

Voluntary Benefits Voice

M A G A Z I N E



**Benefits Guidance:
The Problem
Nobody Is Talking
About**

**Everyone Is
Innovating.
Employees Still
Can't Tell.**

**Industry Innovation
in 2026: From
Product Expansion to
Smarter Benefit
Strategy**

VOLUNTARY ADVANTAGE

ADVISORY BOARD

Jennifer Daniel
Aflac



Paul Hummel



Jack Holder
EBIS



Rachel McCarter
Alliant



Mark Rosenthal
PwC



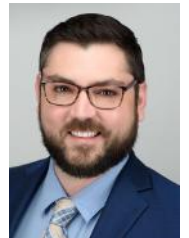
Tim Schnoor
BusinessSolver



Seif Saghri
Founder



**Hunter Sexton,
JD, MHA**
Sydney Consulting
Group



EDITORIAL STAFF

Editors

Heather Garbers | Trevor Garbers

For Media and Marketing Requests Contact:

Heather@voluntary-
advantage.com

Trevor@voluntary-advantage.com

Mailing Address

10940 S Parker Rd #257
Parker, Colorado 80134

KEY CONTRIBUTORS



FOLLOW US ONLINE
www.voluntary-advantage.com



FOLLOW US ON LINKEDIN
Voluntary Advantage

TABLE OF CONTENTS

- **Benefits Guidance: The Problem Nobody Is Talking About**
-
- **How a Shifting Economy Is Rewriting The Rules of Benefits Design**
-
- **Meeting Customers Where They Are: Innovation With a Human Touch**
-
- **From “Check The Box” To “Prove It Works”**
-
- **Everyone is Innovating: Employees Still Can’t Tell**
-

KEY CONTRIBUTORS



**Tapping Into
Tech Talent**



**Industry Innovation
in 2026**



Relational Leadership Experience

**Saying the
“Unsaids”**

From The Editor...

The voluntary benefits industry continues to face a credibility challenge that is largely self-inflicted: a lack of transparency around commissions, claims and utilization data. Employers are increasingly sophisticated purchasers of benefits, yet many carriers still refuse to provide even basic performance metrics that would allow clients and advisors to evaluate plan value objectively.

I had a discussion recently with a health insurance carrier in the VB realm that currently declines to provide any type of claims utilization data for groups with under 500 employees and will never provide loss ratios for any size group. Their reasoning? They do not believe this data is "credible". You can imagine my shock.



Especially, as I then listened to how advanced they are from a medical claim integration perspective. My response? How would I know that this is working when you won't share the data?

Their position is difficult to justify in an era where employers are being asked to absorb rising premiums, contribute more toward employee healthcare costs, and make strategic decisions based on measurable outcomes. We as an industry are being held accountable for the value provided by these plans as you can see from recent legislation and litigation.

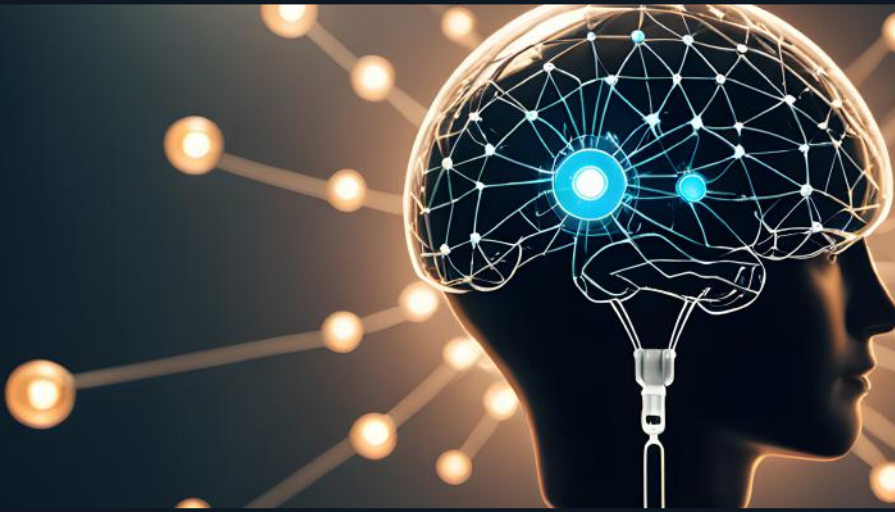
I also believe that utilization reporting should not be reserved only for large employers. Small and mid-sized businesses deserve the same visibility into plan performance as any Fortune 500 company. Without access to utilization trends, paid claims information, or loss ratio data, employers are left making renewal decisions with incomplete information, effectively being asked to trust without verification.

This lack of openness damages the perception of the entire industry. When carriers refuse to share data, it naturally raises the question: what are they trying to protect? Strong-performing programs should withstand scrutiny. In fact, carriers that provide meaningful reporting demonstrate confidence in their products, pricing, and long-term value proposition.

At Voluntary Advantage, we believe transparency is essential to building trust between carriers, brokers, and employers. Data-driven decision-making should be the standard, not the exception. Employers deserve partners willing to share the information necessary to evaluate program performance, control costs, and improve employee outcomes.

The future of voluntary benefits will belong to organizations that embrace accountability, collaboration, and transparency - not those that withhold the very data clients need to make informed decisions.

We may have more exciting news to come on this topic in the near future. Stay tuned.



**JULY 14-15, 2026
VIRTUAL
CONFERENCE**

ANYTHING IS POSSIBLE: THE NEW ERA OF VOLUNTARY BENEFITS

The voluntary benefits industry is no longer limited by traditional distribution models, legacy enrollment methods, or static products. With new technology, data insights, and partnerships, the future of voluntary benefits is limited only by imagination.



➤ REGISTER NOW

PLATINUM SPONSORS

OnePack Plan™
by petpartners



norton™
LifeLock Benefit Solutions

pasito



GOLD SPONSORS



FINEOS

MassMutual 175

VOLUNTARY ADVANTAGE

Tapping Into Tech Talent

What They Want From Their Voluntary Benefits

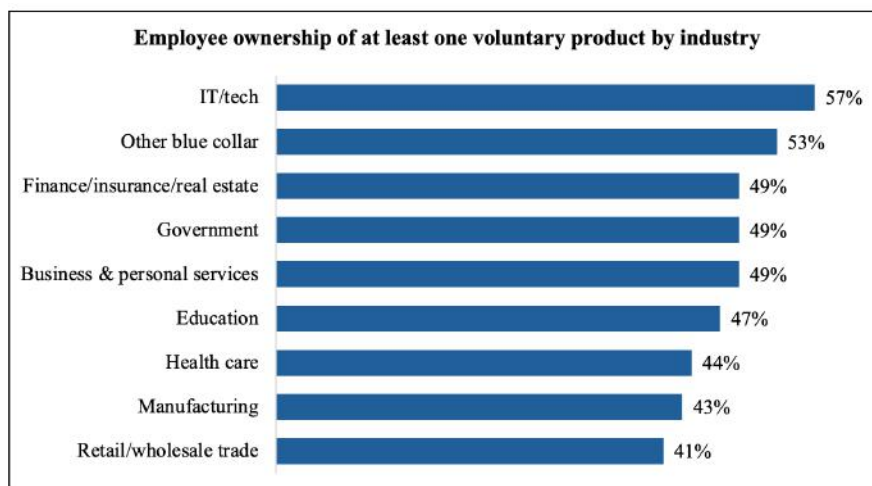
By Eastbridge Consulting Group, Inc.

From easier enrollments to faster claims payment, technology is driving innovation across the employee benefits industry - and pretty much every other industry, too. No wonder, that IT-related occupations are among the fastest-growing, most highly paid career fields in the country according to the [Bureau of Labor Statistics](#).

There is a wide variety in tech industry jobs, but these employees do share some commonalities when it comes to their workplace benefits - and some significant differences from employees in other industries. Voluntary carriers, brokers and employers who want to successfully attract and meet the needs of these highly skilled workers can benefit from taking time to understand their preferences.

High Voluntary Product Ownership

Employees in IT/technology industries are the most likely of all employees to own at least one voluntary product, according to Eastbridge's recent "Employee Demographic Details: Exploring Attitudes and Behaviors About Voluntary/Worksite Benefits - Employer Size and Industry" report. More than half (57%) of tech employees own some type of voluntary coverage, and they are also among those most likely to own multiple products: 78% of those who own voluntary coverage own two or more products, and 43% own three or more.



Source: Eastbridge Consulting Group

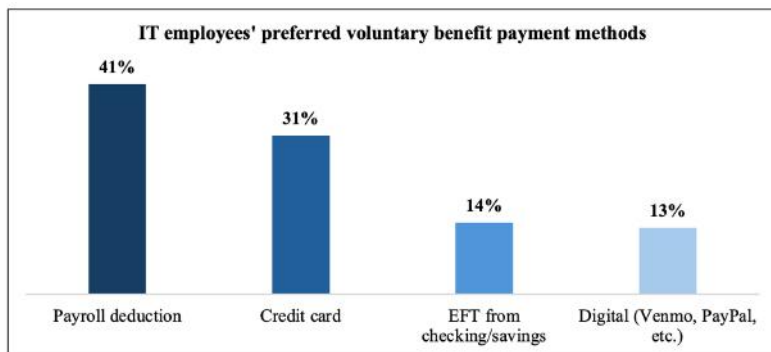
Digging deeper, the research shows tech workers have the highest ownership of voluntary health products including prescription drug, vision, dental and accident insurance. IT employees are significantly more likely than those in any other industry to own hospital indemnity, critical illness and cancer coverage. They also have some of the highest ownership rates of voluntary security products, especially long-term care insurance, owned by 11% of IT employees compared to 2%–8% of employees in other industries.

More than one-quarter (28%) of IT employees own voluntary life insurance (either whole/universal or term) - the highest rate of employees in any industry.

“IT employees also are much more likely to have access to and use a wide range of noninsurance benefits, especially telemedicine, mental health, purchasing programs and financial wellness programs,” points out Ginger Bates, Eastbridge’s Director of Research. “In fact, our study shows IT employees are about twice as likely as any other employees to have access to these benefits.”

Premium Payment Preferences

Payroll deduction continues to be the most popular payment method for voluntary benefits among employees across all industries, but IT/technology/software employees somewhat buck the trend here. They are less likely than employees in other industries to prefer payroll deduction and have a much stronger preference than other employees for using a credit card to pay their voluntary benefit premiums.



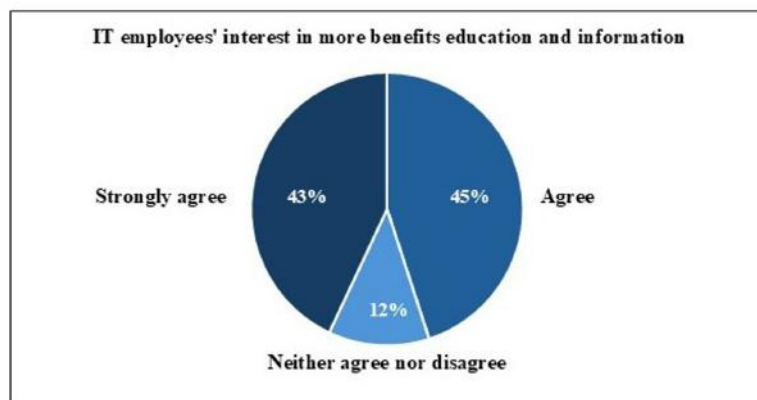
Source: Eastbridge Consulting Group

Purchase Decision Drivers

The reasonable cost of the coverage is the top reason employees in most industries buy voluntary insurance, and IT employees agree - in fact, 100% of them list it number one. They are also the most likely employee group to say these products fill gaps in their medical coverage (99%) and that the insurance fills a personal need (98%).

Tell Me More

IT employees surveyed express strong interest in learning more about their employee benefits. A strong majority (88%) are interested in receiving more education and information from their employer about benefits, a significantly higher percentage than for any other employee group.



Source: Eastbridge Consulting Group

Most Helpful Communication

Not surprisingly, employees in IT industries are much more likely than other employees to say information on a website or mobile app is the most helpful way their employer communicates with them about voluntary benefits. Similar to other employees, tech workers also list emails or newsletters from their employer and group meetings with other employees among the best communication methods. But they're also significantly more likely than other employees to say virtual meetings are helpful - again, perhaps not surprising due to their comfort working in the digital world.

Combining High-Tech And High-Touch

IT employees are fairly aligned with those in other industries when it comes to how they want to learn about their voluntary benefit options. The top preference in most industries is for employees to learn on their own through information sent by their employer. That holds true for IT employees (31%), followed by on their own using the internet (20%).

But just because IT employees' work is high-tech doesn't mean they don't also value personal, individual communication. Speaking with someone in person is tied for the number two option, closely followed by a one-to-one video session, the highest of all employees at 17%.

Plug Into The IT Market

Tech companies can offer a strong market opportunity in the voluntary benefits industry. Understanding the nuances of the needs and preferences of these engaged and often well-compensated employees can help carriers and brokers stand apart from the competition and position themselves for better success.



Danielle Lehman
Senior Consultant

Eastbridge is the source for research, experience, and advice for companies competing in the voluntary space and for those wishing to enter. For over 25 years, they have built the industry's leading data warehouse and industry-specific consulting practice. Today, 20 of the 25 largest voluntary/worksite carriers are both consulting and research clients of Eastbridge.

OnePack Plan™

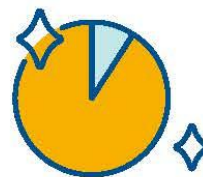
by petpartners

Group Pet Insurance, Made Simple



OnePack Plan™ Benefits

- One policy, one renewal date
- Coverage options for pre-existing conditions after 12 months*
- The only group pet insurance able to fully integrate with most benefits administration platforms.



91% of our groups
have not seen a
rate increase in the
past 5 years.¹



[OnePackPlan.com](https://www.onepackplan.com) | SalesSupport@PetPartners.com | 866-774-1113

¹91% of our groups have not seen a rate increase in the past 5 years. Based on PetPartners rates from 2020-2025.

*Pre-existing conditions may be eligible after 365 days of continuous coverage. Waiting periods, annual deductible, co-insurance, benefit limits and exclusions may apply. For all terms and conditions visit <https://www.petpartners.com/sample-policies>. Products, schedules, and rates may vary and are subject to change. Discounts may vary and are subject to change. Premiums are based on and may increase or decrease due to the age of your pet, the species or breed of your pet, and your home address. Insurance products are underwritten by Independence American Insurance Company (NAIC #26581) or Independence Pet Insurance Company (NAIC #17543), both are domiciled in Delaware with corporate offices in Scottsdale, AZ. Policies are produced by PetPartners, Inc. (NPN #7612549, Scottsdale, AZ. California producer license #0F27261, PPI Pet Insurance Agency, Inc.).



Industry Innovation in 2026

From Product Expansion to Smarter Benefit Strategy

By PES Benefits

Innovation in employee benefits is often framed as a steady stream of new products, however over the past few years, that definition has shifted. What brokers are seeing now is less about adding another offering, and more about rethinking how benefits are structured, delivered, and measured.

In 2026, innovation in the benefits space is being driven by three forces: rising healthcare costs, increased employee choice, and a growing expectation from employers that benefits should produce measurable outcomes. For brokers, this creates an opportunity to move beyond transactional placement and into more strategic advisory roles.

Innovation Is Being Driven by Cost Pressure

Healthcare costs continue to shape employer decision-making. As costs rise, employers are less interested in incremental changes and more focused on structural solutions that improve predictability and efficiency.

One of the clearest examples of this shift is the growth of defined contribution models such as Individual Coverage Health Reimbursement Arrangements. According to data from the HRA Council, ICHRA adoption “grew 29% year-over-year” between 2023 and 2024, reflecting accelerating employer interest in alternative funding strategies [1].

This growth is not limited to small employers. Adoption among applicable large employers increased significantly as well, signaling broader acceptance of non-traditional plan designs.

As costs rise, employers are less interested in incremental changes and more focused on structural solutions that improve predictability and efficiency.

The takeaway for brokers is straightforward. Innovation is no longer optional. Employers are actively seeking models that help control cost volatility while maintaining access to care.

The Shift Toward Individualization

Another defining trend in benefits innovation is the movement away from standardized group offerings toward more individualized experiences.

ICHRA plays a role in this shift by allowing employers to provide a defined contribution while employees select their own coverage. This introduces a level of personalization that traditional group plans cannot easily replicate.

Industry data shows that this model is expanding access as well. In 2024, "83% of employers adopting ICHRA... had not previously offered group coverage," highlighting its role in extending benefits to previously uncovered populations [2].

For brokers, this shift changes how benefits are positioned. Instead of designing a single solution for an entire workforce, the focus moves toward supporting a range of individual decisions. That requires stronger education, better communication, and more integrated support tools.

Technology Is Changing How Benefits Are Used

Innovation is also happening at the infrastructure level. Digital tools, benefits platforms, and virtual care solutions are reshaping how employees interact with their benefits.

This matters because access alone does not guarantee utilization. Employees need to understand what is available and how to use it effectively.

Research from the Agency for Healthcare Research and Quality emphasizes that "effective care coordination can improve health outcomes and reduce unnecessary healthcare utilization" [3].

This highlights a key point. Innovation is not just about offering more services. It is about making those services easier to access and navigate.

Virtual care is a clear example. While it expands access, its value depends on whether employees actually use it instead of higher-cost alternatives such as emergency rooms or urgent care centers.

Technology that connects benefits, simplifies access, and guides decision-making is becoming just as important as the benefits themselves.

Technology that connects benefits, simplifies access, and guides decision-making is becoming just as important as the benefits themselves.

Innovation Is Redefining the Broker's Role

As the benefits landscape evolves, so does the role of the broker. Employers are no longer looking solely for plan recommendations. They are looking for guidance on how to structure benefits in a way that aligns with financial and workforce goals.

This shift is particularly visible in conversations with finance leaders. Rising healthcare costs have pushed benefits strategy into broader business discussions, requiring brokers to speak in terms of outcomes rather than features.

Employers want to know how benefits impact retention, productivity, and overall cost management. They are asking more detailed questions about utilization, engagement, and return on investment.

Innovation, in this context, becomes a tool for differentiation.

Brokers who understand how to connect benefit design with measurable outcomes are better positioned to retain clients and grow their book of business.

Where Voluntary Benefits Fit into Innovation

Voluntary benefits are also being reshaped by these trends. In a more individualized benefits environment, supplemental coverage plays a larger role in addressing gaps created by high deductibles and variable coverage.

Instead of being positioned as optional add-ons, voluntary benefits can be integrated into a broader strategy that supports financial protection and access to care.

This is particularly relevant as employees take on more responsibility for their healthcare decisions. When employees select their own coverage, they are more likely to encounter gaps that voluntary benefits can address.

For brokers, this creates an opportunity to reposition voluntary offerings as part of a coordinated benefits strategy rather than a secondary consideration.

What This Means for 2026

Looking ahead, innovation in benefits will continue to move toward integration, personalization, and measurable outcomes. Employers will expect more transparency, better data, and clearer connections between benefits and business performance.

The rapid growth of models like ICHRA and the continued investment in digital health tools suggest that the traditional group benefits structure will continue to evolve.

For brokers, the opportunity is to stay ahead of that shift. This means understanding not just the products available, but how those products fit into a larger strategy. It also means focusing on execution - education, communication, and navigation are becoming central to the success of any benefits program. Without them, even the most innovative solutions may fail to deliver value.

Innovation in this space is not about chasing trends. It is about identifying what actually works for employers and employees and building strategies that reflect those realities. Brokers who take that approach will be better positioned to grow their relationships, demonstrate value, and compete in a market that is becoming more complex and more demanding.

Sources:

1. HRA Council. (2024). ICHRA Growth and Adoption Data. Referenced via Becker's Payer: <https://www.beckerspayer.com/payer/ichra-growth-up-nearly-30-since-2023/>
2. HRA Council. (2024). 2024 Data Report Insights.
3. <https://flytehcm.com/hra-council-2024-data-report/>
4. Agency for Healthcare Research and Quality. (2024). Care Coordination and Healthcare Quality. <https://www.ahrq.gov/ncepccr/care/coordination.html>



PES Benefits is dedicated to revolutionizing the employee benefits landscape with cutting-edge technology, administration, education, and virtual care solutions. Since its inception, PES Benefits has focused on simplifying the benefits experience, making it more accessible and meaningful for all involved.



Benefits Guidance

The Problem Nobody Is Talking About

By Meg Collins & Ben Yomtoob

Benefits programs exist to protect the health, financial security, and well-being of workers - that is the foundational premise of everything this industry does. Yet, the data tells a troubling story about how well we are actually delivering on that promise.

Businessolver's 2024 Benefits Insights Report (drawn from data across 4.4 million employees), finds that an average of 85% of employees struggle to understand their benefits [1]. LIMRA's 2025 BEAT Study confirms the gap: only 57% of employees say they understand their insurance benefits very or extremely well, meaning nearly 4 in 10 workers enter enrollment without a confident grasp of the coverage they are selecting [2]. This is clearly not a marginal failure. It represents a failure of the entire system. ***Employees default to last year's elections without reassessing their circumstances.***

They skip voluntary benefits they would genuinely value if they understood them.

They may even find themselves financially exposed when a health crisis hits because they did not enroll in the supplemental coverage that would have protected them.

The industry's response has been to deploy technology — a wave of guidance tools, AI-powered platforms, and decision support engines. But the proliferation of tools has not solved the problem, in fact, in many cases it has made it harder to navigate.

Defining the Guidance Framework

Before evaluating the vendor landscape, it is worth establishing a framework for thinking about what benefits guidance actually does, because the category names vendors use tell you very little about when and how a tool serves employees. As a starting point, via input from multiple stakeholders, we propose the following framework for Benefits Guidance.

We call this the **Educate / Decide / Use framework (EDU)**. It effectively organizes the Benefits Guidance challenge into its three constituent events.



The value of this framework is not in ranking tools; it's in exposing gaps. For brokers advising employers and carriers evaluating distribution, that question has real consequences: which moments in the employee journey are covered and which are being left to chance? Beyond online or paper Benefits Guides, most employers have tools that cover only one moment — typically Decide. The Educate and Use moments are the ones most often absent or outdated. For voluntary benefits carriers, the Use moment is the most critical for utilization and persistency — and it is the most underserved.

AI-powered guidance platforms... Care navigation solutions... The category names multiply faster than the independent evidence that any of them really add value.

This proliferation is a sign of genuine innovation, but the market has outpaced the infrastructure needed to evaluate it. The landscape spans at least six distinct categories: decision support tools, communication and education platforms, care navigation and advocacy, benefits administration platforms with embedded guidance, HCM/payroll platforms with benefits modules, and emerging specialized tools.

Most vendors now claim to serve at least two events of the Educate/Decide/Use framework. But most do not achieve this — at least not equally well.

Most vendors now claim to serve at least two events of the Educate/Decide/Use framework. But most do not achieve this - at least not equally well. Furthermore, not all tools operate from a neutral position. Some are carrier-connected, platform-embedded, or vendor-connected in ways that shape what employees see, and those relationships are rarely disclosed proactively.

A Market That Has Never Defined Itself Holistically

Walk into any benefits technology conference today and you will find no shortage of vendors claiming to solve the guidance challenge. Decision support tools... Benefits assistants. Recommendation engines...

“AI-powered guidance” is used to describe tools with fundamentally different architectures (rule-based calculators, algorithmic engines, and large language models) and buyers often cannot tell the difference. The terminology problem is real.

AI Is In The Field. The Governance Is Not.

This is the most urgent dimension of the guidance problem and it contains a contradiction the industry has not yet fully reckoned with.

MetLife's 2026 Employee Benefit Trends Study found that 61% of employees are concerned about the ethical and safety risks of AI, including bias, misinformation, and lack of accountability. At the same time, 67% of employers say AI is creating new points of friction or mistrust between employees and management [3]. Yet a new WTW survey finds that while only 20% of employers actively use AI in benefits today, 72% plan to embed it within the next two years - driven by the need to improve communication (68%) and deliver personalized employee support (57%). The ambition is clear. The readiness is not: 71% of benefit teams lack the internal AI resources needed, 70% cite data privacy and security as top barriers, and only 1% currently have a fully developed AI governance framework for benefits [4]. The tools are coming. The governance is not.

Into that gap steps the Shadow Agent. Employees are not waiting for their employer to provide a better tool — they are already using one, just not one managed by their employer. Recent data shows that 52% of U.S. adults now use large language models like ChatGPT, and nearly two-thirds of Americans have used AI for financial advice [5]. In the benefits context, that means employees are copying their Summary of Benefits and Coverage into ChatGPT, asking Claude to explain their HDHP, or using Gemini to compare premiums. The Shadow Agent fills the void the official guidance stack left open, and it does so with absolute confidence and zero accountability.

The problem is not that employees are using AI. It is that they are using AI that has no knowledge of their specific plan design, no understanding of voluntary benefit eligibility rules, and no ownership for the guidance it provides. A public model trained on the internet (not your plan documents), will confidently answer a question about fertility coverage, HSA eligibility, or supplemental life insurance with information that sounds authoritative but may be completely wrong. If the employee acts on it, the consequences are real.

They are using AI that has no knowledge of their specific plan design, no understanding of voluntary benefit eligibility rules, and no ownership for the guidance it provides

The sanctioned tools being deployed in the market carry their own risks. A rule-based calculator may not handle the underwriting nuances that make voluntary benefits complex. An algorithmic engine trained primarily on core medical data may systematically underweight voluntary products. A generative AI system may produce confident-sounding guidance that is factually incorrect about specific plan designs. But the Shadow Agent carries all of those risks - just without the oversight.

The era of "benefits guidance is a nice-to-have" is over. In a world where the alternative to a company-sponsored tool is a consumer tool not designed for the job, the absence of a governed guidance strategy is itself a decision - and not a defensible one.

The Baseline The Market Has Not Yet Set

Across our work developing an evaluation framework for this market, a consistent picture has emerged of what separates genuinely effective guidance from tools that are guidance in name only.

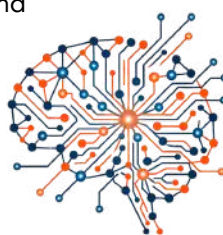
Effective Guidance Requires:

- Year-round presence: Not just at open enrollment, but at every guidance moment (life events, claims questions, mid-year decisions).
- Voluntary benefits depth: Coverage of the full benefits portfolio, not just core medical, dental, and vision.
- Transparency of methodology: The ability to explain why a recommendation was made, and disclosure of any commercial relationships that may shape what employees see.
- Validated outcomes: Independently reviewed demonstrated evidence - proof that those employees who used the tool made better decisions than those who did not.

Rather than being aspirational standards, these measures should be a baseline. And right now, the market does not have a shared framework for measuring whether any given tool meets them.

Building the Infrastructure the Market Needs

The benefits guidance market has the tools it needs. What it lacks is the infrastructure to evaluate them: shared terminology, independent evaluation frameworks, and validation methodologies that give buyers, brokers, and carriers a consistent basis for distinguishing between tools that work and tools that are well-marketed.



**THE BENEFITS GUIDANCE
CONSORTIUM**

The Benefits Guidance Consortium, co-founded by Ben Yomtoob and Meg Collins, is an independent coalition of vendors, brokers, employers, carriers, and investors working to establish a shared standard for benefits guidance. The Consortium is building the infrastructure the market needs to evaluate guidance tools consistently and independently, grounded in three principles: Clarity, Transparency, and Validation.

Learn more at benefitsguidanceconsortium.org.

Building that infrastructure is the work of The Benefits Guidance Consortium, an independent coalition of vendors, brokers, employers, carriers, and investors working to establish a shared standard for benefits guidance grounded in three principles: Clarity, Transparency, and Validation.

Later this year, the Consortium will publish its inaugural State of the Market white paper - the first independent, methodology-driven evaluation of the benefits guidance landscape. It will establish a shared taxonomy and assess tools across the dimensions outlined in this article.

This article is the first in a series. Future installments will examine individual categories in depth and report on the Consortium's findings as the white paper takes shape. The tools recommending, or failing to recommend, your products are already in the field. The standard for how they should perform is still being written. The brokers and carriers who engage in shaping that standard now will be the ones best positioned for what comes next.

Sources

1. Businessolver | 2024 Benefits Insights Report — businessolver.com
2. LIMRA | 2025 BEAT Study: Benefits and Employee Attitude Tracker — limra.com, June 2025
3. MetLife | 2026 Employee Benefit Trends Study — metlife.com, March 2026
4. WTW | 2026 AI Use in Health and Benefits Survey — wtwco.com, May 19, 2026
5. Elon University, Imagining the Digital Future Center | "Close Encounters of the AI Kind" — imaginingthedigitalfuture.org, March 12, 2025; Intuit Credit Karma | Generative AI and Financial Advice Survey — creditkarma.com, October 2025



Financial wellness needs a modern upgrade

Give employees the tools to better understand, manage, and protect their finances every day.

Financial stress affects productivity, engagement, and retention, but education alone isn't enough. Norton Money Workplace helps employees build financial confidence with personalized insights and practical tools all in one platform.

Take action and discover real financial clarity



All-in-one financial view

See spending, savings, and debt in one place



Everyday control

Track trends, manage expenses, and stay on top of your money



Guidance & education

Get expert-backed insights, answers, and coaching for smarter decisions



Built-in protection

Monitoring helps safeguard financial activity

Make financial wellness a priority

An easy-to-position, easy-to-implement benefit that helps employees build confidence with their money.

Reach out today to get started

 EB_Sales@GenDigital.com

 844-698-8640



How can I reduce my discretionary spending?
[Learn more](#)



No one can prevent all identity theft or all cybercrime.

Copyright © 2026 Gen Digital Inc. All rights reserved. Norton LifeLock Benefit Solutions is part of Gen—a global company dedicated to powering Digital Freedom through its trusted consumer brands including Norton, Avast, LifeLock, MoneyLion and more.



How a Shifting Economy Is Rewriting the Rules of Benefits Design

By Rachel Fox

Think back to 2019. Unemployment was near historic lows. Wages were finally ticking upward. The talent war was fierce, and employers were competing on benefits breadth: fertility coverage, pet insurance, student loan repayment, legal services, financial planning apps. The buffet was long and growing.

Underlying it all was a largely unspoken assumption: employees were financially stable enough to engage thoughtfully with long-term planning and optional benefits. For a growing share of today's workforce, that assumption no longer holds.

The economic shocks of the past five years have fundamentally changed that equation. Inflation, rising consumer debt, housing costs, healthcare affordability challenges, and persistent financial instability have reshaped what employees need from their benefits, and what employers can realistically afford to provide.

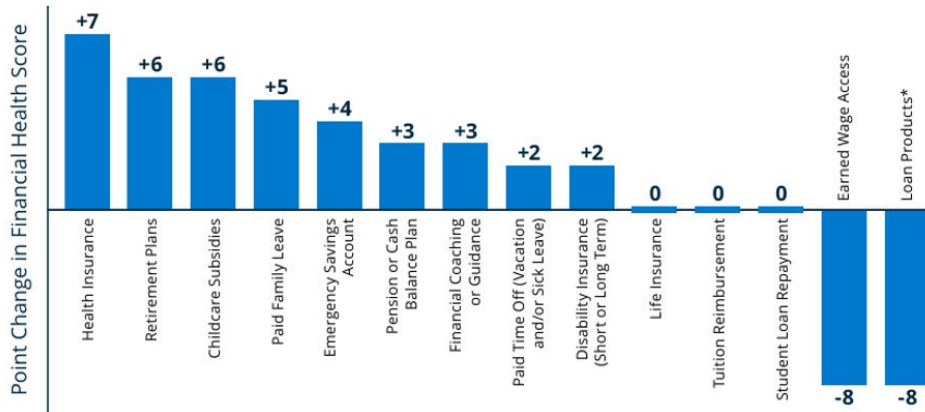
The question for brokers in 2026 is no longer whether the workforce has changed - it has. The question is whether the benefits strategies we recommend reflect the realities of the workforce standing in front of us today, or the one that existed before the floor dropped out.

The Economy Has Changed the Conversation

The numbers are hard to look away from: most American workers are living paycheck to paycheck, credit card and auto delinquencies have climbed to levels not seen since the Great Recession, and retirement plan loans and early withdrawals continue rising across major recordkeepers.

The Federal Reserve says 37% of Americans can't cover a \$400 unexpected expense. According to Empower, the median emergency savings balance for Americans is just \$500, and one in three Americans has no emergency savings at all.

Figure 1. The Relationship Between Essential Benefits and Financial Health Score



Source: Financial Health Network’s Essential Benefits – A New North Star for Wage and Benefit Design

This isn't just a low-wage worker story. A MarketWatch Guide survey found 36% of those earning more than \$200,000 annually are living paycheck-to-paycheck. Morgan Stanley’s workplace financial benefits research found that 56% of employees say financial stress negatively affects their work, while 80% of HR managers say it’s hurting productivity.

Gen Z and Millennials will soon make up over two-thirds of the workforce, and their disengagement from traditional benefits strategies isn’t irrational. In many cases, it’s a response to a system designed around financial assumptions that no longer reflect how much of the workforce actually lives.

Healthcare Is Consuming The Budget and The Conversation

Healthcare costs are not just rising; they are crowding out other areas of benefits investment. Employers aren't saying no to better benefits because they don't care, they are saying no because healthcare has consumed the budget.

This creates a painful irony: the benefit employers spend the most on, is increasingly underutilized because employees can't afford to use it.

When we think about the value of the benefit stack advisors are building, it's worth asking not just whether employees technically have access to benefits, but whether they are financially positioned to use them.

The Benefits Stack Was Built For a Different Employee

Pre-pandemic, advisors could reasonably design around an assumed employee: someone with enough financial stability to make thoughtful, forward-looking decisions during open enrollment. That assumption no longer describes the majority of today’s workforce.

The Financial Health Network (Figure 1) found that benefit design matters as much as benefit access. Benefits built around assumptions of financial stability often fail to reach the employees facing the greatest financial precarity.

An HDHP without employer HSA contributions may technically provide coverage, but it still requires employees to absorb upfront costs they may not be financially positioned to handle. HSAs were intended to help employees prepare for healthcare expenses tax-efficiently. Increasingly, however, they are positioned as long-term investment vehicles, which assumes workers have enough liquidity to leave the money untouched in the first place.

Benefits that assume liquidity don't just underperform; they widen the gap between what employers believe they're providing and what employees are realistically able to use. The manufacturing worker paying off one 401(k) loan only, to take another larger one isn't doing so because he doesn't understand retirement planning. He's responding rationally to immediate financial pressure with the only liquidity option he's been given.

When employees feel benefits weren't built for them, they disengage. The 401(k) match gets left behind, supplemental coverage goes unused, and at renewal, HR is frustrated over nonengagement, and the CFO asks why they're paying for a stack that workers aren't using.

What We've Tried and What It's Cost Us

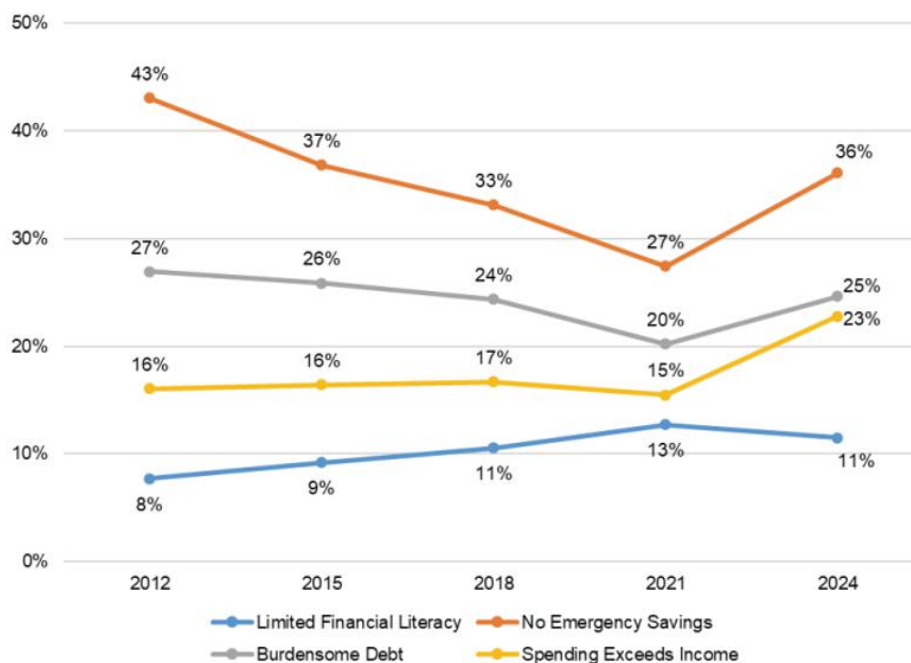
The industry has responded in two main ways: financial education, and emergency assistance through loans, grants or paycheck advances. Both address the symptom and leave the underlying issue in place.

Financial education programs have proliferated for two decades. But behavior change requires a mechanism for action, not just information. Advising someone who can't cover a \$400 unexpected expense to build a three-month emergency fund isn't a strategy, it's handing a cookbook to someone who doesn't have a kitchen.

FINRA reveals (Figure 2) that financial literacy is not the primary driver of financial stability. Cash flow strain, debt burdens, and lack of emergency savings matter more - Meaning employees can fully understand financial concepts and still be broke, in debt, and without savings.

Emergency assistance, when thoughtfully deployed, can absolutely be a bridge when savings are insufficient. But when debt becomes the first line of defense rather than a last resort, it creates a cycle rather than a solution. At a moment when 90-day delinquencies are at Great Recession levels, adding to the debt load of an already-stretched workforce is not innovation - especially when it's free for the employer to offer.

Figure 2. Prevalence of Financial Vulnerabilities Among Retirement Savers, 2012-2024.



Source: FINRA Foundation, National Financial Capability Study (2012-2024)

Earned wage access and payroll-deducted loans may provide short-term relief in crisis but do nothing to prevent the next crisis around the corner. FHN also found these products are disproportionately used by workers already experiencing financial vulnerability. The pattern matters. People are reaching for these solutions when they don't have cash in the crisis, because the benefit structure has prioritized easy access to rescue over resilience.

The reality is simple: if employees are able to pay back a loan through payroll deduction, they are also capable of building savings proactively through payroll deduction.

Emergency assistance grants can also play a valuable role, particularly in catastrophic situations. But without a savings foundation underneath them, employers often find themselves repeatedly stepping into smaller crises that liquid savings could have prevented in the first place. Fundamentally, if employers are always the FEMA, employees will never build the levees on their own.

Meanwhile, retirement savings, where employers have invested heavily for decades, continue leaking because for too many workers, it's the single place for all their savings. "Set it and forget it" was never designed to mean "break in case of emergency." Yet employees continue to reach for the only money they have put away.

According to Empower's CEO, hardship withdrawals from 401(k) plans are running 15% to 20% above the historical norm. For many frontline workers, retirement savings can still feel like a ladder that starts ten feet off the ground. It helps explain why the most common retirement account balance in America today is still zero.

Across all of these approaches, a pattern emerges: most interventions activate after financial instability is already present.

Very few are designed to help employees build unrestricted liquidity before the storm arrives. Many benefit advisors have seen this coming for years and found themselves caught between a workforce signaling distress and employer clients not ready to act on it. But the data is deafening now, and those same employers who weren't ready to listen three years ago are running out of reasons not to.

According to Empower's CEO, hardship withdrawals from 401(k) plans are running 15% to 20% above the historical norm.

What the Industry's Own Research Is Telling Us

The industry's largest research organizations are increasingly pointing toward the same conclusion: financial stress is no longer a peripheral workforce issue. It's operational.

WTW found that 66% of employers say employee financial wellbeing is a priority over the next three years, yet only 14% say they are effective at improving it. Gallagher found that financial wellbeing has risen sharply in employer importance rankings, while Aon tied benefits inequity directly to lower employee wellbeing and retention outcomes.

Disengagement maps to employees feeling their benefit options were built for the HCEs who make decisions around tax optimization and 30-year investment plans, not the majority of the American workforce struggling to make it to Friday.

Financial Stress Has Become a Workforce Issue

The economic pressures reshaping benefits strategy in 2026



37%

NO EMERGENCY SAVINGS

of Americans can't cover a \$400 emergency expense.



36%

HIGH-INCOME STRUGGLE

of households earning more than \$200,000 annually are living paycheck-to-paycheck.



56%

EMPLOYEE IMPACT

of employees say financial stress negatively affects their work.



80%

EMPLOYER IMPACT

of HR leaders say financial stress is hurting productivity.



Financial resilience is increasingly the condition under which every other benefit either **works—or doesn't.**

Commonwealth found that at a major healthcare employer, 73% of eligible employees enrolled in a workplace emergency savings program, and those employees contributed more to retirement savings while taking fewer loans and hardships than nonparticipants.

AARP research found that 77% of employees would participate in a workplace emergency savings program if offered, rising to 90% with an employer incentive. A two-year field study published in ILR Review found an 87% reduction in traffic violations among financially stressed truck drivers who began building liquid savings – a striking illustration of how financial stability can influence focus, decision-making, safety outcomes, and productivity well beyond personal finances.

The policy landscape is shifting as well. SECURE 2.0 brought the first federal legislation around workplace emergency savings account (ESA) programs.

Employers like Best Buy, Starbucks, and Delta have already launched emergency savings initiatives, while EBRI predicts more than 77% of companies plan to offer emergency savings programs in the next year or two. Sunny Day Fund's saver population data, featured by FHN, shows 19.5% lower turnover among employees saving in an ESA compared to nonparticipants.

At a time when most HR executives say hiring and retention is the top strategic financial priority – that number lands differently than it did even two years ago.

During periods of prolonged economic uncertainty, employees gravitate toward simplicity, flexibility, and emotional safety – and liquid savings meets all three. Frontline workers will always prioritize unrestricted access to money over complex or obscure tax advantages.

The Question Worth Asking

The explosion of financial wellness resources on the market reflects how urgently both employers and employees are searching for solutions. But the conversation increasingly needs to move beyond adding more narrow point solutions built around a single life event, when they're all fundamentally trying to address the same underlying issue: the need for accessible money that employees can use for the financial pressures directly in front of them, regardless of the category.

The important question is whether the benefits package being assembled actually improves outcomes for workers, and whether those outcomes can be meaningfully measured across each benefit. If we're trying to manage what isn't measured, the goal posts are floating.

This requires a more honest reckoning with the role financial stability now plays in whether employees can meaningfully engage with any benefit at all. Financial resilience is increasingly the condition under which every other benefit either works or does not.

Rachel Fox, VP of Sales & Partnerships, Sunny Day Fund - is a seasoned industry expert with 24 years in employee benefits – including operating her own voluntary benefits agency, work as a benefit broker, and building financial wellness programs. Rachel brings deep ecosystem fluency to her work supporting employers, brokers, and retirement plan advisors to align benefit strategies with operational objectives. She currently leads partnerships at Sunny Day Fund, the country's first and still highest-yielding out-of-plan Emergency Savings Account (ESA) program.



 **MassMutual**

Workforce Financial Stability Score drops

In May, the Workforce Financial Stability ScoreSM (WFSS) decreased by 1.4 points, reversing the growth seen the previous month, with declines across all dimensions led by a 2.2-point drop in working Americans' ability to manage expenses between paychecks and help others financially. Compared to May 2025, the WFSS is up 2.2 points, with most dimensions higher except for the ability to manage expenses between paychecks, which remained flat, while confidence in meeting longer-term goals saw the largest increase (+3.4 points).

Workforce Financial Stability ScoreSM

58.5

Check out the Latest Scores

Worksite Better.

FOR FINANCIAL PROFESSIONALS. NOT FOR USE WITH THE PUBLIC.

©2026 Massachusetts Mutual Life Insurance Company (MassMutual®), Springfield, MA 01111-0001.

All rights reserved. www.MassMutual.com.

MM202705-316143

58.8



Meeting Customers Where They Are

Innovation with a Human Touch

By Jennifer Beck

In today's benefits environment, employees increasingly evaluate their workplace experience through the same lens they apply to every other service they use. They expect interactions to be intuitive, responsive, and personalized - whether they are opening a banking app, scheduling healthcare, or navigating their employee benefits.

These expectations are increasingly shaped by experiences that emphasize real-time updates, seamless design, and convenient access to support. As a result, the standard for what defines a "good" digital experience at work has fundamentally changed.

That raises the stakes for brokers and providers alike. It is no longer enough for providers to offer strong benefits on paper. The experience surrounding those benefits (how easy they are to access, understand and use) has become part of the value proposition itself.

In a competitive labor market, that experience can also influence how employees perceive their employer overall, shaping satisfaction, trust, and even retention over time.

For brokers, customer experience has become an increasingly important differentiator when evaluating voluntary benefits partners. Employers want solutions that employees will actually engage with, and employees expect support that feels both convenient and human.

As technology continues to evolve, particularly with the rapid advancement of AI-driven tools, the conversation has shifted. The question is no longer whether to incorporate digital innovation into the benefits experience, but how to do so in ways that genuinely improve outcomes without losing the human connection employees still value.

The organizations leading the way are those finding the right balance: leveraging technology to remove friction and improve access while ensuring employees can still connect with knowledgeable experts when it matters most.

From “High Tech vs. High Touch” to “High Tech + High Touch”

For years, customer experience discussions often framed technology and personal service as competing priorities. In reality, employees don’t think in terms of channels. They simply want the right support at the right moment.

That may mean quickly accessing information online during enrollment, scheduling support digitally after hours or using self-service tools to address a straightforward issue independently. In other situations, particularly more complex or emotionally charged ones, employees may need reassurance, guidance, and the ability to speak directly with a trusted expert.

The most effective customer experiences are designed to support the full spectrum of preferences seamlessly.

For brokers evaluating voluntary benefits solutions, this balance matters. Providers that successfully integrate high-tech capabilities with high-touch service are often better positioned to deliver stronger engagement, higher satisfaction, and a more consistent employee experience.

The Three Pillars of a Strong Customer Experience

While expectations continue to evolve, the fundamentals of a strong customer experience remain remarkably consistent. Three key pillars help define what matters most.

1

Relevant, Adaptive Benefits

Employees expect benefits to evolve alongside their changing needs, financial realities, and life stages.

For example, a recent graduate may initially prioritize financial wellness resources or identity protection. Later, estate planning tools, caregiving support or legal assistance tied to major life events may become more meaningful. Benefits that remain aligned with employees’ evolving circumstances are more likely to feel relevant and valuable over time.

Just as important, employees expect benefits to deliver consistently on the brand promise. If the experience of using a benefit feels confusing, slow, or difficult, perceived value can diminish quickly - regardless of how strong the coverage may appear during enrollment.

2

Ease of Use at Critical Moments

The benefits experience is often shaped during pivotal moments, such as when enrolling in coverage, using the benefit, especially for the first time, or seeking support during a stressful situation.

At those moments of truth, simplicity matters. Even small barriers (like unclear next steps, too many clicks or delayed responses), can quickly compound stress and discourage employees from fully using their benefits.

Intuitive digital experiences can help customers access information quickly and take action without unnecessary friction. Conversely, complicated processes, unclear communication or delayed responses can create frustration and erode trust.

Employees may not remember every interaction, but they will remember whether getting help felt easy, responsive, and supportive when they truly needed it.

3 A Thoughtful Blend of Technology and Human Support

As AI and digital capabilities continue to expand, organizations across the benefits ecosystem are exploring new ways to improve efficiency and personalization.

The most effective implementations are designed to enhance the overall experience by applying technology to facilitate routine interactions while preserving meaningful human support where it delivers the greatest value.

Employees appreciate the ability to move fluidly between digital and human interactions depending on the situation and their preferences.

The most effective implementations are designed to enhance the overall experience by applying technology to facilitate routine interactions while preserving meaningful human support where it delivers the greatest value.

A Practical Example: AI-Enhanced Legal Plans

Ultimately technology enhancements should be designed to improve convenience and accessibility, while employees maintain access to professionals when they need more personalized experience.

Personalization. Convenience. Transparency.



Legal Insurance

From simple questions to complex matters, employees get legal support tailored to their needs – with innovative self service tools, clear coverage details and no surprises along the way.

This valuable coverage helps employees avoid costly legal fees, reduce stress and ensure they stay focused and productive at work.

[Learn More About ARAG Legal Insurance](#)



Looking Ahead: The Future of Voluntary Benefits Customer Experience

As technology continues to evolve, so will expectations around the benefits experience. Advances in AI, data analytics and digital platforms will make it possible to deliver more personalized, proactive and efficient interactions than ever before. Employees will increasingly expect benefits that anticipate their needs, provide relevant guidance and offer support in real time.

With technology handling more routine interactions, human expertise will focus more on higher-value conversations. The organizations that will be those that understand how to integrate both elements intentionally rather than treating them as separate experiences.

Ultimately, meeting customers where they are will require a continued focus on both innovation and connection, delivering experiences that are as human as they are efficient.

Jennifer Beck, VP, ARAG Customer Experience & Insights - As VP, Jennifer is responsible for the overall experience of ARAG's members through the research, analysis, and evaluation of current processes and future trends of both consumer expectations and industry innovations. ARAG Legal Insurance, the leading legal insurer worldwide, connects people with affordable and reliable legal counsel for everyday life needs. Contact: Jennifer.Beck@ARAGlegal.com





Everyone Is Innovating. Employees Still Can't Tell.

By Lydia Jilek

Innovation is one of the most overused words in benefits. Every platform claims it, every product launch promises it, and every industry conversation seems to come back to AI, automation and digital transformation.

But employees do not experience innovation as a technology category. They experience it in far more practical terms: whether a claim is easier to file, whether a benefit feels relevant to their life, whether enrollment decisions are easier to make, and whether support is there when something goes wrong.

The data tells the story. Two-thirds of employees spend less than one hour on open enrollment. Only 30% are enrolled in supplemental health benefits through their employer, and another 11% are not sure whether they are enrolled. But when people do use supplemental coverage, 67% say it is helpful [1].

The gap is not that benefits lack value. It is that the value is hard to see, hard to activate, or too disconnected from the moment employees need it.

That disconnect matters even more in a high-cost environment. LIMRA's 2025 BEAT study shows employees' median maximum out-of-pocket spend on benefits is \$150 per month, and 35% say they are spending more than last year [2].

The gap is not that benefits lack value. It is that the value is hard to see, hard to activate, or too disconnected from the moment employees need it.

Under that kind of pressure, progress should be measured by what employees feel: easier claims, more relevant products, clearer decisions and AI they can trust.

Claims Are Where Innovation Should Prove Itself

If innovation is real, the claims experience is where it should show up first. AI can be powerful here, but only if it is used with discipline. Routine claims should feel effortless, while complex claims should still feel human. The goal is not to automate more moments. It is to automate the right moments.

Some claims models can now help eligible supplemental health claims receive decisions within minutes, with payment processing beginning immediately. Real-time status updates can reduce uncertainty, and AI-enabled fraud detection can help protect benefit integrity. But speed cannot come at the expense of judgment. Complex cases should move into human-in-the-loop review, and automation should not be the sole basis for a claim denial [3].

Today's workforce is asking different questions, facing different costs, and building families in different ways than benefit categories were originally designed around.

Claims innovation also has to do more than accelerate adjudication. It must help employees realize the value of coverage they already elected. That is why medical claims integration, or MCI, matters. In one large-employer case study, we saw 43% of employees opt into MCI during enrollment. Subsequently, more than 1,100 qualifying claims were identified that had not yet been submitted, and more than 68% of all 2025 claims were initiated through MCI.³ That is not just process efficiency, it is benefit value realized.

Technology alone is not enough. Not every employer has medical claims integration yet, and even when they do, reminders still matter because employees forget what they have, are not sure what qualifies, and may simply need a clear nudge at the right time.

That calls for better trigger-based communication, clearer claims education and simpler prompts to act. A 2026 workplace benefits study reinforces the point: 14% of employees forget what benefits are available, and quarterly nudges can be the difference between a benefit that pays and one that is forgotten [1].

Product Innovation Matters Just as Much as Process Innovation

Innovation in voluntary benefits is not only about improving how benefits work. It is also about improving what benefits cover.

The industry needs to widen the lens. Today's workforce is asking different questions, facing different costs, and building families in different ways than benefit categories were originally designed around. A family-building research study found that 64% of employees factor current economic conditions into decisions about starting or expanding a family, while 83% of Gen Z and 77% of Millennials say family-building benefits are important in the workplace [4]. The same broader market trend shows up externally. WHO reports that around 1 in 6 adults globally experience infertility, and KFF found that 13% of women ages 18 to 49 say they or their partner needed fertility assistance at some point. KFF also reports that about 27% of large firms offering health benefits cover IVF [5].

Those numbers help explain why product relevance is now central to innovation.

1		AFFORDABILITY 64% factor economic conditions into family-building decisions.
2		DEMAND 83% Gen Z and 77% Millennials value family-building benefits at work.
3		ACCESS 1 in 6 adults face infertility, while only 27% of large employers offer IVF coverage.

Reproductive health is not a niche conversation anymore. It is part of how employers compete for talent and how employees evaluate whether benefits reflect real life. Voluntary benefit designs are beginning to reflect that reality, with some critical illness coverage expanding to address broader reproductive health needs, including fertility-related procedures, menopause-related conditions and other disorders affecting the reproductive system. Hospital indemnity coverage can also support family-building moments through labor and delivery resources [6].

Some needs are foreseeable while others are not. Many hospital indemnity claims tied to maternity are planned, and people can think ahead for those moments. But no one plans to fall on the ice, break a leg, or receive a serious diagnosis earlier than expected. Good product design must do both: support known life-stage needs and help people hedge risk against the moments nobody wants to plan for.

The same mindset applies beyond reproductive health. Accident coverage, caregiver-adjacent benefits, family support features and emergency transport protection all point to a broader shift: product innovation is strongest when it is built around modern risk, not legacy categories [6].

Responsible AI is What Makes Innovation Credible

Responsible AI should not be treated as a separate conversation from innovation. In benefits, it is part of the value story.

That is especially true in fraud prevention. The National Health Care Anti-Fraud Association estimates that health care fraud costs the system tens of billions of dollars annually, with some estimates running far higher [7]. Fraudsters are using more sophisticated tools, including AI.

For brokers and HR leaders, the right question is no longer simply whether a carrier uses AI. It is where AI helps, where a person steps in, and how plan integrity is protected without adding friction for legitimate claims.

Carriers need to keep up, not just to protect themselves, but to help keep benefits affordable and preserve dollars for legitimate claims. For brokers and HR leaders, the right question is no longer simply whether a carrier uses AI. It is where AI helps, where a person steps in, and how plan integrity is protected without adding friction for legitimate claims.

Three Questions Brokers Should Ask When a Carrier Says it Uses AI

1



Which moments are automated, and why?

2



Where does a human always step in?

3



How is plan integrity protected without adding friction for legitimate claims?

A Better Standard for Progress

The next phase of voluntary benefits will favor carriers that turn the word “innovation” into practical value: simpler claims, more relevant coverage, clearer decisions and stronger trust. Brokers and HR leaders who pressure-test carriers on those four dimensions can deliver measurably better outcomes at renewal.

The measure of progress is not what looks impressive in a demo. It is what employees experience when they enroll, file a claim or face a moment they did not plan for.

Sources:

1. The Affordability Trap whitepaper (2026).
<https://www.securian.com/employers/industry-insights/the-affordability-trap.html>.
2. LIMRA, 2025 BEAT Study: Benefits and Employee Attitude Tracker.
3. Securian Financial claims and medical claims integration data, 2025–2026.
4. The Future of Family white paper. Future of Family: Why family-building benefits are essential to engage tomorrow’s workforce study, 2025.
5. World Health Organization, “1 in 6 people globally affected by infertility,” and KFF, “Access to Fertility Care: Findings from the 2024 KFF Women’s Health Survey” and “Will Trump’s Announcement Expand Access to IVF?”
6. Reproductive health and supplemental health product materials; emergency transport product materials; MASA claims data, January 2024; FAIR Health, September 2023.
7. National Health Care Anti-Fraud Association, “The Challenge of Health Care Fraud,” nhcaa.org.

Lydia Jilek, 2nd Vice President, Voluntary Benefits Practice Leader - Securian Financial. In this role, she leads strategy for voluntary benefits and supplemental health solutions, with a focus on product innovation, responsible technology use and the employee experience.



A photograph of two men sitting at a wooden table in a meeting. The man on the right has curly brown hair and is wearing a white button-down shirt, looking towards the other man. The man on the left is seen from the back, wearing a light blue shirt. The background is a blurred office setting with plants and a wooden cabinet.

Saying the “Unsaids”

By Steve Clabaugh, CLU, ChFC

Relational leaders demonstrate that they care for their team members as much as the organization. As a result, they create, build and lead high-performance teams that consistently achieve excellence.

“Small deeds done are better than great deeds planned.” – Peter Marshall

So far, this year we’ve covered the first 4 Principles of Championship Team Behavior:

1. We Work Together as Colleagues
2. We Don’t Accept Case Building When Planning or Executing Business Plans
3. We Don’t Tolerate Blaming
4. We Deal with Breakdowns Not Problems

P & E Products, Inc. was a high quality agricultural equipment manufacturing company that contracted with independent manufacturers’ representatives to sell its products to tractor dealers across the United States. The company financed the dealer’s purchases letting them pay for the equipment as they made sales to their customers.

The financing program was structured so the earlier they paid for the equipment the smaller the amount they owed thus incentivizing quick turnaround to maximize profits. The sales representatives were then paid commissions when the dealers paid for the equipment, so they had great incentive to support the dealers in making sales.

And that’s where the breakdown occurred and continued for many years.

P & E’s Accounting Department calculated commissions due based on payments received by the 20th of each month. Commission checks then were sent out by the last business day of the month.

Commissions for payments received after the 20th were deferred to the following month requiring reps to wait up to 40 additional days before they were paid. And every month there was a virtual explosion of arguments and accusations between the representatives and the accounting team. And those arguments and accusations focused on what went wrong and who was to blame. Accounting blamed the reps for not getting the dealers to pay on time. The reps accused Accounting of not giving them credit for all the payments received.

The management team had to spend valuable time, every month, smoothing over these conflicts and making exceptions for commission payments. This was not a pleasant experience for managers, reps or accounting associates. Until one day, literally by accident, they stumbled into the Championship Team Behavior principle we're considering this month.

Principle 5: We Say the Unsaids

The Vice President of Sales had lost count of how many times he'd had to deal with this situation and he was frustrated with the entire accounting team. After loudly blaming them for creating another conflict with an important rep he concluded by bluntly asking "What's wrong with you people?"

The answer he received ultimately changed everyone's attitudes and impacted the process leading to much desired conditions of satisfaction. One of the accountants answered, "We already paid him several thousand dollars in commissions this month, so we figured it would be okay to defer the rest until next month. We have a lot of other things to do in closing out the month so that's where we put the priority."

Suddenly it dawned on the Vice President that the Accounting Department had no idea about the challenges of being a manufacturer's representative. Instead of continuing to place blame, he took the time to explain that reps had to maintain a warehouse for the equipment they used for sales demonstrations; they had to have big and expensive trucks and trailers to haul the equipment; they had to spend many days traveling to make sales and collections. Their monthly expenses ran well into the thousands of dollars and that was before they paid the bills for their homes and families.

By saying the unsaids he unlocked a whole new level of understanding, compassion and respect that resulted in new work flows and timing.

By saying the unsaids, he unlocked a whole new level of understanding, compassion and respect that resulted in new work flows and timing. Later, the Vice President had similar conversations with the reps which led to more open and positive communication between the reps and accounting, and reduced the amount of time managers had to spend negotiating conflicts. It wasn't coincidental that the company's now high-performance team achieved a threefold sales increase over the next few years.

This is how saying the unsaids blends with the other principles and helps create championship teams. Think about how much easier it would have been if the company had practiced using all the principles of championship team behavior.

Members of a high-performance team are not focused on assigning blame or defending why they are not at fault. This makes it much easier to have open discussion leading to an understanding of the cause of the breakdown. The team's focus, then, is on determining and taking the steps to correct the breakdown and prevent it from happening again. In short, this practice is made possible by principles 1 – 4 and #5 is what makes Principle #6: We Negotiate Conditions of Satisfaction work.

You can begin to see the impact of this principle in the example of the auto parts manufacturing plant we wrote about last month.

In the process of analyzing the situation with the faulty machine there is no part of the process that involves figuring out who was at fault so there is no discussion of discipline or termination.

Here is a real-world story that illustrates how these principles can work together.

An insurance company's sales force was achieving some excellent results which impacted all departments and was beginning to strain the various components of the process chain.

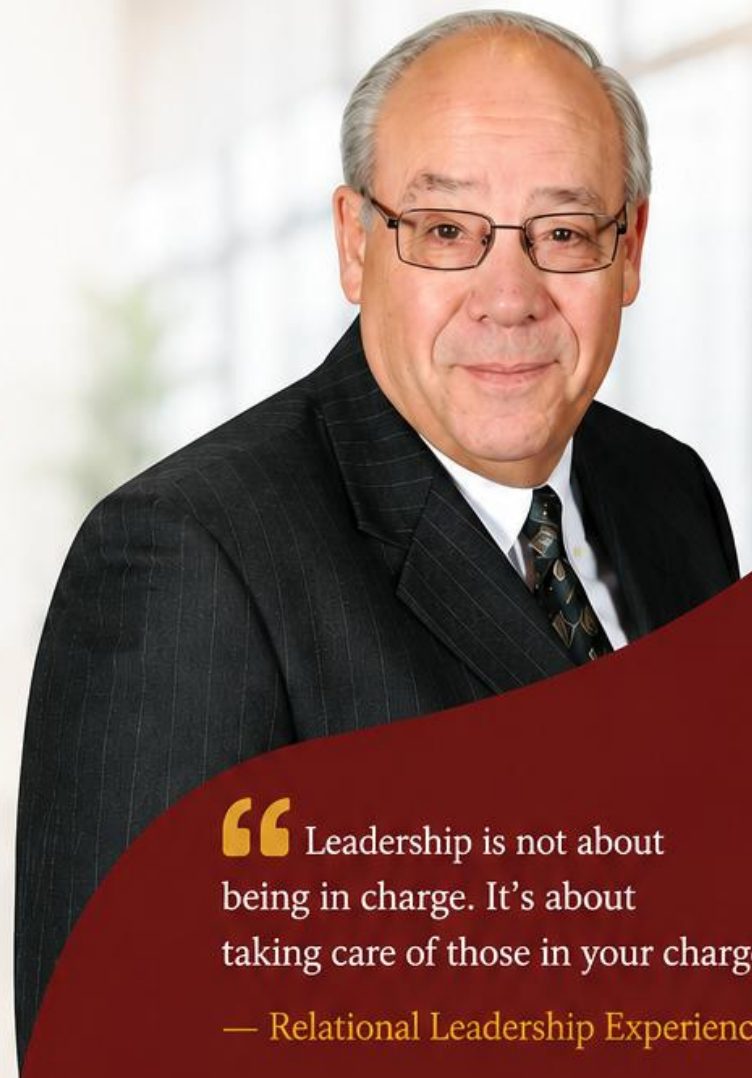


Relational Leadership
— EXPERIENCE —

STRONG LEADERSHIP ISN'T OPTIONAL ANYMORE, IT'S ESSENTIAL.

Our workplaces and communities are facing unprecedented challenges, and the responsibility to lead well has never been greater.

If you are a leader, or aspiring to become one, now is the time to grow, strengthen your skills, and prepare to make a meaningful impact.



“ Leadership is not about being in charge. It's about taking care of those in your charge.

— Relational Leadership Experience



www.relationalleadershipexperience.com



910-977-5934



relational.leadership@yahoo.com

You might think this was a good problem to have - and you would be correct. But the Policy Processing Department, in particular, was struggling with the rapid increase in the number of applications they were processing each week (in less than a year the number literally doubled).

It didn't take long before the company began to observe a dramatic increase in the number of policies returned by customers due to errors. Misspelled names, incorrect social security numbers, missing policy pages, policies sent to the wrong person, policy jackets sent without a policy included, the wrong policy issued - these were among the mistakes that were being made in unacceptably high numbers.

The Customer Service Department was flooded with complaint calls, agents were frustrated on behalf of their clients and the Sales Department was very upset about the likelihood of their sales momentum being squashed.

Department managers acted quickly to correct what they saw as a "problem", by instituting the practice of having each of the processors check each other's work. When this didn't achieve significant improvement, they assigned a couple of associates to double-check the work that had already been checked. This resulted in literally doubling the amount of time it took to process applications and still it didn't gain the quality improvements needed.

The Vice President of Administration and the Department Managers were participants in the Relational Leadership Program. They decided to schedule a "championship team" discussion to determine how to best take on this challenge using the principles of championship team behavior. (Championship Team Discussion is the specific practice used to implement the procedures of "dealing with breakdowns, saying the unsaid, and negotiating conditions of satisfaction.")

First, it was determined that this was a "breakdown" in the process which resulted from the rapid growth of work product due to successful sales results.

In this case, the processors were trying to follow the procedures as they had been taught, but were struggling to keep up the quality standards because of the rapidly increasing quantity. It was clearly a breakdown and needed to be dealt with as such. Even though the processors were totally unfamiliar with championship team behavior, it was decided to introduce them to the principles and apply them to the breakdown.

Championship Team Discussion is the specific practice used to implement the procedures of "dealing with breakdowns, saying the unsaid, and negotiating conditions of satisfaction."

When the processors were gathered together in a conference room, it was apparent that they expected to be criticized and punished for their performance. Imagine their surprise when the 6 principles were briefly shared with them. Discussion was then focused on working together on the breakdowns. Once they understood that they weren't in trouble, team members were able to "say the unsaid," - that is they were free to describe in straight forward language, understood by all, the specific areas of breakdowns.

When asked for their participation in "negotiating the conditions of satisfaction" they were excited to share their ideas. One of the team stated that this was the first time they had ever been asked for their thoughts about how to improve their work performance. Another team member started crying out of relief that they weren't being yelled at, punished or fired.

Together, free from the burden of position, case building or blaming, the team was able to come up with several good ideas. The one that had the biggest impact on turning the department into a winner came from a shy individual who seldom ventured to speak out about anything. She suggested that maybe they could stop all the checking and re-checking and ask each processor to think about the person buying the insurance - focusing on being careful to make sure they did it right rather than fast.

Even though this seemed too simple an idea, it was agreed to try it as one of the overall solutions suggested and, guess what - it worked. With the hiring of only a couple of additional processors, they were able to catch up and keep up with new business while meeting or exceeding quality standards.

Together, free from the burden of position, case building or blaming, the team was able to come up with several good ideas.

Leaders and team members alike, learned from this experience; dealing with breakdowns, saying the unsaids and negotiating conditions of satisfaction is effective when applied in a championship team behavior organization.

Next month, we'll explore Principle 6: Negotiating Relationships and Conditions of Satisfaction. In the meantime, feel free to reach out with ideas, questions or comments. And enjoy the privilege of being a leader.

Principles of Championship Team Behavior	
	We Work Together as Colleagues
	We Don't Accept Case Building When Planning or Executing Business Plans
	We Don't Tolerate Blaming
	We Deal with Breakdowns Not Problems
	We Say the Unsaids
	Next Issue: Relationships and Conditions of Satisfaction



Steve Clabaugh, CLU, ChFC - started his career in insurance as a Field Agent, moving on to Sales Manager, General Manager, Regional Manager, Vice President, Senior Vice President, and President/CEO. A long time student of professional leadership, Steve created the Relational Leadership program that has been used to train home office, field sales associates, mid-level managers, and senior vice presidents.

Copyright © 2026 by Voluntary Advantage, LLC. All rights reserved. No part of this magazine may be reproduced in any form without consent.

The Voluntary Benefits Voice is published monthly in digital format only by Voluntary Advantage, LLC. Subscriptions are available at no cost by subscribing at www.voluntary-advantage.com.