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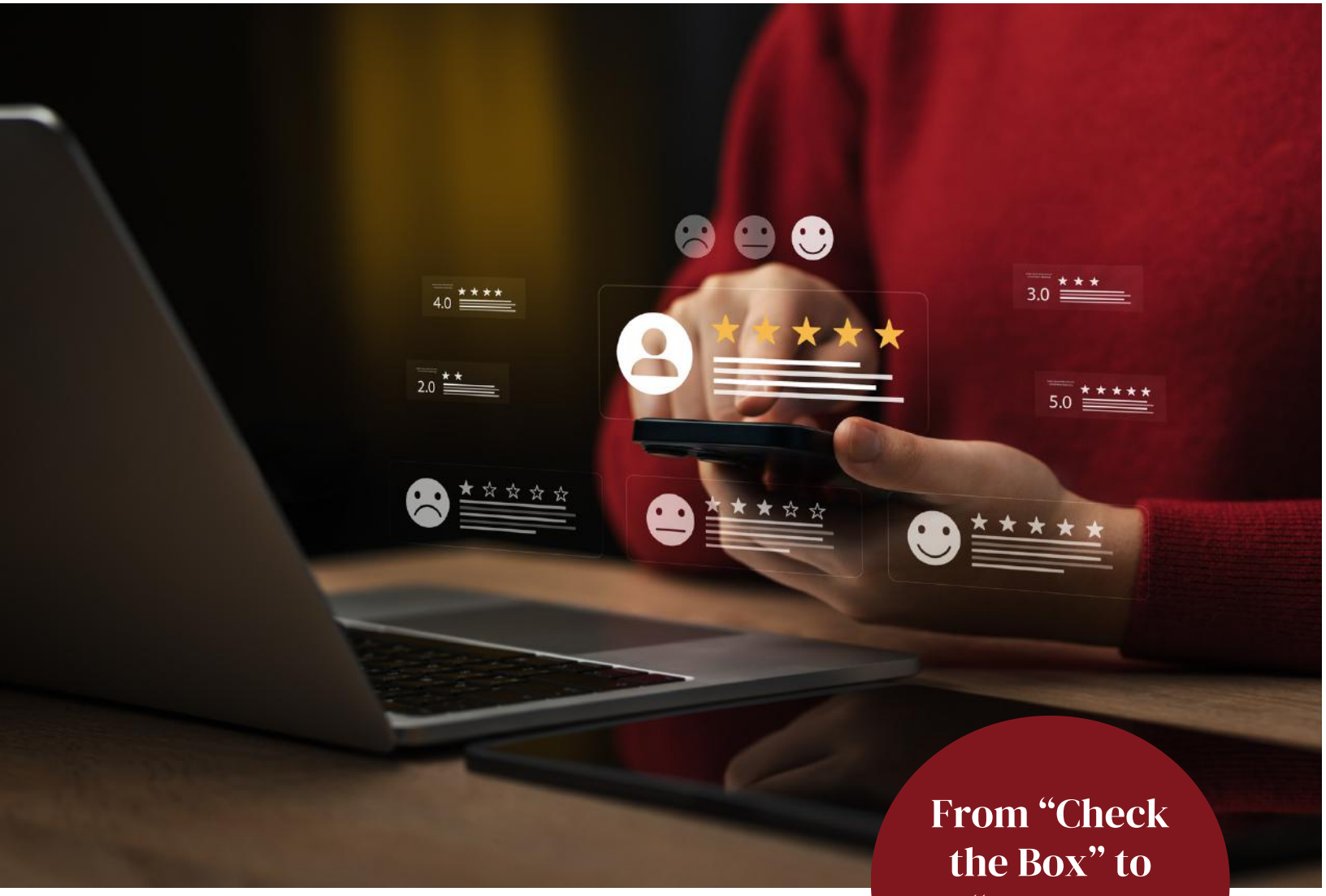
Voluntary Benefits Voice

MAGAZINE



From “Check the Box” to “Prove It Works”

The Utilization Challenge

Integrating Point Solutions With Voluntary Benefits

VOLUNTARY ADVANTAGE

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PES BENEFITS

Relational Leadership Experience

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From The Editor...

When Every Problem Gets Its Own Vendor, Who's Watching the Whole Employee?

A decade ago, building a benefits program meant picking a medical carrier, a PBM, maybe a virtual care vendor, and calling it a strategy. Today, a given employer can easily manage four, eight, twelve separate point solutions with one for musculoskeletal pain, diabetes, mental health and one that's exploded in the past few years, around fertility. Each point solution comes with its own login, its own contract renewal date, and its own idea of what "engagement" looks like.

The data backs up what most of us are hearing anecdotally from carriers and brokers alike. A recent Council of Insurance Agents & Brokers survey found employers are now running three-to-four-point solutions on average, and nearly three-quarters of brokers say that their clients are either actively consolidating vendors or actively considering it. Pharmacy cost management, wellness platforms, and telehealth remain the most common entry points, but the pattern across every corner of this market is the same: proliferation, then fatigue, then a hard look at consolidation.

I don't believe point solutions were a mistake. They exist because traditional carrier benefits genuinely don't reach every corner of employee need, and a targeted digital therapeutic or coaching program can do real, measurable good for a narrow population. The problem isn't the existence of these tools. It's what happens when nobody owns the full picture - when an employee must remember which app handles their back pain, which one handles their blood sugar, and which one handles the enrollment paperwork for the accident policy that's supposed to help pay for all of it.

That last piece is where our industry has real work to do. Voluntary benefits were built to fill gaps - high-deductible exposure, out-of-pocket risk - the financial shock that shows up after the point solution has already done its clinical job. But a supplemental policy that fills a gap nobody can see, inside a benefits ecosystem nobody can navigate, isn't filling anything. It's just one more login.

The employers getting this right aren't the ones adding the most point solutions, or the ones stripping them out in a panic. They are the ones asking a harder question: does this piece connect to the rest of the strategy, or does it just sit next to it? That's a question about enrollment platforms and administrative technology, as much as it's a question about clinical vendors and it's exactly the kind of integration conversation our carriers, brokers, and technology partners need to be having with each other, not just with the employer. If we can't explain in three seconds how a given solution, voluntary or otherwise, protects what matters most and keeps the promise when people need it, it doesn't matter how sophisticated the technology behind it is. The employee won't find it, and the employer won't renew it.

That's the lens I'd encourage everyone in this issue to bring to the point solution conversation: not "what's the newest tool," but "what's the whole picture we're building, and does this actually fit in it."

Bundling Up for Better Benefits

Why Voluntary Brokers, Employers and Carriers are Moving Toward a Package Play

By Eastbridge Consulting Group, Inc.

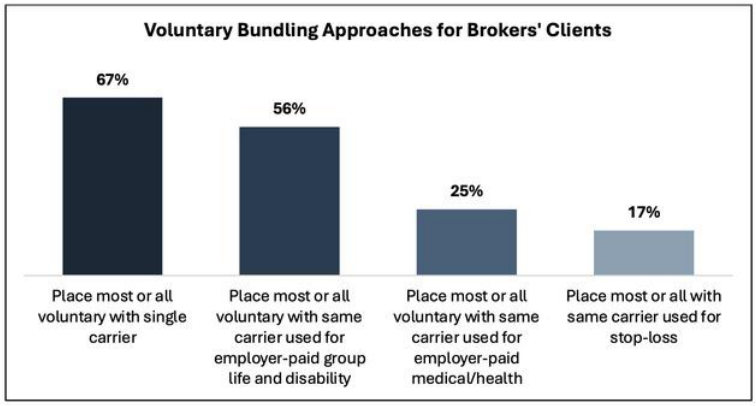
The term "product bundling" can take on different meanings for different stakeholders in the voluntary/workplace market. For carriers, it can mean offering either an informal package or a fixed set of benefits, often at a discount. For brokers and employers, it can mean pulling together different types of benefits from a single source to simplify administration and improve the enrollment experience.

Each of these variations has an important common denominator: the opportunity to create greater value for employers and their employees.

Brokers Aligned With Single-Source Trend

A strong majority of brokers (67%) report that their clients use a single carrier for most or all of the voluntary products. However, these brokers indicate that their clients are often looking farther afield than their traditional voluntary partners to create benefit bundles, according to our most recent "Broker Perspective on the Voluntary/Worksite Market" Spotlight™ report.

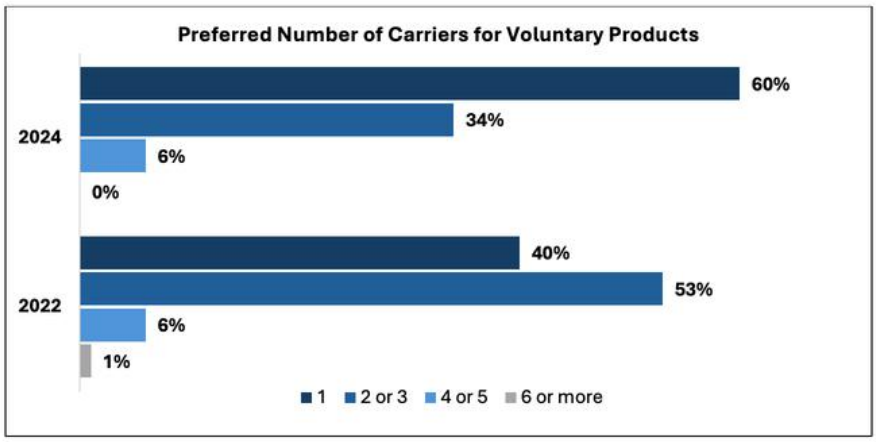
It shows that more than half of brokers' clients (56%), choose to bundle voluntary products with the same carrier they use for employer-funded life and disability products, while a quarter bundle voluntary products with the same carrier they use for health insurance.



Source: Broker Perspectives on the Voluntary/Worksite Market Spotlight™ Report, 2026

Brokers report multiple upsides for their clients in these bundling approaches, according to Ginger Bates, Eastbridge director of research. "Brokers we surveyed for this study say simpler administration, pricing discounts on core lines, and an improved employee enrollment experience are the most important drivers for bundling voluntary products with either an employer-paid life and disability carrier or medical carrier," Bates says. "Claims integration and underwriting flexibility are also key value-adds when bundling voluntary with life and disability."

As shown by the report, pricing discounts on the voluntary coverages and integrations with medical claims are among the top reasons why brokers' clients bundle voluntary with a medical carrier.



Source: MarketVision™ — The Employer Viewpoint,© Eastbridge Consulting Group 2024

Employers Shifting Toward Single Carriers

The bundling trend appears to be growing among employers, who increasingly are using a single carrier for their voluntary products - and many of those using multiple carriers say they would rather use just one.

Our most recent MarketVision™ — The Employer Viewpoint© report shows the percentage of employers using a single voluntary carrier nearly doubled from 29% in 2018 to 50% in 2024. At the same time, the number using two or three carriers has dropped from 55% to 42%.

Smaller employers are the likely force behind this trend: Those with fewer than 100 employees are much more likely than larger employers to use a single carrier, and far less likely to use multiple carriers. Of course, that leaves a significant number of employers still using multiple carriers -but the majority of them (60%) report they would rather use a single carrier in the future. Only about a third say they would prefer to use two or three carriers. To be fair, the smallest employers also strongly influence this overall preference, as the number leaning toward multiple carriers increases with employer size.

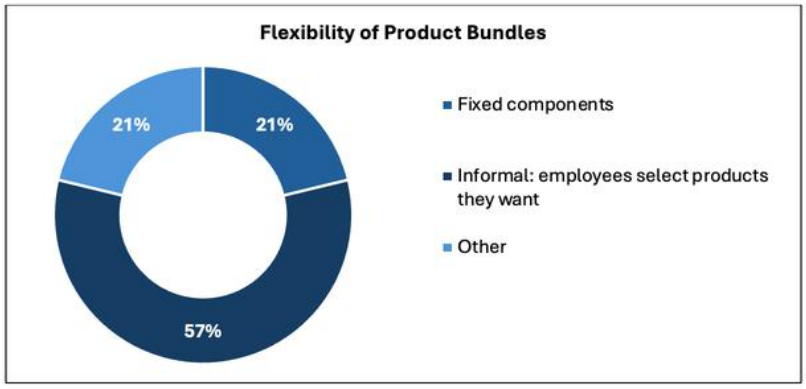
Tapping into different sources for different types of coverage doesn't appear to create a strong divide among employers when it comes to billing preferences.

About the same number say they want to see their medical or core group benefits on the same bill as voluntary products (40%), as those who want voluntary products on a separate bill (38%). The other 22% have no preference one way or the other.

Carriers See Value in Product Bundling

More than a third of voluntary carriers create their own product bundles, according to a recent "Voluntary Product Trends" Frontline™ report. This number has stayed fairly stable for the last few years, but the number of carriers saying they don't bundle products has dropped significantly, from 79% in 2020 to 65% in 2024.

The most common products carriers package together are supplemental health, including accident, critical illness or hospital indemnity, with either core group disability and life products or medical and dental products. These are informal packages for the majority of carriers offering product bundles, where employees can select the coverages they want to buy. Only 21% of carriers offer "fixed" bundles where employees make only a yes or no election and can't choose the components or coverage levels.



Source: Voluntary Product Trends Frontline™ Report, Eastbridge Consulting Group, 2024

These bundles can save employees money. Nearly all carriers put pricing discounts of 2% to 10% on the table, usually based on the type of products and the group's demographics and risk. Some carriers discount voluntary products, while others apply discounts to medical plans or employer-funded nonmedical products, and some vary the decision by case.

A Firm Foothold in the Market

"Approaches to product bundling can vary, and the value of consolidating carriers or combining coverages depends on the needs of each employer and the employees in that group," Bates points out. "But when the approach and the needs align, bundling can lead to more competitive pricing, a better customer experience and easier administration. And that's a win-win for everyone involved."

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.

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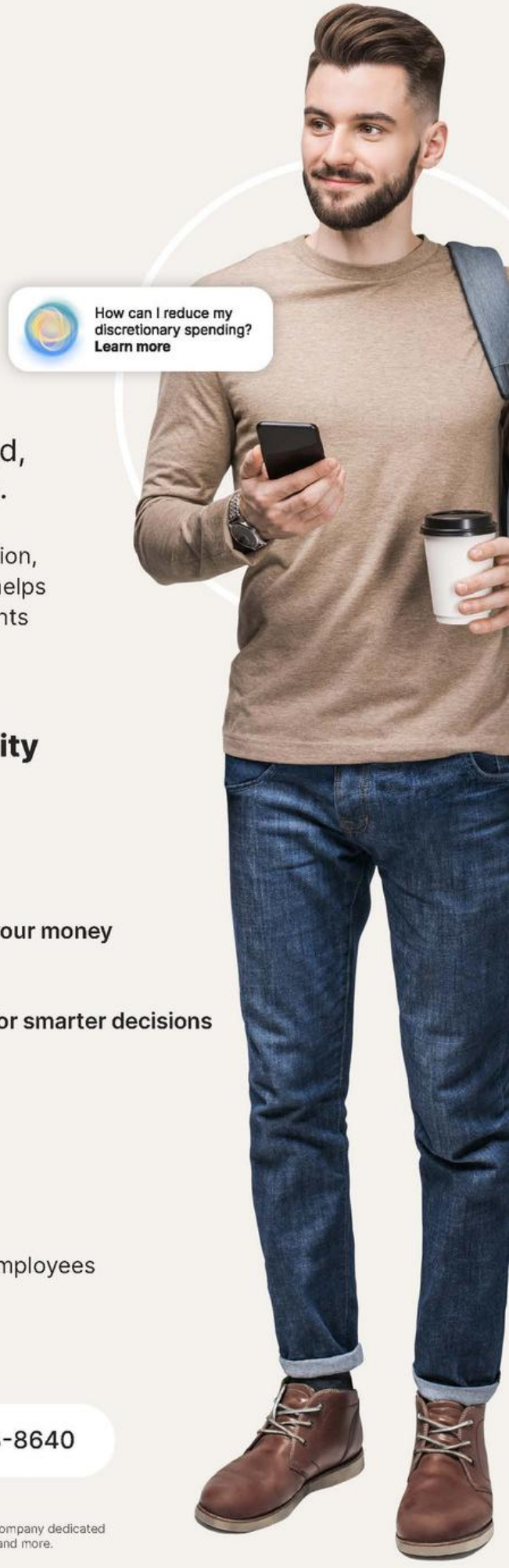

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The Utilization Challenge

Why Benefits Technology, Communication, and Navigation Matter More Than Ever

By PES Benefits

The employee benefits industry has spent the last decade solving a major problem: access.

Employers have expanded healthcare options, introduced voluntary benefits, invested in mental health resources, adopted virtual care solutions, and launched wellbeing initiatives designed to support employees through every stage of life. Today's workforce has access to more resources than at any other point in history.

Yet a new challenge has emerged. Employees cannot benefit from programs they do not understand - They cannot use services they cannot find, and they cannot appreciate the value of benefits they do not know exist.

As a result, many employers are discovering that the next frontier in benefits strategy is not adding more benefits; it is improving how employees engage with the benefits they already have.

For brokers, this shift presents both a challenge and an opportunity. Organizations are no longer looking exclusively for help selecting plans and negotiating renewals.

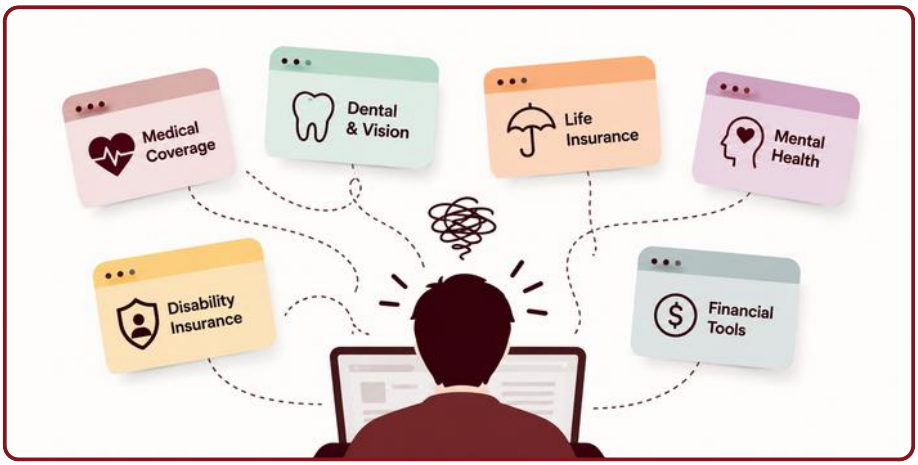
Increasingly, they are looking for ways to improve utilization, strengthen employee engagement, and maximize the return on their benefits investment.

This is where benefits technology, communication, and navigation are becoming some of the most important tools in the modern benefits ecosystem.

Employees cannot benefit from programs they do not understand. They cannot use services they cannot find. And they cannot appreciate the value of benefits they do not know exist.

The Benefits Landscape Has Become More Complex

The average employee today may have access to medical coverage, dental and vision plans, life insurance, disability insurance, critical illness coverage, accident insurance, employee assistance programs, virtual care services, mental health resources, wellness programs, financial wellbeing tools, and a growing number of specialized support services.



From an employer's perspective, this expanded menu of options is a positive development. It reflects a commitment to supporting employees and addressing a wide range of health, financial, and wellbeing needs.

From an employee's perspective, however, the experience can feel very different. Each benefit may have its own website, mobile application, phone number, eligibility requirements, registration process, and communication strategy. What appears comprehensive from an administrative standpoint can sometimes feel fragmented to the people who are expected to use it.

According to the Kaiser Family Foundation's 2024 Employer Health Benefits Survey, employers continue to invest heavily in healthcare and employee benefits despite ongoing cost pressures [1]. At the same time, employees are being asked to make increasingly complex healthcare and financial decisions.

The challenge is no longer simply offering benefits. The challenge is helping employees navigate them.

Employees Think About Problems, Not Benefit Categories

One of the biggest misconceptions in employee benefits is the assumption that employees think about benefits the same way benefits professionals do.

Benefits are in categories: medical plans sit in one bucket, voluntary benefits sit in another, behavioral health resources occupy another, and virtual care services may be managed separately.

Employees do not think this way. An employee with a child who wakes up sick at 2 a.m. is not thinking about telehealth utilization strategies. A worker struggling with anxiety is not considering behavioral health program design. Someone facing a serious diagnosis is not evaluating how multiple benefits work together within the employer's overall benefits package.

They are trying to solve a problem. Their primary concern is finding help quickly, understanding what resources are available, and knowing where to start. When employees cannot easily answer those questions, utilization often suffers.

This reality is one reason why benefits communication has evolved from a once-a-year enrollment activity into a year-round strategic function.

Communication Is Becoming a Core Benefits Strategy

Benefits have become more sophisticated, healthcare decisions have become more complex, and employees increasingly expect information to be available when they need it rather than when employers choose to distribute it.

The Business Group on Health's 2025 Employer Health Care Strategy Survey found that employers continue to prioritize employee experience, engagement, and health outcomes alongside cost management efforts [2].

Communication plays a critical role in achieving those goals. The most successful organizations are moving toward ongoing education strategies that provide timely, relevant information throughout the year. Rather than simply describing benefits, these communications help employees understand how to apply them to real-life situations.

For example, a communication about stress management may remind employees about available counseling resources, mental health support services, virtual care options, and wellbeing programs. Communication about family health may highlight preventive care benefits, pediatric services, and virtual care resources. The goal is not awareness alone. The goal is action.

Why Benefits Navigation Is Gaining Attention

As benefit offerings continue to expand, navigation has become a growing area of focus throughout the industry.

The Agency for Healthcare Research and Quality defines care coordination as deliberately organizing healthcare activities to improve access, quality, and outcomes [3]. While this concept originated in healthcare delivery, its principles are increasingly influencing benefits strategy.

Employees benefit from guidance. They benefit from having a clear starting point when questions arise. They benefit from centralized resources that reduce confusion and simplify decision-making. They benefit from systems that help connect them to appropriate services without requiring them to become benefits experts.

This is particularly important when multiple solutions are available.

Contrary to some industry discussions, the existence of multiple benefits is not inherently a problem. Most benefit programs exist because they address specific employee needs. Mental health resources serve a different purpose than virtual primary care. Life insurance serves a different purpose than wellness coaching. Voluntary benefits address different concerns than medical coverage.

The most successful organizations are moving toward ongoing education strategies that provide timely, relevant information throughout the year.

The issue is not quantity; the issue is connection. Employees are most likely to engage when benefits feel coordinated rather than disconnected.

Technology Is Becoming the Connector

This is where benefits technology is playing an increasingly important role. Technology has evolved far beyond enrollment platforms and administrative systems. Today, employers are looking for technology that creates a more unified employee experience. A centralized platform, benefits app, or navigation tool can help employees access information, locate resources, and connect with support services from a single location. This approach offers advantages for both employers and employees.

Employees spend less time searching for information and more time accessing care and support. Employers gain greater visibility into engagement and utilization trends. Brokers gain opportunities to help clients improve outcomes without necessarily increasing benefit spending.

Technology also supports one of the industry's most persistent challenges: benefits literacy. Many employees struggle to understand insurance terminology, coverage details, eligibility requirements, and available resources. Technology can simplify these interactions by presenting information in a more accessible, user-friendly format.

When paired with effective communication and education, technology becomes more than an administrative tool. It becomes an engagement strategy.

The Growing Importance of Virtual Care Integration

Virtual care offers a useful example of why navigation and communication matter.

Over the past several years, virtual healthcare solutions have expanded dramatically. Employees may now have access to urgent care, primary care, behavioral health services, wellness coaching, dermatology, and other virtual services. The challenge is not availability - the challenge is ensuring employees understand when these services are appropriate and how they fit within the broader healthcare experience.

Employees who understand their options are more likely to seek care early, access preventive services, and engage with available resources before small issues become larger problems.

This is another reason brokers are increasingly discussing engagement strategies alongside benefit design. A benefit that is rarely used delivers limited value regardless of its quality.

When paired with effective communication and education, technology becomes more than an administrative tool. It becomes an engagement strategy.

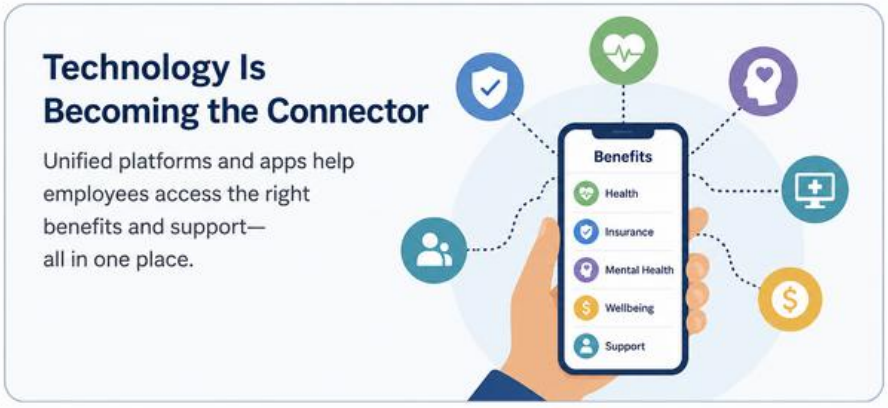
What Brokers Should Be Discussing With Clients

As employers continue evaluating their benefits strategies, brokers have an opportunity to broaden the conversation beyond plan design and pricing.

Questions worth exploring include:

- How easy is it for employees to find and access benefits?
- Are benefits communicated throughout the year or only during enrollment?
- Do employees understand how available resources work together?
- Is there a centralized location for benefits information and support?
- How is engagement measured?
- Are employers evaluating utilization alongside participation?

These discussions help position brokers as strategic advisors focused on outcomes, not simply coverage.



Turning Investment into Impact

The organizations that achieve the greatest return on those investments will not necessarily be those offering the most benefits. They will be the organizations that make those benefits easy to understand, easy to access, and easy to use. Benefits technology, communication, and navigation are becoming essential components of that effort.

For brokers, helping clients improve engagement may ultimately create more value than introducing another benefit offering. In today's environment, the most successful benefits strategies are not defined solely by what is offered. They are defined by how effectively employees connect with the resources available to them.

As the industry continues to evolve, one reality is becoming increasingly clear: access matters, but engagement is what turns benefits into outcomes.

Sources:

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PES Benefits is dedicated to revolutionizing the employee benefits landscape with cutting-edge technology, administration, education, ACA, HR Compliance, 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.

Educate, Decide, Use

Which Moment Is Your Guidance Tool Actually Serving?

By Ben Yomtoob and Meg Collins

The Educate / Decide / Use framework (EDU) organizes the benefits guidance challenge into three constituent events. When we introduced it last month, we argued that most tools cover one moment well and leave the others to chance. Readers agreed, then asked the obvious follow-up: What is the current state of play for each? The answer is that the three moments are unevenly served. Use is the one that matters most once coverage is in force, and yet Use is the furthest behind.

Educate: The Moment Everyone Assumes Is Handled

Educate is the easiest event to claim and the hardest to verify. Nearly every benefits communication vendor, administration platform, and carrier portal includes some version of an education layer: plan summaries, short videos, or a chatbot trained on a benefits glossary. The bar to entry is low: producing content that explains deductibles isn't something that requires deep integration with plan documents or claims systems.

That low bar is part of the problem.

Comprehension content built once at the start of a plan year, and not recontextualized as workers' needs evolve throughout the year, is less than adequate. LIMRA finds that 73% of employees want to hear about their benefits more often, yet half hear about them only at open enrollment [1]. Educate-moment guidance must be persistent and contextual: available the day an employee gets married, the day a new dependent is added, the week before a high-deductible plan's coinsurance resets.

As an example of the shortcomings of today's tools, LIMRA finds that supplemental health and disability plans are the least understood benefits offering, and that employees who don't understand a benefit may assume something is covered when it isn't, or may neglect to file a claim they were eligible for [1]. That is not a Decide-moment failure; these employees were enrolled. Nor is it a Use-moment failure in the mechanical sense: they never reach for the claim form, because they never understood what the voluntary policy was meant to cover. It is an Educate-moment failure, persisting year-round, on a product the worker is already paying for.

The deeper failure is that Educate rarely operates as a discrete event at all: it collapses into Decide. The two get lumped together at 4:30pm on the last day of open enrollment, when the employee finally opens the portal, and tries to learn the plan and choose it in the same rushed session. Education becomes a formality the worker rushes through on the way to clicking "enroll".

LIMRA finds that supplemental health and disability plans are the least understood benefits offering, and that employees who don't understand a benefit may assume something is covered when it isn't, or may neglect to file a claim they were eligible for

Decide: The Most Crowded, Most Funded, Most Visible Moment

Decide is where the market has concentrated its capital and its attention, for a straightforward reason: it is the moment with the clearest commercial hook.

A tool that helps an employee choose a plan can point to enrollment completion rates, time-to-enroll, and adoption of voluntary products as concrete, demonstrable outcomes. Carriers and brokers can see the effect in the numbers they already track. Cost calculators, side-by-side comparison tools and recommendation engines have all built their value proposition around this single event, and the result is a competitive, fast-iterating category.

This category is also where AI adoption is most visible. Alight reported 8.5 million AI chatbot interactions during 2025 open enrollment, roughly three times the prior year, and found that 43% of workers now trust AI for benefits advice [2]. Businessolver reported that 84% of employees rated their enrollment experience "great" or "excellent," with the ones using AI guidance 129% more likely to enroll in an HSA [3].

Unfortunately, these are activity and experience metrics rather than outcome metrics: they describe what employees did and how they felt about it, not whether they ended up in the right plan, or whether their enrollment choices improved utilization.

Use: The Most Underserved Moment and the Hardest to Prove

Use is where the guidance stack falls apart, and it is also where the consequences of that failure are most concrete. This is the event that determines whether the coverage an employee selected actually functions when it comes time to file a claim. For voluntary benefits specifically, Use is the event tied most directly to persistency and renewal, because an employee who never used a policy is an employee who is unlikely to renew it.

It is also the event with the thinnest tooling. Most benefits administration platforms end their guidance functionality at the enrollment confirmation screen. Care navigation vendors cover medical claims reasonably well, but rarely extend the same depth to voluntary products.

The downstream cost of the Use gap is visible in the data, even without claims utilization numbers. 32.1% of members report having no primary care provider at all, up nearly two points since 2024 [4]. This is a direct measure of disengagement from the preventive side of the Use moment, since deferred care simply becomes more expensive acute care later.

This dynamic compounds for supplemental coverage: disengaged members skip preventive care, overuse the emergency room, and do not file the supplemental health claims for the voluntary products they are already enrolled in.

The more significant problem is that the data needed to measure the Use moment is largely unavailable. Enrollment data is collected obsessively, reported in every benchmarking study, and cited in every vendor pitch deck.

Claims utilization data (who files a claim after enrolling in a voluntary product, and whether they even understood how to do so) is not publicly reported in any comparable way. This point shows up in the very questions employers and brokers are asking right now: whether employees ended up in the right plan and whether utilization actually improved. The real answer across the market is: nobody currently knows.

What the Framework Exposes

Laid side by side, the three EDU events tell a consistent story. Educate is widely claimed and weakly evidenced. Decide is heavily resourced and validated against an incomplete endpoint. Use is the most consequential for voluntary benefits and the most thinly covered.

None of this means existing tools are without value. It means that the language used by vendors (“AI-powered guidance,” “decision support,” “benefits assistant”) describes very little about which of the three events a tool is actually built to serve, and even less about how well it does it. A buyer evaluating a vendor's claim to cover the full employee journey should ask three direct questions for each EDU event:

- What does this tool do here?
- What evidence supports that it works?
- And, is that evidence independently verifiable or only self-reported?

Those questions are the starting point for the next phase of our work.

The Benefits Guidance Consortium's forthcoming State of the Market white paper will apply this lens across the vendor landscape, organizing tools by where they actually operate, rather than by the category name they have chosen for themselves. Future installments in this series will look more closely at the disclosure problem in Decide-moment recommendation engines, and at what it would take to build the data infrastructure the Use moment is currently missing.

Learn more at benefitsguidanceconsortium.org.

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1. [1] LIMRA | 2024 BEAT (Benefits and Employee Attitude Tracker) Study — https://www.limra.com/en/newsroom/news-releases/2024/limra-tightening-budgets--employees-are-spending-less-on-benefits-according-to-new-study/
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THE BENEFITS GUIDANCE CONSORTIUM

Ben Yomtoob and Meg Collins co-founded the Benefits Guidance Consortium to define and promote the Benefits Guidance category. Ben is Founder / Lead Consultant at BuckleyRoberts and a former CEO of Workterra. Meg is Founder and CEO of RevGem Consulting and a former Chief Growth Officer at Ideon.

Integrating Point Solutions with Voluntary Benefits

Moving from Offerings to Outcomes

By Tina Santelli

The benefits landscape has shifted. Employers are no longer evaluating individual solutions in isolation: they are building ecosystems. Yet many organizations are still struggling with a critical gap: they have more tools than ever, but not necessarily more value.

Point solutions like Garner Health and Surest are a great example. These platforms are designed to improve outcomes steering employees to higher-quality care, reducing friction, and lowering total cost of care. And the data is compelling. Employers implementing Garner have seen **7.4% lower medical costs in the first year without changing plan design [1]**, while solutions like Surest can reduce total cost of care by **up to 15% and significantly increase preventive care utilization [2].**

But here's the reality: even the best solutions fail if employees don't understand or use them. Across the industry, this remains the biggest challenge.

Research shows that **only 69% of employees feel they understand their medical benefits well and that drops to just 39% for voluntary benefits**. At the same time, participation in many voluntary products still ranges from **10% to 30%** in the first year, largely driven by communication quality, not product design. [3]

This is where brokers have an opportunity to lead differently.

But here's the reality: even the best solutions fail if employees don't understand or use them.

Voluntary benefits should not be positioned as separate, employee-paid add-ons. When integrated effectively, they become a critical layer that reinforces point solutions and closes financial gaps. If a navigation tool guides an employee to the right provider, voluntary benefits like accident, critical illness, or hospital indemnity ensure that the financial impact of that event is covered. It's the combination of clinical guidance and financial protection that drives meaningful outcomes.

I've seen this play out firsthand when integrating a point solution into client strategies, success wasn't driven by simply adding another vendor. It came from pairing the solution with a disciplined enrollment and communication strategy through thoughtful education and communication.

A 700-life auto dealer group faced a **~40% medical increase** and a concurrent rolling out of a point solution, creating a real risk for low participation and employee confusion.

Here's what happened:

- **624 employees met 1:1 with a benefit counselor**
- **71% downloaded the point solution app during enrollment (driven by real-time education)**
- **Voluntary participation increased 10%+ across every line**
- **Minimal disruption to medical enrollment despite the rate increase**
- **Communication and education on ALL benefits**

Why It Matters

Counselors were trained on the point solution and worked directly with employees to explain the change, walk through the app, and drive adoption on the spot. That level of engagement is typically a year-one goal: we delivered it during open enrollment.

By embedding a point solution into the broader benefits ecosystem, including how we position medical and voluntary benefits together and investing heavily in employee education, clients are able to drive meaningful engagement early in the plan year. Employees didn't just enroll; they understood how and when to use the solution. That's what ultimately drives utilization, outcomes, and ROI.

The lesson for brokers is clear:

- Stop thinking about **point solutions as standalone innovations**
- Start designing integrated strategies that connect **navigation, core benefits, and voluntary benefits**
- **Prioritize education** as much as plan design

Because in today's environment, value is no longer defined by what you offer. It's defined by what employees actually use. The next generation of benefits strategies will not be built on adding more. They will be built on aligning what already exists, intentionally, cohesively, and with the employee experience at the center.

Source:

1. Garner Health
2. UnitedHealth Group
3. Benefitfocus.com

Tina Santelli CBC, GBDS - Vice President, National Voluntary Benefits & Enrollment Solutions, Alera Group - With extensive leadership experience in the employee benefits industry, she serves as National Vice President of Voluntary Benefits and Enrollment Solutions at Alera Group, leading the growth and strategic delivery of voluntary benefits and enrollment solutions across the country. Drawing on more than two decades of experience - she is passionate about helping employers enhance employee engagement through innovative, cost-effective benefits strategies.

Functional Medicine and the Future of Employee Benefits

What's Changing in Employer Health and Why it Matters for Your Clients

By Erica Armstrong, MD, FMCP-M

If you've been in benefits long enough, you've seen the pattern. An employer invests in the next promising solution: telehealth, onsite clinics, gut health apps, diabetes programs. For a moment, there's optimism. Then renewal arrives and costs climb again. Access may have improved. Satisfaction scores may look decent. But the underlying health of the workforce? It hasn't meaningfully changed.

That frustration is exactly what's driving the conversation around functional medicine and root cause health benefits. *Here's what you should know.*

The Problem isn't Access Anymore

For years, the employer healthcare conversation centered on access. Today there is no shortage of ways for employees to get it: direct primary care, telehealth, onsite clinics, and even wearable devices designed to put meaningful health data in people's hands. These tools have their place, but the one thing missing from all of it: actually identifying and reversing root causes.

When care only manages symptoms, employees stay stuck. Their health doesn't improve, their quality of life suffers, and that bleeds into everything: their families, their focus at work, and eventually their claims. Around 60% of American adults are living with at least one chronic condition, and more than 40% have two or more. Type 2 diabetes, autoimmune disease, gut disorders, hormonal issues, migraines. And then there are the countless people living with mystery symptoms that have never even received a diagnosis. These are chronic conditions that don't resolve with a visit and a prescription, and that compound in cost and complexity over time.

Access may have improved. Satisfaction scores may look decent. But the underlying health of the workforce? It hasn't meaningfully changed.

For the individual, this means years of feeling dismissed, cycling through appointments, collecting diagnoses that don't quite fit, and never getting a real answer.

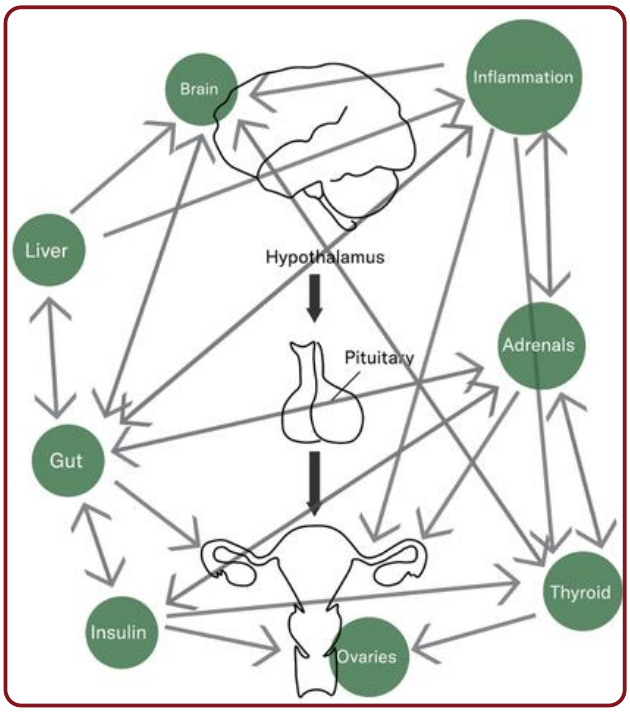
Where Conventional Medicine Falls Short

Conventional medicine, to its credit, is really good at acute care. A broken bone, a heart attack, a surgical emergency: that's its wheelhouse. But for chronic conditions, the model has real limitations. Insurance-driven schedules push most primary care visits to 15 minutes or less. That's not enough time to take a thorough history, dig into root causes, or build a meaningful action plan. What tends to fill the gap is a prescription, which manages the symptom but doesn't touch what's driving it. Over time, medication lists get longer. Conditions progress. Costs compound.

All of that shows up directly in your clients' claims.

What's needed is an entirely new model of care, built to address chronic disease at its root, not manage it indefinitely within a system designed for something else.

Better access to the existing model isn't enough. What's needed is an entirely new model of care, built to address chronic disease at its root, not manage it indefinitely within a system designed for something else. That's the premise behind root cause health benefits, and it's a concept that's gaining serious traction among forward-thinking employers and the brokers advising them.



Source: Root Functional Medicine

So What is Functional Medicine, Exactly?

At its core, functional medicine is a science-based clinical approach that asks why a condition is happening, not just what to call it.

Where conventional medicine is built around diagnosing a condition and prescribing a protocol, functional medicine treats the body as an interconnected system and looks for underlying drivers: metabolic dysfunction, gut health, nutrient deficiencies, inflammation, hormonal imbalances, environmental triggers, and lifestyle factors. Hormones, mood, skin, and digestion are often connected to the same root causes, rather than separate problems requiring separate specialists.

In practice: longer appointments that give physicians time to understand a patient's full history; advanced lab testing well beyond standard annual panels; treatment plans built around nutrition, lifestyle, and targeted supplementation; and ongoing support rather than one-and-done visits.

The goal is to resolve a condition where possible, not manage it indefinitely.

How It Fits Into a Benefits Strategy

Functional medicine is complementary to conventional care, not a replacement for it. It fills in the gaps, asking the questions a 15-minute visit can't accommodate and catching what standard labs miss. For brokers, that makes the conversation simpler. It's an add, not an overhaul.

As this approach has moved into the employer benefits space, it's given rise to an entirely new category: root cause health benefits. Rather than offering employees another disease management tool, employers offer a benefit designed to find and fix what's actually causing their health problems.

What It Looks Like in Practice

How it Actually Works:
It starts with a comprehensive lab panel going well beyond a typical annual physical: inflammation markers, blood sugar metabolism, fasting insulin, nutrients, a full thyroid panel including antibodies, advanced lipids, and more. These labs can typically be drawn at Quest Diagnostics or LabCorp, making functional medicine accessible nationwide. A doctor reviews the results and delivers a personalized written action plan covering nutrition, supplements, lifestyle changes, and next steps, built around that individual, not a generic protocol.

If anything is flagged as abnormal, employees have the option to work with board certified doctors (MDs/DOs) and dietitians *(actual humans - we thought that was worth clarifying in 2026),* who take the time, often up to 45 minutes, to connect the dots and build a real plan around their results. From there, members can engage continuously through dietitian touchpoints, monthly virtual Q&As, and an online platform, supported between visits rather than waiting for the next appointment.

Real Clinical Outcomes
Take autoimmune disease, one of the most expensive categories in employer health. Standard care typically involves biologics running $5,000 to $60,000 per year that quiet the immune system without addressing what triggered the dysfunction. Patients get partial relief and often escalating medication needs over time.

A functional medicine approach looks for the triggers: intestinal permeability (a fancy term for poor gut health), inflammatory foods, micronutrient deficiencies, and stress. Addressing those directly leads to fewer flares, reduced symptom severity, and in many cases the ability to reduce or come off medications entirely under physician supervision.

A few real patient examples that we have seen illustrate the pattern. A woman with psoriasis and psoriatic arthritis had been on Otezla (around $5,000/month) for years and had seen five providers without lasting relief.

After eight months of functional medicine care (gut healing, blood sugar optimization, targeted nutrition), she was able to discontinue the medication and her skin remained clear, with an 82% improvement in her symptom score. A man with rheumatoid arthritis on Enbrel and Methotrexate went into full remission within six months, came off both medications, and saw a 97% improvement in symptoms.

Across the board, these cases reflect a consistent clinical pattern when care is designed to address what's actually driving the problem.

What Happens to Costs

Fewer Claims, Lower Spend
The financial impact follows directly from the clinical outcomes. When chronic conditions improve or reverse, downstream costs drop in parallel. Emergency visits and hospitalizations become less frequent. Specialist referrals decline. Pharmacy spend goes down as medications are reduced or eliminated. Employees who feel better show up more and perform at a higher level.

Real Numbers From Real Employers
Among employers who have made the shift, the numbers have been substantial. A large construction company already running an onsite DPC clinic saw roughly 45% year-over-year reduction in total health claims costs after adding a functional medicine model focused on metabolic health. A mid-sized manufacturer dealing with high autoimmune and migraine burden achieved a 44.7% year-over-year reduction in overall healthcare claims.

Both reflect a genuine shift in workforce health trajectory, not one-time savings from a single intervention.

When root causes are addressed, the improvements hold - driving compounding savings year over year rather than the single-year bump many point solutions produce before flattening out.

A Note on Scale (Because This Comes Up)

A fair question from brokers new to this space: isn't functional medicine inherently boutique? Something that works for a small group of engaged employees but can't scale across a whole workforce?

Built for Employer Populations

Historically, functional medicine has lived outside of insurance, making it hard to access and cost-prohibitive for most people. But that's changed. Technology-enabled platforms with real humans in the loop now make it possible to bring root cause care to an entire workforce without the cost ballooning alongside it. Functional medicine telehealth visits mean geography is never a barrier, and employees can participate from anywhere. Root cause health benefits work alongside what employers already have in place, making existing benefits more effective rather than replacing them. For brokers, that makes it an easy conversation: no need to totally restructure a benefits strategy, just strengthen it.

Why This Matters for the Broker Conversation

The employer benefits market has cycled through a lot of point solutions. Mental health apps, musculoskeletal programs, weight management platforms, diabetes tools. Each useful in isolation, but together they've left many employers with a complicated benefits stack and costs that keep climbing.

A Different Kind of Benefit

Functional medicine is structurally different. Rather than adding another condition-specific layer, it addresses the dysfunction underlying many of the costliest conditions at once and works toward resolving them, not managing them indefinitely.

For brokers advising self-funded employers, the financial data is increasingly hard to ignore. It also speaks directly to what employees are asking for: care that actually helps them understand what's going on and gives them a real path to feeling better.

Good for People, Good for Business

At the end of the day, people want to feel better. They want real data about what's going on in their bodies and a real plan to do something about it. Functional medicine delivers that. And when employees get well, employers spend less. Better health, lower claims, a workforce that actually feels good coming to work. That's not a hard sell. Root cause health benefits are just giving people what they've been asking for all along.

Erica Armstrong, MD, IFMCP-M - is a board certified physician and the CEO and founder of Root, a leading nationwide functional medicine telehealth practice and online platform. She is deeply committed to helping people reverse disease by addressing its root causes, rather than merely managing symptoms. In addition to leading a team of functional medicine MDs, DOs, and dietitians who practice virtually across the country, she is spearheading the development of cutting-edge software designed to scale functional medicine to employers.

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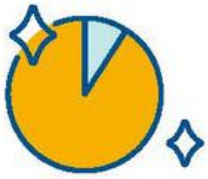

91% of our groups have not seen a rate increase in the past 5 years.[1]

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[1] 91% 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.).

From "Check the Box" to "Prove It Works"

The New Standard for Voluntary Benefits

By Christin Kuretich

For years, voluntary benefits have occupied a relatively comfortable position in the benefits mix. Because employees typically fund these offerings themselves, employers and brokers have often treated them as low-risk additions - valuable, yes, but not always subject to the same level of scrutiny as core medical plans.

That's changing. Today, employers are asking tougher questions about voluntary benefits. They are looking beyond plan design and pricing; and focusing more directly on outcomes. In a climate shaped by tighter budgets, evolving workforce needs and increased legal attention, one question is rising to the surface: Are these benefits actually delivering value to employees?

The Shift Away from "Set It and Forget It"

Historically, voluntary benefits have been evaluated through a familiar lens: competitive pricing, broad coverage and an attractive set of features. But that approach often overlooks what matters most, whether employees actually use the benefit when they need it.

A plan can look comprehensive on paper but fall short in practice. If employees don't understand it, can't access it easily, if coverage doesn't match treatments, or they don't receive timely payouts, its real-world value quickly erodes. As a result, employers are beginning to rethink how they define success.

The conversation is shifting from what's included to what's experienced.

Utilization Becomes the New Measure of Value

In this new environment, utilization is emerging as a critical proof point. Employers want to understand:

- Are employees engaging with these benefits?
- Do they know when and how to use them?
- Is the plan designed around the health issues employees will face?
- Are claims processed smoothly and paid in a way that feels meaningful?

This matters more than ever, because today's employees are navigating an increasingly complex benefits landscape. They have more options, but often less clarity.

What resonates isn't just access. It's simplicity, relevance and reliability. And at the end of the day, employees recognize value when a benefit delivers, clearly and quickly, at a moment that matters.

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Designing Benefits for Real Life

As expectations evolve, so does product design. Forward-thinking voluntary benefits are moving away from "more is better" and toward "more usable is better." That means:

- **Prioritizing common, high-impact health events** over exhaustive (but rarely used) coverage lists
- **Offering earlier-stage payouts** that align with how care actually unfolds
- **Simplifying eligibility triggers and claims processes**
- **Reducing friction** so employees can access benefits without confusion or delay

For example, some carriers have introduced critical illness solutions that provide staged payouts, delivering partial benefits at earlier points in a diagnosis and increasing support as conditions progress. This type of design better reflects real-world care journeys and increases the likelihood that employees will both use, and recognize, the value of the benefit.

In practice, we've seen that when benefits are structured this way (and paired with a straightforward claims experience), employees are far more likely to access them when it matters most.

Similarly, hospital indemnity products are evolving to reflect how care is delivered today. Some newer designs now recognize events like observation stays and simplify how benefits are triggered. This is helping ensure coverage aligns more closely with real-world scenarios.

The Rise of Human-Centered Benefits

Another notable shift is the growing emphasis on benefits that reflect the realities of everyday life - not just catastrophic events. Employees are looking for support in areas like:

- Mental health
- Caregiving responsibilities
- Early detection and intervention

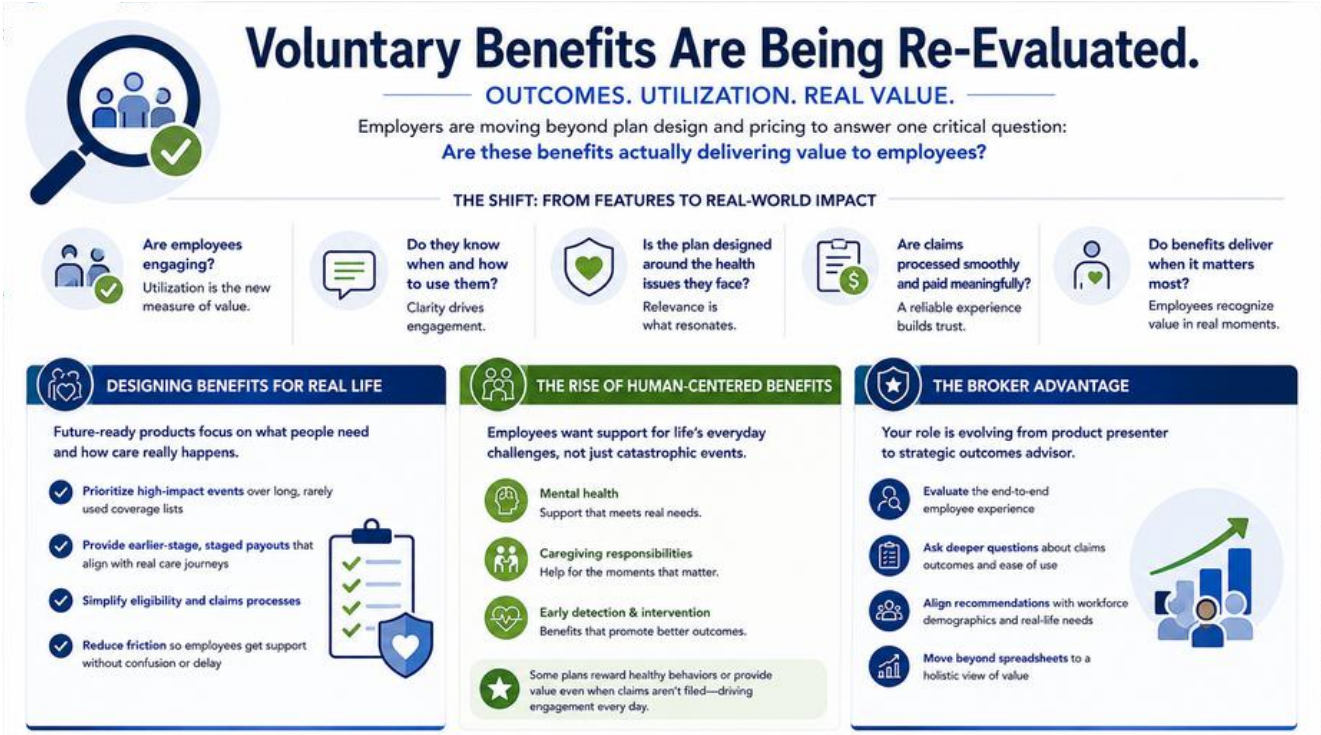
Some voluntary benefit offerings are also beginning to incorporate features that reward healthy behaviors or provide added value when claims aren't filed, helping reinforce engagement even outside of major health events.

Benefits that address these needs (and treat them as essential, not supplemental) tend to drive stronger engagement and broader relevance across diverse workforces.

A More Active Role for Brokers

For brokers, this evolution changes the nature of the role. It's no longer enough to present a competitive slate of options. Employers are expecting guidance that goes deeper, grounded in how benefits perform, not just how they're priced. That means:

- Evaluating the **end-to-end employee experience**
- Asking more pointed questions about **claims outcomes** and **ease of use**
- Aligning recommendations with workforce demographics and **real-life needs**
- Moving beyond spreadsheet comparisons towards a more **holistic view of value**



It also means helping employers and employees better understand what they're buying and how to use it effectively.

The Bottom Line

Voluntary benefits are entering a new phase. What was once a relatively passive category is becoming more accountable, more scrutinized and more closely tied to real outcomes.

The key question is no longer: Is this benefit competitive?

It's: Will employees actually use it, and will it deliver when they do?

For brokers and employers alike, the ability to answer that question clearly will define success moving forward.

Christin Kuretich - Vice President of Product, Trustmark: Christin joined Trustmark in 2026. Prior to joining Trustmark, she led the development and product strategy team for Voya's supplemental product portfolio. Christin has a broad and varied background in voluntary benefits, excels at bringing insights from the field, and is known for her market expertise and human-centered approach to product development and problem solving.

The Bandwidth AI Will Give Back

What's Changing in Voluntary Benefits, Enrollment, and Ben-Admin — and Why it Lands Differently Depending on Where You Sit

By Mark Head

The problem with innovation is that it's… well… *change*. As Geoffrey Moore wrote in Crossing the Chasm (35 years ago now), the early adopters are tasked with building the bridge from the (rare) true innovators to the "early majority." But now, with AI, the early adopters and the early majority are getting crammed into the same marketspace.

APIs are connecting systems. AI is answering questions. Analytics are surfacing patterns. Decision support is guiding elections. Everyone knows they're table stakes, but table stakes don't generate new "wins."

"The win" is starting to get game-planned with:

- How employers choose and place products
- The role that enrollment and ben-admin firms play in shaping (and executing on), those decisions
- How the pre- and post-enrollment "plumbing" works, and, critically
- The almighty Employee eXperience (EX)

Increasingly, the EX is mirroring CX (consumer experiences).

Three Keys: Configuration, Decision Support, and Software

First: the leverage-point for systems is moving from "who controls the data" to "how sophisticated and flexible is the configuration?" Yes, getting elections, changes, and terminations from a platform to a carrier without a manual file feed in the middle took a while to become common.

But bigger improvements will keep coming as real-time APIs start routing information based on AI-informed needs, risk mitigation, compliance, and efficiency gains.

The move up the stack is even more important than just establishing secure APIs and webhooks. It's becoming more about powering the configurations: the products, rates, age bands, tier logic, and eligibility rules themselves, expressed in a shared, API- and Agent-ready form – than just exchanging enrollment data. Who wants to keep rebuilding the same workflows for every case?

Second: Decision Support (DS) is migrating beyond the O/E window.

It used to be a three-week tool: it appeared at O/E and then went dark. It's now moving towards always-on, a year-round assistant, conversational rather than scripted. More broadly, DS is expanding to include other employer programs like well-being, cost & quality transparency, and point solutions.

The move up the stack is even more important than just establishing secure APIs and webhooks. It's becoming more about powering the configurations: the products, rates, age bands, tier logic, and eligibility rules themselves, expressed in a shared, API- and Agent-ready form – than just exchanging enrollment data.

Third: software is starting to act, not just inform. In retail and payments (CX), the current conversations are about "agents" that don't just recommend but actually transact on a person's behalf, within limits that the person sets. The analog is coming toward benefits: once a plan's design and rules are API- and Agent-ready, the question of whether an employee's assistant could compare and even elect coverage on their behalf, based on rules the employees themselves set, stops being science fiction.

If You're a Broker or Benefits Consultant

Configuration isn't about what you offer, it's more about what to offer. Employers are increasingly sensitive to too much choice. The question begins to shift toward "How do the VB choices we offer compete with, or complement, our well-being and point solution offerings?"

This also becomes an opportunity to partner / drive the ben-admin vendor decision. Always-on decision support for employees changes what you can credibly promise an employer about engagement - not just at enrollment, but at the moment of need, which is where perceived value (and renewal conversations) actually live. And the emergent AI / Agent dynamic is key here; it's already beginning to touch the thing brokers have typically owned: guidance.

As AI becomes core to **Employee** decision support, how long before enterprising tech entrepreneurs start pushing out **Employer** Decision Support Agents – for programs, vendors, and consultants!?

Being the **designer** of the choice architecture, with trusted "humans-in-the-loop", is worth being early to.

If You're an Enrollment Firm

Online self-service (OSS) is everywhere – for all the reasons we already know. But counselor-assist models aren't likely to go away. In fact, they're becoming early adopters of new-tech. With more and more live-video calls replacing onsite experiences, this is a knife-edge moment for the industry; **counselors are already using AI agents during sessions.**

Developing strict configuration standards compresses the very setup-and-exception work that has historically justified part of the broker "cost", and it also frees operations people from babysitting the processes. Counselor-assist firms will likely need to compete on what configurability can't commoditize: the quality of the enrollment conversation, the personalization / segmentation and the messaging that actually drive conversions.

That's the case strategy you bring to the broker-consultant. And the more platform-flexible you can be, the better.

Some firms gain efficiencies by standardizing to a single platform. But good configurability lowers the cost of being flexible across multiple platforms, it increases the ability to scale efficiently, and it helps with building on an employer's existing system.

Configuration beats customization every time. Customization creates snowflakes. No company can scale while they're also trying to manage the snowfall. There are probably 4 or 5 standardized configurations that actually handle the "customization needs" of 90% of your clients. Standardize to configuration, with true customization needs to be scoped and charged separately for, and you'll have a documented, manageable engine where the client-specific nuances don't live only in the brains of the account team!

If You're a Ben-Admin Platform

Enrollment tech, consolidated billing, and data exchange – how exciting! It's critically necessary, of course, and to do it well should be the definition of boring. But given the shift towards configurability, API-native is what will cross the chasm, and it is becoming an existential reality. Just bolting on APIs will look like an afterthought, because that's what it'll be.

The competitive question stops being just "how do you connect to the carriers?" and becomes "how fast and how cheaply can a new product or a new carrier go live on you?"

The AI agent factor matters a lot here, longer-term, because whoever's pipes are the most agent-fluent (well-documented, real-time, and governed), become what Gandhi might have said, "Become the standard you want to see in the RFPs."

Standardization is not just a leveler; it actually rewards the genuinely better product and quietly strands the ones that were coasting on legacy integration lock-in.

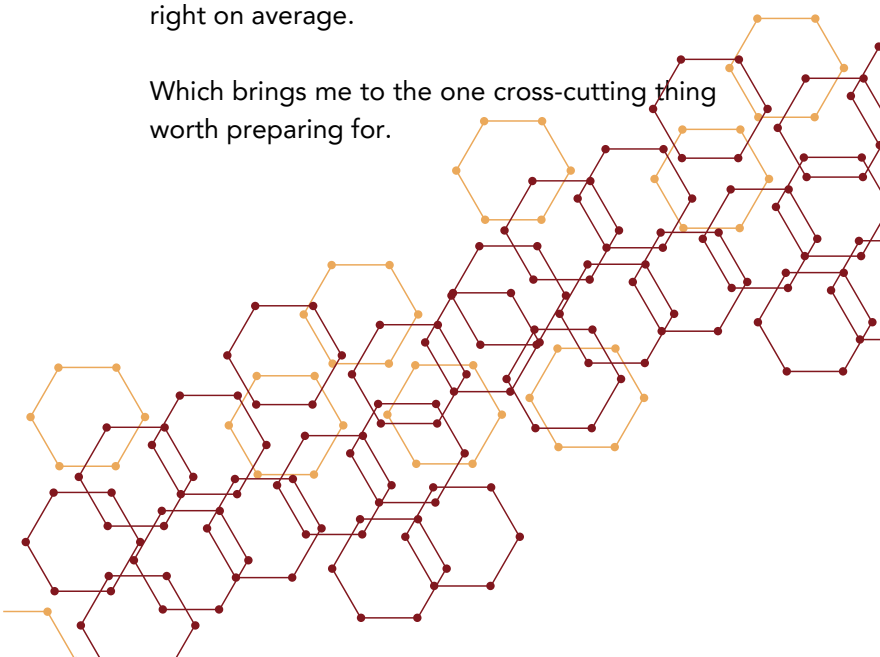
If You're a Carrier

You want to try to live at the Venn-Diagram center of all the other shifts. They're hitting your new-policy, ongoing administrative costs, and distribution-reach dynamics. Tech credits, no-charge enrollment platform access, and standardized configurations all lower the friction of getting your products onto more platforms and into more cases: pure distribution upside.

It also means your products get compared more cleanly against your competitors', because the data that describes them is no longer trapped in bespoke formats. Standardization is not just a leveler; it actually rewards the genuinely better product and quietly strands the ones that were coasting on legacy integration lock-in.

The operational shifts will land hardest on the back office, where the trackable, completed-unit work has to be right under audit, not just right on average.

Which brings me to the one cross-cutting thing worth preparing for.



Token-Budgeting is Coming

The enterprise conversation about AI is shifting from "is this useful?" to "where is it actually worth the money?" The "token" is the new cost unit, and the uncomfortable part is that a rising AI bill can mean real work is getting done - or it can mean the system is thrashing.

Re-reading context the LLM should remember, retrying, or using frontier models for simple tasks that don't need graduate-level compute, can get ruinously expensive, ruinously fast.

Anyone who's wrestled with ChatGPT on a complex task and found themselves re-explaining the same background for the fourth time has felt the frustration firsthand. That frustration, at enterprise-scale? Well, it just ain't gonna be allowed to happen. Not for long, at least.

Why does this belong in a benefits article? Because the easiest place to measure AI's value is against work already priced in completed units - which describes our operational cores pretty well: cost per processed claim, per resolved service case, per counselor session, per OSS session, etc.

As always-on assistants and agents move into those workflows, the ones that forget a member between sessions or thrash through an exception won't just feel clunky - they'll cost more to run, and that cost will land on whoever operates them: the enrollment firm, the consultant, the platform, the carrier.

None of this is fully here yet. It will tend to arrive quietly, at first, inside everyone's previously unmeasured cost structures, right up until when the costs start shouting. AI plumbing, not API plumbing, is where tomorrow's stories may well come from.

The real innovative advantage will belong to whoever redirects newly-freed capacity toward judgment, design, and real-time "one who comes alongside" support.

The Last Word

Things that used to be competitive moats - custom pipes, bespoke integrations, exquisite open enrollment orientation - are becoming commodities. We all know that. The real innovative advantage will belong to whoever redirects newly-freed capacity toward judgment, design, and real-time "one who comes alongside" support. That's where sustainable differentiation and higher case-win percentages will actually come from. The conduits have finally gotten good enough to stop thinking about; the question is what we'll do with the bandwidth we get back.

Mark Head, President, Benefit Personas - Mark focuses on innovation, strategy, business culture, business intelligence and analytics, as well as sales and marketing. S In 2015, he established BenefitPersonas™ in recognition of the need to drive increased enrollment and engagement in benefit programs. He works with enrollment firms, consultants and other benefit vendors to develop personalized, values-based communications using behavioral science and psychographic profiling.

Negotiating Conditions of Satisfaction and Relationships

by Steve Gabaugh, CEO, CNFC

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.

"Little by little, one travels far." - J.R.R. Tolkein

Championship Team Behavior

Principle #6: We Negotiate Relationships and Conditions of Satisfaction

The CEO of a multinational manufacturing firm received an irate call one day from the most important customer of one of their subsidiaries. The customer was very angry about chronic delays in receiving the products they purchased in a timely manner. He gave the CEO an earful about the stress it was causing the company in trying to meet the time demands of their customers.

Immediately thereafter, the CEO placed a call to the plant manager and unloaded on her about the customer's complaints, concluding with a blunt demand that the situation be corrected immediately and that it never happen again.

This call, of course, led to a tense meeting where the plant manager called in all the department heads and unloaded her frustrations on them, ending with the requirement that they fix the problem immediately. She added a new rule that they report to her daily specifically about the status of orders for the disgruntled customer.

As you might guess, the department managers then called in their direct reports and "let them have it" about this unacceptable situation. The end result, was an organization in turmoil with no clear direction as to how to correct the situation in both the short and long term. Clearly, this company did not have a relational leadership culture.

In case you were wondering, they eventually resolved the chronically delayed shipments when the heads of the Parts, Painting, and Assembly Departments sat down together to break down the situation and discovered some changes they could make in their workflow process.

It turns out that the Parts Department was using a "just in time" ordering process, which limited the quantity of parts they kept in stock in order to control the company's inventory expense. When the Painting Department received the parts, they were already needed for assembly. By the time the Assembly Department received the parts for assembly, it was already at the deadline date for shipping to the customer.

No wonder they were perpetually late delivering the products to their most important customer – and other customers too.

The solution they arrived at was for the Parts Department to place one additional order for the needed parts in expectation of future orders. That additional order was then sent ahead of any orders to Painting, who then forwarded them to Assembly, where they were able to find space to keep the finished parts in storage for quick assembly when an order was received.

If you've been following this series of articles about Championship Team Behavior this should sound familiar to you, as Principle #4 says: We Deal with Breakdowns and not Problems. This was not a company with a culture of relational leadership and yet the concept of negotiating conditions of satisfaction worked – because it makes good sense. ***Imagine how much better the environment would have been if they had established principle #6 as a standard for their company.***

Negotiation is a much more positive way to improve work processes and procedures than arguing, criticizing or demanding. It takes into consideration the challenges and concerns of each team member, and promotes working together so that both (or all) parties can meet the needs of their particular purpose for the betterment of the entire team.

Another important area for negotiation would be that of relationships. It is a mistake to believe that everyone on a team is going to like, and be glad to work with, every other member. That's just not reality.

But just because two individuals don't like each other or see eye-to-eye on how to approach decision making, doesn't mean they can't work together effectively. A relational leader is aware of this situation and helps to guide the individuals to a negotiated relationship, whereby they can agree to put aside their differences for the sake of the team's performance.

Negotiation is a much more positive way to improve work processes and procedures than arguing, criticizing or demanding.

In any team endeavor, there is a chain of processes and actions that lead to an ultimate conclusion. In sports, that could be executing plays that lead to scoring points or taking defensive actions that stop the other team from scoring. In school, it's completing assignments, which leads to promotion to a higher grade level, which leads to more assignment completion, which leads to another higher grade level, and so on. In the insurance industry, for example, product development leads to marketing, which leads to sales, which leads to underwriting and policy issue, which leads to premium collection, which leads to commission and expense payment and reserving for future claims, which leads to customer service, which leads to claims payment and … there's a lot more detail here but you get the point.

Dave Moore, the creator of Championship Team Behavior in a business environment, expected each of his direct reports to adhere to these principles. His high-performance team consisted of exceptional individuals with a passion for the business and a commitment to excellence.

They also, as a general rule, were each very confident in their thinking about the right way to take on any challenge or opportunity. As a result, discussions leading to a final decision were often spirited in nature, requiring negotiation among each other to successfully address the situation at hand.

There were a couple of members of the team who, frankly, didn't care for each other personally. They were both highly regarded professionals and critically important to the team's overall success. Their inability to work together more than once brought the entire team's momentum to a dead stop. In this case, it was clearly a problem that needed to be addressed by the boss.

Dave met with both members of the team individually and then together, to resolve the situation. During this "Championship Team Discussion" they were able to say the unsaids and negotiate a working relationship going forward. Word has it that a part of the discussion was an opportunity for both individuals to consider what life would be like for themselves and the team if they weren't on it.

This is an example of how the principles of Championship Team Behavior work together to help a team become and grow as a high-performance team.

It is also how you create an organizational system that continually develops leaders. The culture created by this relational leadership approach developed several senior level leaders including: two division presidents, an executive vice president for another company, a senior vice president of a Fortune 100 company and the president and CEO of another company. And those leaders have gone on to develop other leaders who are currently continuing the process.

Over the past seven months we have considered each of the 6 principles of Championship Team Behavior. Taken together they provide a framework that not only creates and grows a positive relational leadership culture but continually provides development opportunities for future leaders. I hope you will consider applying them to your team.

Here they are again as a reminder:

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**
5. **We Say the Unsaids**
6. **We Negotiate 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.

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