The Renewal Process:

How to Prepare for Your Upcoming Renewal

A Strategic Approach to Managing Employee Benefits

Webinar Series Pt. 3

September 17th, 2025

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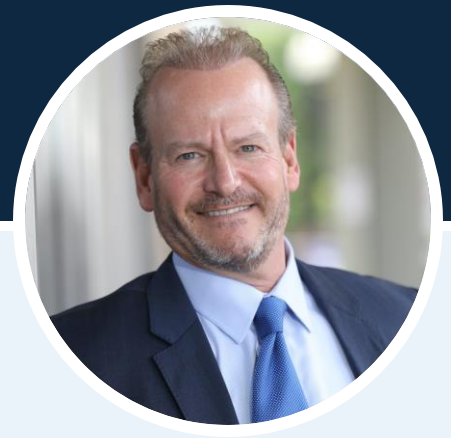

- Born in Brooklyn, NY, grew up in Manalapan, NJ.
- Attended Carnegie Mellon, graduated from Rutgers University.
- After college, I began working in the insurance business, where it took only a few years to recognize I did not like the way large insurance companies operated.
- In 1990, I started Potomac Companies, Inc. with a mission to make a difference in people's lives, by focusing on clients' unique needs and building long-standing relationships.
- Potomac Companies was ranked one of the top employee benefits brokerage and consulting firms in the DC metro area for over two decades.
- In 2022, Potomac merged with Acrisure, LLC, the world's 6th largest FinTech & fastest growing in industry history.
- I have been an insurance practitioner for 40+ years. Insuring ISRI/ReMA for 35 years.

Benefits Education & Funding
Part 1 – April 16th

Employee Turnover / Attrition
Part 1 – April 16th

Recap

High-Cost Claimant Offset
Part 2 – April 30th

Controlling Healthcare Costs
Part 2 – April 30th

Streamline the Renewal Process

Learn how to be proactive and avoid the last-minute fire-drill

Know what's coming 4-6 months in advance – access insights months before renewal deadlines

How to mitigate high-cost increases

How many full-time benefit eligible employees do you have?

Who has already received their renewal for 2026?

Calendar year plans

PwC project medical cost trend in 2026 to be 8.5% for Group coverage and 7.5% for the Individual market

Claims costs continue to rise as hospitals and health systems shoulder heavier operating outlays and find innovative ways to collect additional revenue.

Behavioral health spending is climbing dramatically. Spending on drugs is also increasing, in part due to the popularity of GLP-1s and launches of new drugs.

The Renewal Process:

Step 1: Underwriting Review

The carrier's underwriting team reviews:

- **Medical Cost Trend:** 8.5% projection for 2026
- **Claims Data:** Paid claims vs premiums (loss ratio), large claimant activity, pharmacy spend.
- **Demographics:** Average age, dependent coverage levels, location, gender mix.
- **Plan design:** Deductibles, copays, out-of-pocket maximums, utilization patterns.
- **Utilization Trends:** ER visits, preventive care, chronic conditions.

For fully insured groups: renewal is formula-driven, based on pooled risk and claims.

For self-funded/level-funded groups: deeper stop-loss analysis, high-cost claimant reporting, and utilization projections.

Your broker should also analyze these trends and provide you with an estimated renewal. Our estimates are typically always within 1% of the actual renewal.

The Renewal Process:

Step 2: Renewal Notice

The carrier sends a renewal notice to the employer (via the broker) detailing the terms of the new policy:

- Proposed Rates
- Updated plan documents
- Justification for changes

If you're an organization with less than 50 employees:

- Typically, you would receive your renewal from your broker, 30 - 60 days in advance.
- Not a lot of time to plan and/or make changes.

The Renewal Process:

Step 3: Review & Benchmark

Broker/consultant compares the renewal against:

- Market benchmarks (similar size, location and industry groups).
- Historical experience (your own prior renewals).

The goal is to identify if increases are in line with market averages and decide if it’s worth going out to bid (Request for Proposal / RFP).

Scenario: Company X receives a 10% increase with relatively no changes to the plan designs.

- How are your employees doing with that plan?
- Are there any negative optics?
- Is it doing the right job to attract and retain quality staff?
- Do you want to enhance it or take away from it?

Now we have our laundry list and we go back to the drawing board, whether it's with the same carrier or others and we illustrate what those expected costs would be.

The Renewal Process:

Step 4: Negotiation

- Broker/consultant negotiate with the carrier for better terms.
- The broker may request a “second look” or leverage competing quotes.
- Adjustments could include plan design tweaks, stop-loss level changes, or wellness program integration.

The Renewal Process:

Step 5: Evaluate Plan Options

Employer decides whether to:

- Renew current plan “as-is”
- Adjust plan design (deductibles, copays, wellness incentives, etc.)
- Switch carriers or funding arrangement (e.g., move from fully insured to self-funded)

It is important to align plan options with company goals (cost control vs rich benefits) and consider employee satisfaction, recruitment, and retention impacts when evaluating.

The Renewal Process:

Step 6: Employer Decision & Approval

Employer signs off on:

- Carrier choice
- Plan design
- Employer vs employee premium contributions

The Renewal Process:

Step 7: Open Enrollment

Employer & Broker launch communication campaign:

- Open enrollment portal
- Plan comparison guides & FAQs.
- Presentations or videos to explain changes.
- Employees make elections.

It is important to provide clear, plain-language messaging (what changed, what stayed the same, why).

The Renewal Process:

Step 8: Carrier Processing

- Employer submits final enrollment data to carrier.
  - Carrier issues:
    - ID cards.
    - Confirmation of plan setup.
    - Billing setup.
- Payroll/HRIS updated for new deductions.
- Confirm enrollment data accuracy (avoid coverage errors).
- Double-check billing reconciliation on first month’s invoice.

The Renewal Process:

Step 9: Effective Date

- New plan year goes live
- Employees begin using new coverage
- HR monitors first-month issues (ID cards, provider access, billing errors)
- Collect employee feedback during first 30–60 days.

Fire-Drill Renewal Timeline

~45 days before renewal	Carrier delivers renewal late (or HR/Finance waits to review). Little/no time for underwriting questions, benchmarking, or negotiation.~
~30 days before renewal	HR scrambles to review renewal, maybe shops 1–2 carriers quickly. Limited leverage — carriers know time is short. Plan design changes (if any) are rushed and poorly communicated.
~20 days before renewal	Employer leadership makes a fast decision, often defaulting to “accept the increase.” Contribution strategy set with minimal financial modeling.
~15–10 days before renewal	Open enrollment is compressed into 1 week or less. Employees get rushed communication, leading to confusion or errors.
Plan effective date	Employees get ID cards late. Payroll deductions may be incorrect. HR spends the first month fixing mistakes.

Result:

- Higher renewal increases
- Poor employee experience
- Higher error rate.

Pro-active Renewal Timeline

5 - 6 months out	Carrier underwriting begins (claims/utilization review). Employer provides updated census. Broker may provide estimated renewal (+/- 1%)
4 months out	Carrier issues initial renewal package. Broker reviews assumptions. Benchmarking begins (market survey, competitor quotes if needed).
3 months out	Renewal strategy meeting with leadership. Broker negotiates with carrier; may request second look. Employer decides whether to market to additional carriers.
2 months out	Final quotes received. Leadership approves carrier, plan design, and employer/employee contribution split. Employer prepares employee communications and open enrollment materials.
30 - 45 days before renewal	Employee open enrollment period (2–3 weeks). Employer/Broker hosts Q&A sessions, webinars, or benefit fairs. Employees make elections with time to ask questions.
15 - 30 days before renewal	Employer submits enrollment files to carrier Payroll updated with new deductions. Carrier issues ID cards before effective date.
Plan effective date	Employees start new plan with cards and info ready. HR monitors for issues but process is smooth.

Result:

- Better negotiating leverage
- Cost control
- Smoother employee experience

ISRI Convention in Vancouver: Benefits & Attrition (Turnover)

- I spoke at an ISRI Convention to **20** attendees about benefits and turnover
- The turnover rates varied across the room from **25% - 100%**
- Wide range of employees from **10 – 600**
- One person said they had a **4%** turnover rate
- **110** employees, **100%** employer paid healthcare, **100%** employer funded HSA, **401(k)** with a 3% safe harbor match and **100%** employer paid ancillary benefits.
- How do you take a page out of their book and reduce your turnover and increase profits?

Case Studies

800 employees | 550 insured | January 1 Renewal (2 Carriers)

- We received the initial renewals at the end of June.
- Beginning of July, we negotiated back and forth twice between the carrier and the HR / C-suite.
- Monday, August 11th, final decisions are made.
- $8.5m premium. 15.3% increase ($1.1m) negotiated down to a 6.57% increase ($472,000) with no changes to the plans.
- Done inside of approximately 4 weeks with both carriers, the third-party administrator and the client. We now have the time to plan and start open enrollment either at the end of September or beginning of October and ensure timely processing of data.
- We also added in a voluntary GLP one program for weight management at a reduced cost to members and no cost to the organization.

Case Studies

45 Employees | December 1 Renewal

- Pre-renewal in beginning of July (9% increase)
- Met with HR and CFO, finalized the renewal in the first week of August.
- 2.3% final increase and switched to a plan that covers every deductible and co-payment in a national PPO plan, with one exception, $100 emergency room visit.

200 Employees | October 1 Renewal

- We received the renewal the end of May.
- Negotiated in June.
- Finalized in July.
- Staying with the same carrier and benefit program when we took an 18% renewal down to 6.2%.

39 Employees | Referred to by a client

- 60 days until renewal 20% increase ($70,000) with UHC
- Within 10 days, we showed them an option to take the renewal down to -1%, remaining with UHC.
- We also showed another option that would have saved them $50,000 (-15%) with more guardrails but still with UHC, this would have been a more targeted approach and require more education for the employees.

How do you mitigate high-cost increases?

What is a High-Cost Claimant?

- According to the latest data from CMS, the United States spent approximately **$4.9 trillion**[6] on healthcare in 2023 and a projected **$5.4 trillion**[4] in 2024.
- High-cost claimants are those whose claims cost **$50,000** or more per year.
- Only **1.2%** of all members are high-cost claimants but they make up **over a third of employer health care spending.**
- A high-cost claimant has a **29X** average member cost.[7]
- *Recently, a client had a 50% increase due to 1 claim - a $100,000 per month prescription*

High-Cost Claimant Offset *(For groups over 50 EEs)*

Scenario: John is diagnosed with cancer.

- John has **excellent health insurance** through his employer.
- He initiates Short-Term Disability which transitions into Long-Term Disability.
- John then decides to **terminate his employment** due to the ongoing treatment.
- His employer is **legally required to offer COBRA**, and John enrolls because the group plan has excellent benefits, and he can keep the same doctors.

How long can John remain on COBRA?

- John can remain on COBRA for the next **18 – 36 months**. His claims cost **$300,000 per year** and will impact the employers group health plan for the up to the **next 3 years**.

High-Cost Claimant Offset *(For groups over 50 EEs)*

Scenario: John is diagnosed with cancer.

- John's employer creates a **highly specialized ERISA legal agreement** which is signed by both parties.
- Instead of taking COBRA, John is offered to purchase **Plan X** from the individual marketplace where his doctors are still in-network, to avoid any disruption to his treatment.
- Under the agreement, Plan X is paid for by the employer and costs them **$14,000 per year** (tax-deductible) plus **$3,000** in legal fees for the creation of the agreement.
  - John's employer can choose how long they wish to cover John.
- John is grateful for the continuation of employer paid healthcare and the transitional support during this difficult time.
- After the first year, John renews or changes the plan based upon his needs.
- John's employer saves approximately **$285,000** in future claim cost per year for the **next three years.**

Individual Coverage Health Reimbursement Arrangement (ICHRA)

An ICHRA is an employer-funded health benefit plan that allows employers to reimburse employees for individual health insurance premiums and other medical expenses. Introduced in 2020, as part of healthcare reform to offer more flexibility than traditional group health insurance.*

Employers:

- Allocate a fixed monthly allowance for employees to use for health insurance.
- Choose which employee classes (e.g., full-time vs. part-time) are eligible.
- Contributions made by the employer are tax-deductible.

Employees:

- Purchase health insurance plans through the individual marketplace.
- Submit proof of purchase to get reimbursed by the employer.

Limitations

- Remember - the individual marketplace is the highest cost of health insurance.
- Employees can't claim premium tax credits for the year if they accept the ICHRA.
- Cannot be enrolled in their employer's traditional group health plan simultaneously.
- Location class(es) have their own set of specific guidelines.

Medicare COB Rules

- Employers sponsoring group health plans that cover individuals enrolled in Medicare should understand **Medicare's "coordination of benefits" (COB)** rules, which determine whether the group health plan or Medicare pays first on health care claims.

- The **"primary payer"** pays what it owes on a health care claim first. If the primary payer does not pay the health care claim in full, the claim is sent to the **"secondary payer"** to pay any remaining covered portion.

- When an individual has both Medicare and employer sponsored health plan coverage, the payer status of each type of coverage depends on a number of factors, including the reason for Medicare entitlement and, in some cases, the size of the employer.

Medicare COB Rules

Reason for Medicare entitlement	Situation		Employer size	Pays first	Pays second
Age	Individual is covered by an employer's group health plan because they (or a spouse) are still working		20 or more employees	Group health plan	Medicare
			Fewer than 20 employees	Medicare	Group health plan
	Individual has coverage under the Consolidated Omnibus Budget Reconciliation Act (COBRA) or is covered by a former employer's group health plan as a retiree		N/A	Medicare	Group health plan (COBRA coverage or retiree coverage)
Disability	Individual is covered by an employer's group health plan because of their own employment or a family member's employment		100 or more employees	Group health plan	Medicare
			Fewer than 100 employees	Medicare	Group health plan
	Individual has COBRA coverage or is covered by a former employer's group health plan as a retiree		N/A	Medicare	Group health plan (COBRA coverage or retiree coverage)
End-stage renal disease (ESRD)	Individual has group health plan coverage (including retiree coverage or COBRA coverage)	First 30 months of eligibility or entitlement to Medicare	N/A	Group health plan	Medicare
		After 30 months of eligibility or entitlement to Medicare	N/A	Medicare	Group health plan

Medicare Secondary Payer (MSP)

- Under the Medicare Secondary Payer (MSP) rules, it is illegal for an employer to offer to pay for Medicare and/or a supplement in lieu of employer sponsored health benefits.
- In other words, the government doesn't want you enticing an employee of that age bracket to get off your plan.
- Now, what happens if it's an owner, partner in a law firm or a Doctor?
- Why would you want to impede your own company?
- If there is an avenue that costs less for the company, then of course anyone who might have a financial benefit in the company would explore that avenue.

Thank you for listening!

Tune in for Pt. 4 on October 1st:

Could outsourcing your back-office and HR save you money?

See you there!