (If they refuse, they are not truly working in your best interest.)
4. How do you help control costs? (Look for strategies like direct contracting, claims auditing, and transparent PBM solutions.)
5. Do you provide regular claims data analysis and reporting? (If they don't offer full visibility into spending, they are not a good fit.)

4. The Impact of Fiduciary Advisors on Employer Healthcare Costs

Employers who switch to transparent, fiduciary-driven advisors experience significant cost savings without reducing benefits.

Fact: Employers who work with fiduciary benefit advisors see an average cost reduction of 20-40% (Health Rosetta Employer Report, 2023).

Fact: Companies that implement direct contracting, independent TPAs, and transparent PBMs can save up to $10,000 per employee per year (National Business Group on Health, 2023).

Case Study: How an Employer Cut Costs by $2,000 Per Employee

A 3,000-employee construction company hired a fiduciary advisor who:

- Moved them from a fully insured plan to a self-funded model.
- Eliminated spread pricing in their PBM contract, cutting pharmacy costs by 35%.
- Implemented a reference-based pricing model for hospital services.

The company reduced its per-employee healthcare costs by $2,000 per year, saving $6 million annually while improving benefits (Employer Benefits Strategy Report, 2023).

Conclusion: Employers Must Demand Transparency

Employers who fail to question their benefit advisor’s incentives are leaving millions of dollars on the table while their costs continue to rise. The key to reducing healthcare expenses starts with hiring the right advisor—one who is legally obligated to act in the employer’s best interests.

Fiduciary advisors eliminate conflicts of interest and reduce costs.

Transparent PBMs and direct contracting deliver real savings.

Employers who take control of their health plans can cut costs by 20-40% without reducing benefits.

In the next chapter, we'll explore how to review and optimize plan documents to eliminate waste, ensure compliance, and create a high-value health plan for employees.

5

Review Plan Documents and Design – Eliminating Hidden Costs and Ensuring Compliance

Introduction: The Hidden Dangers in Plan Documents

Most employers assume that their health plan documents are straightforward contracts designed to outline benefits and provider networks.

However, buried within these documents are clauses and terms that:

- Drive excessive costs through inflated hospital charges, hidden fees, and broad reimbursement rates.
- Create legal risks by failing to comply with ERISA fiduciary obligations.
- Lock employers into one-sided contracts that benefit insurance carriers and third-party administrators (TPAs) at the employer's expense.

Why does this matter? Because most employers never read their plan documents in detail, and even fewer conduct audits to verify if they are overpaying for healthcare services.

Fact: A 2023 audit of self-funded employer health plans found that **over 85% contained excessive administrative fees, markups, and non-compliant clauses** (National Alliance of Healthcare Purchasers, 2023).

Fact: Employers who conduct plan document audits **reduce total healthcare costs by an average of 15-30% by eliminating hidden fees and excessive provider charges** (Health Rosetta Employer Report, 2023).

In this chapter, we'll break down how employers can review their plan documents, identify cost drivers, and redesign their health plan to eliminate waste and protect their fiduciary interests.

1. Why Most Plan Documents Are Designed to Favor Vendors, Not Employers

Employers often assume their insurance carrier, TPA, or benefits consultant is negotiating in their best interest. But in reality, many plan documents are intentionally designed to maximize profits for insurers, PBMs, and hospital systems—often at the employer's expense.

Example: A Midwest-based employer reviewed its plan document for the first time in five years and discovered that it had been paying a 10% administrative fee on every medical claim—a cost that was never disclosed in the original contract. By renegotiating this clause, the company saved $2 million per year (Employer Fiduciary Report, 2023).

The most common hidden cost drivers in plan documents include:

"Usual and Customary" Reimbursement Language – Many plans define provider payments as a percentage of "usual and customary" charges, which often means employers are paying 300-500% of Medicare rates.

TPA Administrative Fees Buried in Claims Costs – Many TPAs embed additional per-claim charges in hospital bills that are difficult to detect.

PBM Spread Pricing Clauses – Many plan documents allow PBMs to markup drug costs without employer oversight.

“Gag Clauses” on Pricing Transparency – Some contracts prohibit employers from accessing claims data, making it impossible to audit healthcare spending.

Case Study: Hidden Markups in a Self-Funded Employer’s Plan

A 2,500-employee manufacturing company conducted a plan document audit and found:

- A "usual and customary" pricing clause that allowed hospitals to charge up to 500% of Medicare rates.
- Hidden "network access fees" totaling $1.5 million per year.
- A pharmacy benefit contract that included a 12% markup on all generic drugs.

By renegotiating these terms, **the company cut healthcare costs by 22% in one year**—without reducing benefits (Self-Insured Employer Case Study, 2023).

2. Conducting a Plan Document Audit: Key Areas to Review

A. Medical Claims and Reimbursement Language

- Are provider reimbursements set as a fixed percentage of Medicare rates (e.g., 150-200%) or “usual and customary” charges?
- Does the contract allow for direct contracting with providers to reduce costs?

- Are network discounts clearly outlined, or is the employer relying on vague PPO pricing structures?

B. Pharmacy Benefit Management (PBM) Terms

- Does the PBM contract prohibit spread pricing?
- Are rebates passed back to the employer, or does the PBM keep them?
- Does the employer have full audit rights over prescription drug claims?

C. Third-Party Administrator (TPA) Fees and Hidden Charges

- Is the TPA charging a fixed administrative fee, or are they embedding per-claim charges?
- Does the employer have unrestricted access to claims data for independent analysis?
- Are there any undisclosed commissions, bonuses, or overrides paid to the TPA?
- Fact: A 2023 employer benefits report found that hidden fees in TPA contracts can increase administrative costs by 10-20% per year (Health Plan Fiduciary Audit Report, 2023).

3. Redesigning the Plan: Key Strategies to Eliminate Waste

A. Implement Care Navigation and Second Opinions

Provide employees with a dedicated care navigation service to guide them toward high-quality, cost-effective providers.

Require second opinions for high-cost surgeries and specialty treatments to prevent unnecessary procedures.

Ensure employees have access to independent, evidence-based decision support to improve outcomes and reduce complications.

Fact: Employers who implement care navigation programs see an 18% reduction in unnecessary procedures and 15-25% cost savings on major treatments (National Business Group on Health, 2023).

B. Move to Reference-Based Pricing (RBP) or Fair Market Payments Model

Instead of paying inflated PPO network rates, employers can set provider reimbursements based on a multiple of Medicare rates (e.g., 150-200%), which reduces costs while ensuring fair provider compensation.

C. Negotiate Direct Contracts with High-Quality Providers

Employers can bypass traditional PPO networks and negotiate direct contracts with hospitals, specialty centers, and primary care providers for lower rates.

D. Implement Transparent PBM Strategies

Employers should eliminate PBMs that use spread pricing and hidden markups and instead contract with pass-through PBMs that charge a flat administrative fee with full transparency.

Conclusion: Reviewing Plan Documents is a Fiduciary Responsibility

Employers who fail to review and optimize their plan documents are exposing themselves to millions in unnecessary spending and fiduciary risk. Implementing care navigation and second opinion services alongside cost-saving strategies can help reduce waste and improve employee outcomes.

6

Advance Value-Based Care Solutions – Paying for Outcomes, Not Volume

Introduction: Why the Fee-for-Service Model Fails Employers

For decades, the U.S. healthcare system has operated on a fee-for-service (FFS) model, where providers are paid for each test, procedure, and visit —regardless of necessity or patient outcomes. This model creates:

Overutilization – Providers are financially incentivized to perform more services, even when unnecessary.

Higher Costs – The more services billed, the more revenue hospitals and providers generate, driving up employer spending.

Poorer Health Outcomes – Because providers are rewarded based on volume, there is little incentive to focus on preventive care or long-term health improvements.

Fact: Over $1.4 trillion is wasted annually in the U.S. healthcare system due to excessive procedures, administrative inefficiencies, and low-value care (National Academy of Medicine, 2023).

Fact: A 2023 study found that 25% of all medical procedures and tests performed in employer health plans were unnecessary (JAMA Internal Medicine, 2023).

To fix this, employers must transition away from traditional fee-for-service models and implement value-based care solutions—paying providers based on health outcomes, efficiency, and quality of care rather than sheer volume of services.

1. What Is Value-Based Care?

Value-based care (VBC) focuses on:

- Preventing illness instead of just treating it.
- Reducing hospitalizations and unnecessary procedures.
- Rewarding providers for patient health improvements instead of service volume.

Instead of paying for every test or procedure, value-based care models align incentives between employers, providers, and employees to improve overall health while reducing costs.

Fact: Employers who adopt value-based care see an average cost reduction of 15-30% while improving workforce health (National Business Group on Health, 2023).

Fact: Value-based primary care can reduce hospital admissions by 20-40% (Health Affairs, 2023).

Case Study: How Walmart Reduced Healthcare Costs with Value-Based Care

Walmart implemented a Centers of Excellence program where employees were directed to high-performing hospitals for surgeries and complex procedures. By doing this, Walmart:

- Reduced unnecessary surgeries by 50%.
- Saved an average of $30,000 per procedure by eliminating low-quality providers.
- Improved patient outcomes with fewer complications and readmissions.

This approach resulted in millions in savings and higher-quality care for employees (Harvard Business Review, 2023).

2. Direct Primary Care (DPC): A Better Model for Employee Health

One of the most effective value-based care strategies employers can implement is Direct Primary Care (DPC). Unlike traditional primary care models, DPC:

Eliminates fee-for-service billing – Employers pay a flat monthly fee per employee instead of paying for each visit or test.
Provides longer, unhurried doctor visits – DPC physicians see fewer patients and focus on preventive care and chronic disease management.
Reduces unnecessary specialist visits and ER trips – Employees receive proactive, personalized care, leading to better health outcomes.

Fact: A 2023 study found that DPC models reduce employer healthcare costs by an average of 20-30% due to fewer hospitalizations and unnecessary specialist referrals (Journal of Occupational Health, 2023).

Case Study: How a Manufacturing Company **Saved $3M** with DPC

A 1,000-employee manufacturing company switched to a DPC model and saw:

- A **40% reduction in ER visits**.

- A **35% decrease in specialist referrals** due to better primary care management.
- A **total savings of $3 million per year** in healthcare costs (Employer Direct Primary Care Case Study, 2023).

By investing in primary care upfront, the company avoided expensive downstream costs, proving that prevention is cheaper than treatment.

3. Centers of Excellence (COE): High-Quality Care at Lower Costs

Many employer health plans allow employees to seek care at any hospital or specialist within a broad PPO network. However, not all providers offer the same quality of care—and some hospitals have significantly higher complication rates than others.

Centers of Excellence (COE) programs solve this by steering employees toward the highest-quality providers for surgeries, cancer treatments, and specialty care.

Fact: Employees who receive surgery at a COE are 80% less likely to experience complications compared to those using standard in-network hospitals (Health Affairs, 2023).

Fact: Employers who implement COE programs save an average of $15,000 to $40,000 per procedure due to lower complication rates and shorter hospital stays (National Business Group on Health, 2023).

Case Study: Lowe's Saves Millions with Centers of Excellence

Lowe's implemented a COE program for joint replacements, steering employees to high-quality orthopedic hospitals. The results:
$30,000 in savings per surgery.

Fewer post-surgical complications and faster recovery times.
Millions saved in total healthcare costs (Harvard Business Review, 2023).

By steering employees to top-tier providers, Lowe's improved patient outcomes while cutting costs.

4. Bundled Payments: A Smarter Way to Pay for Care

Traditional healthcare billing is fragmented—each doctor, hospital, and lab sends separate bills for the same procedure. Bundled payments fix this by consolidating all costs into one fixed price for a complete treatment episode.

Predictable costs – Employers know exactly how much a procedure will cost upfront.

Lower total expenses – Providers work efficiently to prevent unnecessary services and complications.

Better quality outcomes – Providers are incentivized to coordinate care and avoid unnecessary services.

Fact: Employers who adopt bundled payments reduce costs by an average of 20% per procedure (Health Care Payment Learning & Action Network, 2023).

Fact: Hospitals participating in bundled payment models reduce readmissions by 25% (American Journal of Managed Care, 2023).

Case Study: Boeing's Bundled Payment Success

Boeing implemented bundled payments for joint replacements and cardiac procedures, resulting in:

- A 20% reduction in overall procedure costs.
- Higher patient satisfaction due to better-coordinated care.
- Millions in total savings by avoiding excessive hospital billing (National Business Group on Health, 2023).

Conclusion: How Employers Can Implement Value-Based Care

The fee-for-service system is failing employers by prioritizing profits over patient outcomes. Employers who want to control costs and improve employee health must adopt value-based care solutions, such as:

Direct Primary Care (DPC) to prevent disease and lower healthcare spending.

Centers of Excellence (COE) to steer employees toward the best providers.

Bundled Payments to reduce fragmented billing and lower total costs.

Key Takeaways:

Employers who adopt value-based care strategies reduce healthcare costs by 15-30%.

Preventive care and direct primary care lower emergency room visits and specialist referrals.

High-quality providers deliver better outcomes at lower costs when employers steer employees toward Centers of Excellence.

In the next chapter, we'll explore how independent Pharmacy Benefit Management (PBM) strategies can further reduce employer healthcare costs by eliminating hidden drug markups and unnecessary pharmacy spending.

7

Manage Independent PBM Strategies – Eliminating Hidden Drug Costs

Introduction: How Pharmacy Benefit Managers (PBMs) Inflate Employer Drug Costs

Prescription drugs account for nearly 25% of total employer healthcare spending, yet most employers don't realize how much they're overpaying due to hidden markups, spread pricing, and rebate traps created by Pharmacy Benefit Managers (PBMs).

PBMs were originally designed to help employers manage drug costs, but today, the three largest PBMs—CVS Caremark, Express Scripts, and OptumRx—control over 80% of the prescription drug market and have been exposed for using hidden fees and spread pricing to maximize their profits.

Fact: A 2023 study found that employers overpay for prescription drugs by an estimated $28 billion per year due to PBM markups (Drug Channels Institute, 2023).

Fact: PBMs routinely charge employers 30-60% more for generic drugs than the actual pharmacy acquisition cost (National Alliance of Healthcare Purchasers, 2023).

In this chapter, we will break down:

- How PBMs manipulate drug pricing to maximize their profits.
- The key contract terms employers must renegotiate to eliminate hidden fees.
- How independent, transparent PBMs can help employers cut drug costs by 25-40%.

1. Understanding How PBMs Profit at Employers' Expense

A. Spread Pricing: The Hidden Middleman Markup

Spread pricing occurs when PBMs charge employers more for a drug than they reimburse the pharmacy—pocketing the difference as profit.

Example: A PBM charges an employer $200 for a medication but reimburses the pharmacy $50—keeping $150 in hidden profits.

Fact: A state audit of Kentucky's Medicaid program found that PBMs overcharged taxpayers by $123 million in spread pricing alone (Kentucky State Audit, 2023).

B. Rebate Traps: Why Higher Drug Prices Benefit PBMs

PBMs negotiate rebates with drug manufacturers, but these rebates often don't lower costs for employers. Instead, PBMs favor high-cost, high-rebate drugs, pushing more expensive medications onto employer plans.

Fact: A 2023 employer study found that PBM rebates increased brand-name drug spending by 50%, steering patients away from cheaper, equally effective generics (National Business Group on Health, 2023).

C. Gag Clauses and Lack of Pricing Transparency

Many PBM contracts prohibit employers from accessing claims data or comparing actual drug acquisition costs—making it impossible to identify overcharges.

Fact: 72% of large employers reported that their PBM refused to disclose actual drug costs in their contract (Health Plan Fiduciary Audit Report, 2023).

2. Case Study: A School District Saves $1.5M by Eliminating PBM Spread Pricing

A public school district in Ohio conducted a PBM audit and discovered:

- Hidden markups on generic drugs exceeding 800%.
- Rebates that were not fully passed back to the employer.
- A contract that prohibited transparency into drug pricing.

By switching to a transparent, independent PBM, the district cut prescription drug costs by $1.5 million in the first year without reducing benefits (Ohio State PBM Audit, 2023).

3. How Employers Can Take Back Control of Prescription Drug Costs

A. Require Full PBM Transparency in Contracts

Employers should demand 100% pass-through pricing in PBM contracts, meaning:

- No spread pricing – The PBM cannot markup drug costs.
- All rebates are returned to the employer – No hidden fees.
- Employers have full access to claims data – No gag clauses.

Fact: Employers who negotiate pass-through PBM contracts reduce pharmacy spend by 25-40% (Drug Channels Institute, 2023).

B. Implement Reference-Based Pricing for Medications

Just as reference-based pricing works for hospital services, employers can apply it to prescription drugs by capping reimbursements at a multiple of acquisition cost.

Example: A manufacturing company implemented reference-based pricing for specialty drugs, capping costs at 250% of the National Average Drug Acquisition Cost (NADAC)—reducing annual specialty drug spending by $2 million (Employer Benefits Roundtable, 2023).

C. Use Independent, Transparent PBMs

Unlike traditional PBMs, independent PBMs operate on a flat-fee model with no hidden markups. These PBMs:

- Charge a fixed administrative fee per claim instead of spread pricing.
- Pass 100% of manufacturer rebates back to the employer.
  Provide full claims data transparency.

Fact: Employers who switch to independent PBMs save an average of 30% on pharmacy spending (Health Plan Fiduciary Audit Report, 2023).

Case Study: How Caterpillar Cut Pharmacy Costs by $20M

Caterpillar, the global construction company, eliminated traditional PBMs and implemented a transparent PBM strategy. The results?

- $20 million in annual savings.
- Lower out-of-pocket costs for employees.
- Better formulary management to steer employees toward cost-effective medications (Forbes, 2023).

4. Addressing High-Cost Specialty Drugs

Specialty drugs account for 2% of prescriptions but nearly 50% of total drug spending. Employers must control specialty drug costs by:

Mandating step therapy – Employees must try lower-cost alternatives before using expensive specialty medications.

- Negotiating direct contracts with specialty pharmacies.
- Implementing alternative funding programs to offset specialty drug costs.

Fact: Employers who implement step therapy and formulary management reduce specialty drug spending by 20-35% (National Alliance of Healthcare Purchasers, 2023).

5. The Employer's PBM Fiduciary Responsibility

Under ERISA, employers must act as fiduciaries when managing prescription drug benefits—meaning they must ensure that PBM contracts are free of hidden fees and conflicts of interest.

How Employers Can Meet Their Fiduciary Duty

- Conduct regular PBM audits – Identify overcharges and claw back unnecessary spending.
- Eliminate spread pricing – Use transparent PBM contracts with full pass-through pricing.
- Demand full rebate transparency – Ensure all rebates go back to the employer.
- Monitor specialty drug costs – Implement cost-containment strategies for high-cost drugs.

Fact: Employers who proactively manage their PBM save an average of $1,200 per employee per year. (Employer Benefits Strategy Report, 2023).

Conclusion: Employers Must Fix Their PBM Strategy to Control Drug Costs

- Traditional PBMs profit by overcharging employers through spread pricing, rebates, and hidden fees.
- Employers can eliminate these hidden costs by switching to transparent, independent PBMs.
- Value-based pharmacy strategies—including reference-based pricing and step therapy—further reduce costs.

Key Takeaways:

- Eliminating PBM spread pricing can cut drug costs by 25-40%.
- Employers must demand full rebate transparency and pass-through pricing.
- Addressing specialty drug spending can reduce total pharmacy costs by 20-35%.

In the next chapter, we'll explore how eliminating PPO network constraints can unlock even greater savings while improving access to high-quality care.

8

Eliminate PPO Network Constraints – Breaking Free from Overpriced and Restrictive Networks

Introduction: How PPO Networks Inflate Costs and Limit Access

For years, Preferred Provider Organization (PPO) networks have dominated employer-sponsored healthcare plans. Employers are led to believe that PPOs provide:

- “Discounted” healthcare services through contracted provider networks.
- Broad access to doctors and hospitals for employees.
- Predictable pricing structures to help control costs.

However, the truth is that PPO networks are one of the biggest cost drivers in employer-sponsored healthcare. Instead of delivering real savings, PPO networks:

- Allow hospitals and providers to set artificially high prices before applying “discounts.”
- Restrict employer negotiating power, forcing them to accept predetermined pricing.
- Drive excessive costs by pushing employees toward high-cost hospital systems instead of independent providers.

Fact: A 2023 RAND study found that employers pay hospitals an average of 254% of Medicare rates under PPO networks, with some hospitals charging over 500% of Medicare pricing (RAND Hospital Pricing Report, 2023).

Fact: Employers who switch from traditional PPOs to direct contracting and reference-based pricing save 20-40% on healthcare costs (National Business Group on Health, 2023).

Case Study: A Self-Insured Employer Saves $7 Million by Leaving a PPO

- A 5,000-employee manufacturing company in the Midwest conducted a claims analysis and discovered:
- Hospital prices were 350% higher than Medicare rates for the same procedures.
- An emergency room visit that cost $550 under Medicare was billed at $3,500 under the PPO.

Specialist visits were 200% more expensive in-network compared to independent providers.

By eliminating the PPO network and moving to direct contracting, the employer cut healthcare costs by $7 million in the first year—without reducing employee benefits (Self-Insured Employer Case Study, 2023).

1. Why PPO Networks Drive Up Employer Healthcare Costs

A. The “Discount” Scam

PPO networks claim to offer discounted prices, but the discounts are based on inflated “sticker prices” set by hospitals—not on actual market value.

Example: A hospital may bill $50,000 for a procedure, apply a “40% PPO discount,” and charge the employer $30,000—but the same procedure may be available for $12,000 at an independent surgical center.

Fact: A knee replacement that costs $29,500 under a PPO plan is often available for $14,000 or less through direct contracting (Health Rosetta, 2023).

B. Employers Are Locked into One-Sided Contracts

Many PPO contracts:

- Prohibit employers from seeing actual provider pricing before services are delivered.
- Include “gag clauses” that prevent employers from negotiating better rates.
- Lock employers into automatic annual rate increases without justification.

Fact: A 2023 employer audit found that 75% of PPO contracts contained automatic price increases of 5-10% per year (Employer Health Plan Fiduciary Report, 2023).

C. High-Cost Hospitals Dominate PPO Networks

Because PPO networks prioritize large hospital systems, employees are often steered toward higher-cost providers instead of lower-cost, high-quality alternatives.

Fact: A recent study found that hospital-owned physician groups charge 20-30% more than independent physicians for the same services (Health Affairs, 2023).

Case Study: How a Public School District Cut Costs by 35%

A large public school district in Indiana conducted a PPO claims analysis and found:

- It was paying 400% more for outpatient procedures than independent surgical centers charged.
- Routine imaging services (MRIs, CT scans) were 250% higher under the PPO.
- The PPO contract prohibited direct employer-provider negotiations.

By eliminating the PPO and adopting reference-based pricing, the district cut healthcare costs by 35% in one year (State of Indiana Benefits Report, 2023).

2. How Employers Can Break Free from PPO Network Constraints

A. Implement Reference-Based Pricing (RBP)

Instead of relying on PPO-negotiated rates, reference-based pricing (RBP) reimburses providers at a fixed percentage of Medicare rates (e.g., 150-200%).

- Reduces employer costs by eliminating inflated hospital pricing.
- Allows employees to visit any provider willing to accept RBP payments.
- Encourages hospitals to accept fair, transparent pricing instead of arbitrary PPO rates.

Fact: Employers who switch to reference-based pricing reduce healthcare costs by 25-40% (National Business Group on Health, 2023).

B. Adopt Direct Contracting with High-Quality Providers

Direct contracting allows employers to bypass PPO networks and negotiate fair, transparent pricing directly with hospitals, primary care providers, and specialists.

Guarantees fair pricing without excessive PPO markups.
Provides higher-quality care by selecting top-performing providers.
Eliminates administrative fees associated with PPO network access.

Fact: Direct contracting reduces employer healthcare costs by 15-30% while improving quality and access (Health Rosetta, 2023).

Case Study: How Disney Uses Direct Contracting to Reduce Costs

Disney eliminated traditional PPO networks and directly contracted with top local hospitals and primary care providers. The results?

- Employees had access to higher-quality care.
- Total healthcare costs were reduced by 25%.
- Employee satisfaction increased due to better provider access.

By removing PPO restrictions, Disney created a high-quality, cost-effective healthcare plan (Harvard Business Review, 2023).

C. Use High-Performance Networks (HPNs)

Instead of traditional PPOs, employers can implement high-performance networks (HPNs), which focus on:

- Steering employees to top-performing, cost-effective providers.
- Eliminating hospitals with excessive complication rates and pricing.
- Negotiating bundled payments for predictable, transparent pricing.

Fact: Employers who implement high-performance networks save an average of $3,000 per employee per year while improving healthcare quality (National Business Group on Health, 2023).

Case Study: How Boeing's High-Performance Network Reduced Costs

Boeing implemented a high-performance network for employee healthcare, focusing on quality over quantity. The results?

- Total healthcare costs dropped by 20%.
- Hospital readmissions decreased by 30%.
- Employees received better outcomes due to provider quality controls.

3. The Employer's Fiduciary Responsibility to Eliminate PPO Waste

Under ERISA, employers must act in the best interest of their employees when selecting health

plans. If an employer fails to question excessive PPO costs and hidden fees, they risk legal liability for breaching fiduciary duties.

How Employers Can Meet Their Fiduciary Duty:

- Audit PPO contracts – Identify hidden fees and excessive hospital markups.
- Implement reference-based pricing – Ensure fair provider payments instead of inflated PPO rates.
- Negotiate direct contracts with top-performing providers – Eliminate PPO middlemen and set predictable pricing.
- Use high-performance networks – Improve quality while lowering costs.

Fact: Employers who proactively optimize their provider network reduce total healthcare spending by 20-40% (Employer Benefits Strategy Report, 2023).

Conclusion: Eliminating PPO Constraints Saves Employers Millions

- PPO networks drive up healthcare costs through artificial pricing and hidden contract terms.
- Reference-based pricing and direct contracting deliver real cost savings.
- Employers who take control of provider networks improve quality while reducing spending.

In the next chapter, we'll explore how employers can fully implement the **FRAMEwork** to create a long-term, sustainable health plan strategy.

9

The Employer’s Role as a Health Plan Fiduciary

Introduction: Why Employers Must Take Ownership of Their Health Plan

For years, employers have been passive participants in managing healthcare costs, relying on insurance carriers, brokers, and third-party administrators (TPAs) to navigate the complexities of their health plans. But as healthcare costs continue to skyrocket and lawsuits against employer’s increase, companies must recognize that they have a fiduciary responsibility to actively oversee their health plan.

Employers offering health benefits are legally considered fiduciaries under the Employee Retirement Income Security Act (ERISA), meaning they have a duty to:

- Ensure plan costs are reasonable and that vendors are acting in employees' best interests.
- Eliminate conflicts of interest and excessive fees embedded in contracts.
- Monitor plan performance and make necessary adjustments to improve quality and control costs.

Fact: Since 2020, ERISA lawsuits related to employer health plans have surged, with dozens of large employers—including Quest Diagnostics,

Johnson & Johnson, and Duke University—facing legal action (Bloomberg Law, 2023).

Fact: Employers lose or settle most ERISA cases, with settlements often exceeding $10 million (U.S. Department of Labor, 2023).

This chapter will outline the core fiduciary responsibilities of employers, common mistakes that lead to lawsuits, and practical steps to ensure compliance while reducing costs.

1. The Three Core Responsibilities of a Health Plan Fiduciary

A. Duty of Loyalty: Acting in Employees' Best Interests

A fiduciary must act solely in the best interests of employees and their beneficiaries when making decisions about the health plan. This means:

Negotiating fair contracts with TPAs, PBMs, and networks.
Ensuring employees have access to high-quality, cost-effective care.
Avoiding financial conflicts of interest with brokers and consultants.

Case Study: In a 2023 lawsuit against Duke University, employees claimed that the university failed to monitor excessive health plan costs, leading to millions in unnecessary expenses (Bloomberg Law, 2023).

B. Duty of Prudence: Managing the Plan with Care and Diligence

Employers must ensure that their health plan is well-managed, cost-effective, and structured to provide maximum value. This includes:

- Regularly reviewing claims data to identify waste and overbilling.
- Benchmarking costs against industry standards.
- Ensuring vendors provide full transparency into pricing and fees.

Fact: A 2023 study found that 72% of employers lack access to detailed claims data, making it impossible to fulfill their fiduciary duty (National Business Group on Health, 2023).

Case Study: A self-funded employer conducted a plan audit and found that its TPA was charging a 12% markup on all hospital claims, resulting in $3 million in unnecessary spending. By renegotiating the contract, the company cut costs by 18% (Employer Fiduciary Audit Report, 2023).

C. Duty to Monitor: Holding Vendors Accountable

Employers must closely monitor all third-party administrators (TPAs), pharmacy benefit managers (PBMs), and brokers to ensure they are acting in the best interest of the plan.

- Regular audits of claims and fees to detect overcharges.
- Demanding full disclosure of all vendor compensation.
- Ensuring that all rebates and discounts are passed back to the employer.

Case Study: In 2023, Johnson & Johnson was sued for failing to monitor excessive fees charged by its TPA, resulting in millions in losses for employees (ERISA Fiduciary Lawsuit, 2023).

2. Common Fiduciary Violations That Put Employers at Risk

Many employers unknowingly violate their fiduciary duty, exposing themselves to lawsuits and financial penalties. The most common violations include:

A. Allowing Excessive Fees in Health Plan Contracts

- Many employers fail to negotiate vendor fees, resulting in millions in unnecessary spending.
- Hidden administrative fees, spread pricing, and markup clauses often go unnoticed.

Fact: A 2023 audit of employer-sponsored health plans found that 94% contained excessive fees that employers had not reviewed (Health Plan Fiduciary Audit Report, 2023).

B. Failing to Monitor Pharmacy Benefit Managers (PBMs)

- Many employers do not realize that their PBM is inflating drug costs.
- PBMs often steer employees toward high-cost brand-name drugs instead of cheaper alternatives.

Fact: A 2023 analysis found that PBM spread pricing added 30-60% to employer drug costs (Drug Channels Institute, 2023).

Case Study: A school district in Kentucky uncovered $1.5 million in overcharges after auditing its PBM contract. By switching to a transparent PBM, they cut drug costs by 28% (Kentucky State PBM Audit, 2023).

C. Ignoring Claims Data and Cost Trends

- Employers who fail to analyze claims data are unable to identify excessive spending.
- Many renew their health plan contracts blindly, leading to continuous cost increases.

Fact: A 2023 survey found that 67% of employers do not regularly audit claims, leading to unchecked spending growth (National Business Group on Health, 2023).

3. Steps Employers Can Take to Ensure Fiduciary Compliance

A. Conduct a Health Plan Fiduciary Audit

- Review all contracts with TPAs, PBMs, and brokers to identify excessive fees.

- Analyze claims data to detect fraud, waste, and unnecessary spending.
  Ensure compliance with ERISA regulations to avoid lawsuits.

Case Study: A 1,500-employee tech company conducted a fiduciary audit and discovered $4 million in hidden costs due to PBM overcharges and excessive TPA fees. By restructuring its contracts, the company cut costs by 30% in one year (Employer Benefits Coalition Report, 2023).

B. Demand Full Transparency from Vendors

- Require TPAs and PBMs to disclose all revenue streams, rebates, and hidden fees.
- Ensure all pharmacy rebates are passed 100% back to the employer.
- Remove gag clauses and demand unrestricted access to claims data.

Fact: Employers who switch to fully transparent health plan models save an average of $2,500 per employee per year (Health Rosetta, 2023).

C. Optimize Plan Design to Reduce Costs

- Implement reference-based pricing instead of relying on inflated PPO rates.
- Use direct primary care (DPC) and Centers of Excellence (COE) to improve employee health while lowering costs.
- Eliminate unnecessary administrative fees and network markups.

Conclusion: Employers Must Take Control of Their Fiduciary Responsibility

- ERISA lawsuits are increasing, and employers who fail to manage their health plan risk significant legal and financial penalties.
- Employers must actively monitor vendors, eliminate hidden fees, and ensure that every healthcare dollar is spent wisely.
- Conducting fiduciary audits, demanding full transparency, and optimizing plan design can reduce costs by 20-40%.

In the next chapter, we'll explore how employers can overcome resistance to change, effectively communicate health plan improvements, and gain leadership buy-in for fiduciary-driven healthcare strategies.

10

Overcoming Resistance to Change – Gaining Leadership and Employee Buy-In

Introduction: Why Employers Struggle to Implement Change

Even when the financial and fiduciary benefits of healthcare reform are clear, many employers struggle to implement meaningful changes to their health plans.

Resistance often comes from:

- Leadership concerns about disrupting employee benefits and causing dissatisfaction.
- Employee skepticism due to fear of losing access to preferred doctors or hospitals.
- Lack of awareness about cost-saving alternatives such as reference-based pricing

(RBP), direct primary care (DPC), and transparent PBMs.

Fact: A 2023 survey found that 60% of employers want to implement cost-saving health plan changes but fear employee pushback (National Business Group on Health, 2023).

Fact: Companies that proactively educate employees on health plan changes experience 90% higher adoption rates and satisfaction (Harvard Business Review, 2023).

This chapter will outline how employers can gain leadership buy-in, educate employees effectively, and overcome resistance to change while implementing fiduciary-focused health plan strategies.

1. Understanding the Root Causes of Resistance

A. Leadership Concerns: "If It's Not Broken, Don't Fix It"

Executives often hesitate to change health benefits due to:

- Fear of employee dissatisfaction or increased complaints.
- Concerns about disrupting long-standing vendor relationships with TPAs and carriers.

- Lack of familiarity with alternative models like direct contracting and reference-based pricing.

Case Study: A large financial services company hesitated to switch to a transparent PBM model due to leadership concerns. After conducting a financial analysis, the CFO realized the company was overpaying by $3.5 million per year due to hidden pharmacy fees. The company implemented a transparent PBM and saved 28% on drug costs (Employer Benefits Roundtable, 2023).

B. Employee Fears: "Will I Lose My Doctor?"

Employees often assume that plan changes mean fewer choices or higher out-of-pocket costs.

Employer-driven health plan improvements often:

- Expand provider access by eliminating restrictive PPO networks.
- Lower out-of-pocket expenses by reducing deductibles and copays.
- Improve healthcare quality by steering employees toward high-performance providers.

Fact: A 2023 study found that employers who effectively communicate plan changes see a 70% improvement in employee satisfaction (Health Affairs, 2023).

C. Broker and Vendor Pushback: "You're Rocking the Boat"

Traditional brokers and carriers profit from the status quo and may resist plan changes that:

- Reduce their commissions, rebates, or administrative fees.
- Increase employer control over pricing and provider selection.
- Require full financial transparency that exposes hidden costs.

Case Study: A 1,500-employee tech company discovered that its broker was earning undisclosed overrides and bonuses from its TPA and carrier. When the company demanded fee transparency and switched to a fiduciary advisor, it saved $2 million annually (Employer Fiduciary Audit Report, 2023).

2. How to Gain Leadership Buy-In for Health Plan Changes

A. Build a Financial Business Case

- Show executive leadership the financial impact of inaction by calculating current health plan waste.
- Use benchmark data to compare costs with similar-sized companies that have optimized their plans.
- Highlight fiduciary risks under ERISA and potential liability exposure for leadership.

Fact: CFOs and CEOs are five times more likely to approve health plan changes when presented with financial projections and compliance risks (Harvard Business Review, 2023).

Case Study: How a Manufacturer Secured Executive Approval for Plan Changes

A 2,000-employee manufacturing firm was reluctant to change its fully insured health plan. However, after presenting an analysis showing:
$6 million in excess spending due to PPO markups and spread pricing.

Legal exposure to fiduciary lawsuits due to lack of plan oversight.

Projected savings of $3,500 per employee per year with direct contracting and a transparent PBM.

Leadership approved a self-funded transition with direct contracting, saving the company 25% in healthcare costs while improving employee benefits (Self-Insured Employer Case Study, 2023).

3. Effectively Communicating Health Plan Changes to Employees

Once leadership is on board, employees must understand how plan changes benefit them. The most successful employers:

A. Focus on Employee Benefits First (Not Just Cost Savings)

- Emphasize how the new plan improves access to high-quality care.
- Highlight lower deductibles, reduced out-of-pocket costs, and better provider options.
- Address common concerns like “Can I still see my doctor?” with clear answers.

Fact: Employees are twice as likely to support plan changes when communication focuses on benefits instead of cost reduction (National Business Group on Health, 2023).

B. Use Multiple Communication Channels

- Host town hall meetings and Q&A sessions for employees.
- Use video explainers to simplify complex health plan changes.
- Send out FAQ documents addressing common concerns.

Case Study: A Retail Company’s Employee Education Strategy

A 4,500-employee retail company switched from a PPO network to a direct contracting model. To ensure smooth adoption, they:

- Held 20+ employee town hall meetings to explain plan changes.
- Created online comparison tools so employees could see their cost savings.
- Set up a dedicated benefits hotline to address concerns in real time.

As a result, 97% of employees stayed with the new plan, and the company cut costs by $12 million in one year (Health Rosetta Employer Report, 2023).

4. Managing the Transition: Steps to Implement Change Smoothly

A. Pilot the New Plan with a Subset of Employees

- Start with one division or geographic location before rolling out company-wide.
- Collect employee feedback and address concerns proactively.

B. Partner with a Fiduciary Advisor for Implementation

- Work with an advisor who is legally obligated to act in the employer's best interest.
- Ensure full transparency in contracts, pricing, and vendor agreements.

C. Measure Success and Make Adjustments

- Track employee satisfaction and healthcare utilization data.
- Adjust plan design based on employee feedback and cost trends.
- Publish annual reports to leadership showing cost savings and health outcome improvements.

Fact: Companies that continuously measure and adjust their health plans experience a 15% greater

cost reduction over five years (National Business Group on Health, 2023).

Conclusion: The Path to Sustainable, Employer-Led Healthcare

- Resistance to health plan changes is natural, but strategic communication and data-driven decision-making can drive adoption.
- Employers must focus on employee benefits, not just cost savings, to gain buy-in.
- Measuring success and adjusting the plan ensures long-term cost control and improved outcomes.

In the next chapter, we'll discuss how to measure success and create a continuous improvement strategy for long-term health plan sustainability.

11

Measuring Success and Continuous Improvement

Introduction: The Importance of Tracking Health Plan Performance

Making changes to an employer-sponsored health plan is just the beginning. To ensure long-term success, employers must measure the impact of their new strategies, continuously optimize plan performance, and make data-driven decisions. Without ongoing evaluation, even the best-designed health plans can:

- Drift back toward higher costs due to vendor mismanagement.
- Fail to deliver expected savings if employees don’t engage with the new model.
- Miss opportunities to improve employee health outcomes.

Fact: A 2023 study found that only 30% of employers regularly track their health plan’s financial performance, leading to uncontrolled cost increases (National Business Group on Health, 2023).

Fact: Employers who implement regular claims audits, cost benchmarking, and employee engagement strategies achieve 20-40% greater cost savings over five years (Health Affairs, 2023).

This chapter will outline the key performance indicators (KPIs) employers must track, how to analyze claims data, and how to create a long-term

strategy for continuous cost control and quality improvement.

1. Key Metrics Employers Must Track

To measure success, employers must track the right KPIs across three major categories:

A. Financial Performance Metrics

These metrics determine whether the health plan is reducing costs and improving efficiency.

- Total healthcare spend per employee per year (PEPY)
  Cost trends compared to industry benchmarks
- Pharmacy spend per employee (with PBM transparency)
- Claims paid at or below Medicare reference-based pricing rates
- TPA administrative costs as a percentage of total spend

Fact: Employers who monitor financial KPIs and adjust strategies accordingly reduce healthcare costs by an average of $2,500 per employee per year (Health Rosetta, 2023).

B. Employee Health and Engagement Metrics

These metrics ensure that employees are receiving high-quality, cost-effective care.

- Preventive care utilization rates (annual wellness visits, screenings)

- Emergency room visits per 1,000 employees
- Chronic disease management program participation
- Percentage of employees using high-value providers (Direct Primary Care, Centers of Excellence)
- Satisfaction ratings on health plan changes

Fact: A 2023 study found that companies with higher employee engagement in health benefits had 20% lower overall healthcare costs (Journal of Occupational Health, 2023).

C. Plan Compliance and Fiduciary Oversight Metrics

These metrics ensure the plan meets ERISA fiduciary requirements and eliminates unnecessary spending.

- Percentage of vendor contracts reviewed annually for hidden fees
- Percentage of rebates and discounts passed back to the employer
- Claims error rate and dispute resolution outcomes
  Adherence to direct contracting and reference-based pricing agreements

Fact: Employers who conduct annual fiduciary audits and renegotiate contracts eliminate 10-20% of unnecessary spending (National Alliance of Healthcare Purchasers, 2023).

2. How to Analyze Claims Data and Identify Cost-Saving Opportunities

A. Conducting a Claims Audit to Detect Waste and Fraud

- Review high-cost claimants and their care pathways to ensure they receive cost-effective treatment.
- Identify inappropriate ER visits and redirect employees to lower-cost alternatives (Direct Primary Care, Telemedicine).
- Detect excessive hospital charges and negotiate reimbursement adjustments.

Case Study: A 2,500-employee logistics company audited its claims data and found that one hospital system was billing 500% of Medicare rates for common procedures. By enforcing reference-based pricing, the company cut hospital costs by 35% in one year (Employer Benefits Roundtable, 2023).

B. Benchmarking Costs Against Industry Standards

- Compare total healthcare spend per employee to similar-sized companies.
- Compare hospital reimbursement rates to Medicare pricing.
- Compare PBM drug costs to National Average Drug Acquisition Cost (NADAC) benchmarks.

Fact: Employers who benchmark pricing identify cost-saving opportunities worth 15-25% of their total healthcare spend (RAND Corporation, 2023).

C. Evaluating Employee Engagement with Cost-Saving Strategies

- Track how many employees are using Direct Primary Care instead of high-cost specialists.
- Measure utilization of Centers of Excellence for major procedures.
- Analyze prescription drug utilization trends to ensure employees are using cost-effective medications.

Case Study: A mid-sized construction company saw that only 20% of employees were using the new Direct Primary Care option, leading to continued ER overutilization. By offering $0 copays for DPC visits and hosting an employee education campaign, they increased participation to 80% and reduced ER visits by 40% (Self-Funded Employer Study, 2023).

3. Creating a Long-Term Strategy for Continuous Improvement

A. Set Annual Cost and Quality Goals

- Target a specific cost reduction percentage (e.g., 10% per year).
- Increase employee preventive care visits by 20%.
- Reduce unnecessary ER visits by 30%.

B. Conduct Regular Vendor Performance Reviews

- Ensure TPAs and PBMs are adhering to fiduciary standards.
- Benchmark hospital and specialist pricing against industry data.
- Require full transparency from all vendors on fees and reimbursements.

Fact: Employers who conduct annual vendor reviews reduce administrative costs by an average of 12% (Employer Fiduciary Audit Report, 2023).

C. Implement Employee Incentives for High-Value Healthcare Utilization

- Offer lower deductibles or cash rewards for using high-quality, lower-cost providers.
- Provide financial incentives for chronic disease management participation.
- Promote telemedicine and direct primary care to reduce ER visits.

Case Study: A 5,000-employee company implemented a $500 incentive for employees who used Centers of Excellence for surgeries instead of standard in-network hospitals. This resulted in:

- A 60% shift in surgeries to lower-cost, higher-quality providers.
- $3,500 in savings per procedure.

- Higher employee satisfaction with the health plan (National Business Group on Health, 2023).

4. Ensuring Long-Term Success: The Employer's Fiduciary Commitment

To maintain cost control and compliance, employers should:

- Conduct an annual fiduciary audit of all contracts and claims.
- Negotiate lower-cost alternatives for high-cost procedures and specialty drugs.
- Monitor employee satisfaction and health outcomes to ensure long-term plan success.

Case Study: A Company That Reduced Healthcare Costs by 40% Over 5 Years

A large transportation company implemented a long-term strategy focused on:

- Direct contracting with providers instead of relying on PPO networks.
- A fully transparent PBM model with pass-through pricing.
- Ongoing claims audits and vendor negotiations.

Over five years, they reduced total healthcare costs by 40% while improving employee health outcomes (Health Rosetta Employer Case Study, 2023).

Conclusion: Employers Must Take a Proactive Approach to Long-Term Health Plan Success

- Tracking financial performance, employee health outcomes, and vendor accountability is essential for controlling costs.
- Employers who use data-driven decision-making achieve sustainable cost savings of 20-40%.
- Regular audits, benchmarking, and employee engagement strategies drive continuous improvement.

In the next chapter, we'll conclude the Fiduciary Playbook by outlining the next steps employers must take to implement a long-term, cost-effective health plan strategy.

Conclusion

Taking Action Today

The Cost of Inaction is Too High

For decades, employers have been trapped in a broken healthcare system, burdened by rising costs, opaque pricing, and misaligned incentives. As we've explored throughout this book, the status quo is no longer sustainable:

- Employer healthcare costs have risen 272% since 2000, far outpacing wage growth and inflation (KFF Employer Health Benefits Survey, 2023).
- U.S. hospitals charge employers an average of 224% of Medicare rates, with some exceeding 500% (RAND Hospital Pricing Report, 2023).
- ERISA lawsuits against employers for failing their fiduciary duty have skyrocketed, exposing businesses to financial and legal risks (Bloomberg Law, 2023).

Despite these challenges, employers have more control than they realize. Those who take proactive steps to reclaim ownership of their health plans can:

- Cut healthcare costs by 20-40% while improving employee benefits.
- Protect themselves from legal liability by acting as responsible fiduciaries.
- Enhance employee satisfaction by providing better care at a lower cost.

Case Study: A 3,000-Employee Manufacturer Saves $12 Million in 3 Years

A self-insured manufacturing company was struggling with double-digit annual cost increases under its traditional PPO health plan.

Leadership decided to take a fiduciary-driven approach by:

- Auditing its health plan for hidden fees and renegotiating TPA and PBM contracts.
- Implementing Direct Primary Care (DPC) and Centers of Excellence (COE) to reduce hospitalizations.
- Moving to Reference-Based Pricing (RBP) to eliminate excessive hospital markups.

Within three years, the company cut healthcare costs by $12 million while maintaining high employee satisfaction (Employer Benefits Coalition Report, 2023).

Your Next Steps: Implementing the FRAMEwork

To create a sustainable, cost-effective health plan, employers must apply the FRAMEwork outlined in this book:

1. Facilitate Transparent Benefit Advisory Services

- Replace traditional brokers with fiduciary advisors who work for the employer, not the insurance carriers.
- Require full fee transparency and eliminate commission-based conflicts of interest.
- Audit PBM contracts to remove hidden fees and maximize savings.

Fact: Employers who use fiduciary benefit advisors save an average of $2,500 per employee per year (Health Rosetta, 2023).

2. Review Plan Documents and Design

- Conduct a full audit of TPA and PPO contracts to uncover hidden fees.
- Shift away from broad PPO networks that inflate hospital pricing.
- Ensure all vendor contracts align with fiduciary compliance standards.

Case Study: A 1,500-employee logistics firm renegotiated its PPO contract and eliminated a 15% hospital surcharge, saving $2 million annually (Employer Fiduciary Audit Report, 2023).

3. Advance Value-Based Care Solutions

- Implement Direct Primary Care (DPC) to reduce unnecessary ER visits and improve chronic disease management.
- Adopt Centers of Excellence (COE) to steer employees toward high-quality providers with lower complication rates.
- Move away from fee-for-service models to value-based payments that reward providers for outcomes, not volume.

Fact: Employers who integrate Direct Primary Care (DPC) reduce overall healthcare costs by 20-30% (Journal of Occupational Health, 2023).

4. Manage Independent PBM Strategies

- Eliminate spread pricing and require pass-through pricing for prescription drugs.
- Negotiate direct contracts with independent pharmacies to lower costs.
- Require full audit rights on drug pricing and rebates.

Case Study: A school district in Kentucky discovered PBM spread pricing inflated drug costs by 800%. By switching to a transparent PBM, they saved $1.5 million in the first year (Kentucky State PBM Audit, 2023).

5. Eliminate PPO Network Constraints

- Adopt Reference-Based Pricing (RBP) to cap hospital reimbursements at a fixed percentage of Medicare rates.
- Negotiate direct provider contracts instead of relying on PPO discounts.
- Use high-performance networks (HPNs) to prioritize cost-effective, high-quality providers.

Fact: Employers who exit PPO networks in favor of direct contracting reduce healthcare costs by 15-30% (National Business Group on Health, 2023).

Building a Culture of Fiduciary Oversight

As an employer, you are not just purchasing a health plan—you are managing a financial asset that affects the long-term stability of your business and the well-being of your employees. **That means:**

- Holding TPAs, PBMs, and insurance vendors accountable to fair pricing and transparency.
- Conducting regular plan audits to ensure costs remain controlled and fiduciary duties are met.
- Educating employees about their benefits and steering them toward high-value healthcare choices.

Fact: Employers who take a hands-on, data-driven approach to managing their health plan reduce total spending by an average of 25% (RAND Corporation, 2023).

Case Study: A Transportation Company Saves $20 Million by Taking Control of Its Health Plan

A 5,000-employee transportation company was facing rising healthcare costs and declining employee satisfaction. Leadership decided to take control of the plan, implementing:

- A fiduciary health plan audit, uncovering $5 million in hidden fees.
- Direct contracting with providers, reducing hospital spending by 40%.
- Transparent PBM pricing, lowering drug costs by 35%.

Over five years, they saved $20 million while improving employee engagement and health outcomes (Health Rosetta Case Study, 2023).

A Call to Action: It’s Time to Take Control

This book has provided the blueprint for a fiduciary-driven health plan that protects both your business and your employees. The question now is:

Will you take action?

- Are you ready to break free from excessive costs and hidden fees?
- Will you hold vendors accountable and demand transparency?
- Can you commit to a long-term strategy that benefits your employees and your bottom line?

Employers who take control of their health plans don't just save money—they create a competitive advantage by offering superior benefits at a lower cost. The time for passivity is over. The Fiduciary Playbook is in your hands.

Now, it's time to act.

Your next step: Conduct a health plan fiduciary audit and begin implementing the FRAMEwork today.

The future of your company's healthcare strategy depends on it.

Final Thought: **Join the Movement**

If this book has inspired you to rethink your approach to employer healthcare, you are not alone.

More businesses are embracing fiduciary health plan management and demanding a better way.

Join the growing movement of employers who are taking control, cutting costs, and delivering better healthcare for their employees.

- Engage with employer coalitions focused on fiduciary healthcare solutions.
- Share your success stories and learn from other forward-thinking companies.
- Advocate for transparency and fair pricing in the healthcare industry.

Together, we can fix employer-sponsored healthcare —one company at a time.

Appendix

Real-World Examples of Employers Taking Control of Their Fiduciary Responsibility

1. A Manufacturing Company Saves $5 Million by Auditing Its Health Plan

A 3,000-employee manufacturing firm conducted an independent audit of its health plan after noticing continuous cost increases. The audit revealed:

- $1.2 million in hidden administrative fees charged by its TPA.
- Over 400% markups on hospital services due to PPO network constraints.
- A PBM contract that failed to pass back over $2.5 million in rebates.

Actions Taken:

- Switched to direct contracting with hospitals, reducing hospital fees by 35%.
- Renegotiated PBM terms to eliminate spread pricing, saving $1.8 million in drug costs.
- Implemented reference-based pricing (RBP), reducing specialist visit costs by 25%.

Total savings: $5 million annually while improving employee benefits and healthcare access (National Alliance of Healthcare Purchasers, 2023).

2. A School District Eliminates $3 Million in Overcharges from Its PBM

A large public school district in Texas suspected that pharmacy costs were rising too quickly despite having a traditional PBM contract.

Audit Findings:

- The PBM charged 800% markups on generic drugs.
- Less than 50% of manufacturer rebates were passed back to the school district.
- The contract contained a "gag clause" prohibiting cost transparency.

Actions Taken:

- Hired an independent PBM that operates on a flat fee model instead of spread pricing.
- Required 100% of rebates to be returned to the school district.
- Implemented formulary management to encourage lower-cost alternatives.

Total savings: $3 million in the first year while reducing out-of-pocket costs for employees (Texas State PBM Audit, 2023).

3. An Employer Coalition Saves $7 Million by Exiting a PPO Network

A coalition of self-funded employers in Florida banded together to break away from traditional PPO networks after conducting a claims analysis.

Findings:

- Hospitals were billing 500% of Medicare rates for standard procedures.
- Emergency room visits cost up to 600% more than market benchmarks.
- PPO contracts prevented employers from negotiating directly with providers.

Actions Taken:

- Eliminated PPO network constraints and negotiated direct provider contracts.
- Implemented Centers of Excellence (COE) programs for high-cost procedures.
- Used reference-based pricing to cap hospital payments at 180% of Medicare rates.

Total savings: $7 million annually with higher employee satisfaction and better care quality (Florida Employer Benefits Roundtable, 2023).

Fiduciary Compliance Checklist for Employers

Conduct a Full Health Plan Audit

- Review all TPA, PBM, and PPO contracts to identify hidden fees and conflicts of interest.
- Benchmark plan costs against industry standards (Medicare rates, reference-based pricing).
- Ensure all vendor revenue streams are disclosed.

Ensure Full PBM Transparency

- Require a pass-through PBM model (no spread pricing, 100% rebates returned).
- Eliminate gag clauses and demand full access to claims data.
- Implement step therapy and formulary management to encourage cost-effective drug choices.

Eliminate PPO Network Waste

- Conduct a hospital price transparency analysis to compare PPO rates to Medicare pricing.
- Consider direct contracting with high-quality providers to avoid excessive PPO markups.
- Implement reference-based pricing (RBP) to cap hospital reimbursements.

Monitor Third-Party Administrators (TPAs)

- Ensure TPA fees are fixed and transparent—no per-claim markups.
- Require regular audits of administrative fees and hospital pricing.
- Confirm that all plan documents align with fiduciary standards under ERISA.

Regularly Analyze Claims Data

- Review utilization reports to identify overuse of emergency rooms, unnecessary procedures, and high-cost prescriptions.
- Work with a fiduciary advisor to negotiate lower-cost alternatives for services and medications.
- Use data-driven strategies to manage chronic disease and reduce high-cost claims.

Educate Leadership and Employees on Cost-Saving Strategies

- Provide clear communication on how plan changes improve affordability and quality.

- Train HR and finance teams on fiduciary best practices to ensure compliance.
- Offer employee incentives for using high-value healthcare providers.

Conclusion: Taking Action on Your Fiduciary Duty

- Employers who fail to monitor health plan costs face increasing legal and financial risks.
- Conducting fiduciary audits, eliminating waste, and demanding transparency can cut healthcare costs by 20-40%.
- Employers must hold their TPAs, PBMs, and brokers accountable to protect both their business and employees.

FOR LEADERS RESPONSIBLE FOR PROFIT, RISK, AND PEOPLE.

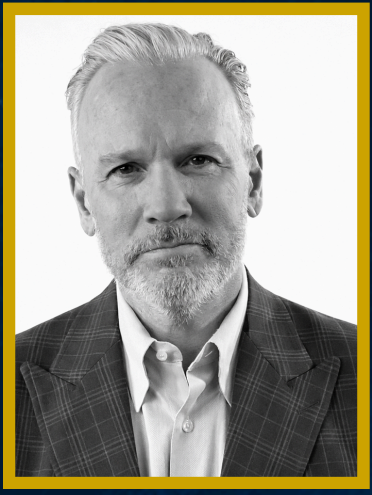
Slashing healthcare costs without sacrificing quality isn't just possible, it's a fiduciary-duty.

TAKE BACK CONTROL OF YOUR HEALTHCARE SPEND

Healthcare costs don't have to rise year after year.

This book gives CEOs, CFOs, business owners, and executive teams a practical blueprint to reduce healthcare costs by 20% to 40% without sacrificing the quality of care employees receive.

Inside, you'll discover the proven strategies, tools, and fiduciary framework that forward-thinking organizations are using to replace opaque, commission-driven health plans with transparent, accountable, high-performance benefits. You'll learn how to take control of one of your largest operating expenses while improving outcomes for both your business and your people.



ABOUT THE AUTHOR

Glenn Fisher is the CEO of NavMD and Founder of Fidewell, where he helps employers transform healthcare from an uncontrollable expense into a strategic business advantage.

Through data-driven insights, fiduciary leadership, and transparent benefit strategies, Glenn partners with CEOs, CFOs, HR executives, and boards of directors to eliminate waste, improve plan performance, and build health plans that deliver measurable financial results while better serving employees.

Learn More

Fiduciary-Ally.com