2024 SIIA NATIONAL CONFERENCE ROUND-UP

Written By Bruce Shutan

Mercury was rising as a record number of attendees gathered for the Self-Insurance Institute of America's (SIIA) 44th Annual National Educational Conference & Expo at the JW Marriott Desert Ridge in Phoenix, where unseasonably high temperatures were recorded.

In the opening keynote address, pollster Kristen Soltis Anderson sought to handicap the 2024 presidential election and explain how polls haven't squared with outcomes over the past several decades. Anderson, a founding partner of Echelon Insights and author of "The Selfie Vote: Where Millennials Are Leading America (And How Republicans Can Keep Up)," was both informative and entertaining in her assessment of generational and partisan differences among American voters.

What followed were a series of workshops and panel discussions on the current state of reinsurance and captive markets, TPA trends, the latest AI applications, behavioral health, prescription drugs, regulatory and compliance matters, mentoring and partnership opportunities. Below is a smattering of coverage from some of those noteworthy sessions. – Bruce Shutan

REINSURANCE MARKET RIPE FOR SIGNIFICANT CAPITAL INVESTMENT

Healthcare continues to pique the imagination of venture capitalists and entrepreneurs alike who are looking to disrupt a staid industry by pouring significant dollars into meaningful solutions. Self-insurance appears to be riding those coattails, serving as an incubator for innovative partnerships and consolidation across this growing ecosystem.

Samantha Engel, global head of accident and health for Renaissance Reinsurance U.S., Inc., noted that "a lot has changed over the past 100 years, and it's important to recognize how the market has adapted, stepped up, offered new products and found new solutions."

She cited a number of historical developments spanning that time frame. They included the emergence of stop-loss wraparound products following the passage of ERISA and PPOs seeking to manage uncontrollable growth in healthcare costs. Other key markers included small group market reforms in the early '90s that allowed self-insured solutions to trickle down the market, premium trend dropping from double digits nearly down to zero, then rising again, while states like Vermont and Massachusetts took action on universal healthcare coverage, the Affordable Care Act passed in 2010 and elective care being deferred during the pandemic.

About 80% of reinsurance premium is written by the top 20% of market players, according to Dan Bolgar, CEO of Carbon Stop Loss Solutions, who noted the growing role of group captive managers. He also said about 50 managing general underwriters have invested in this space with about $2.5 billion in premium.

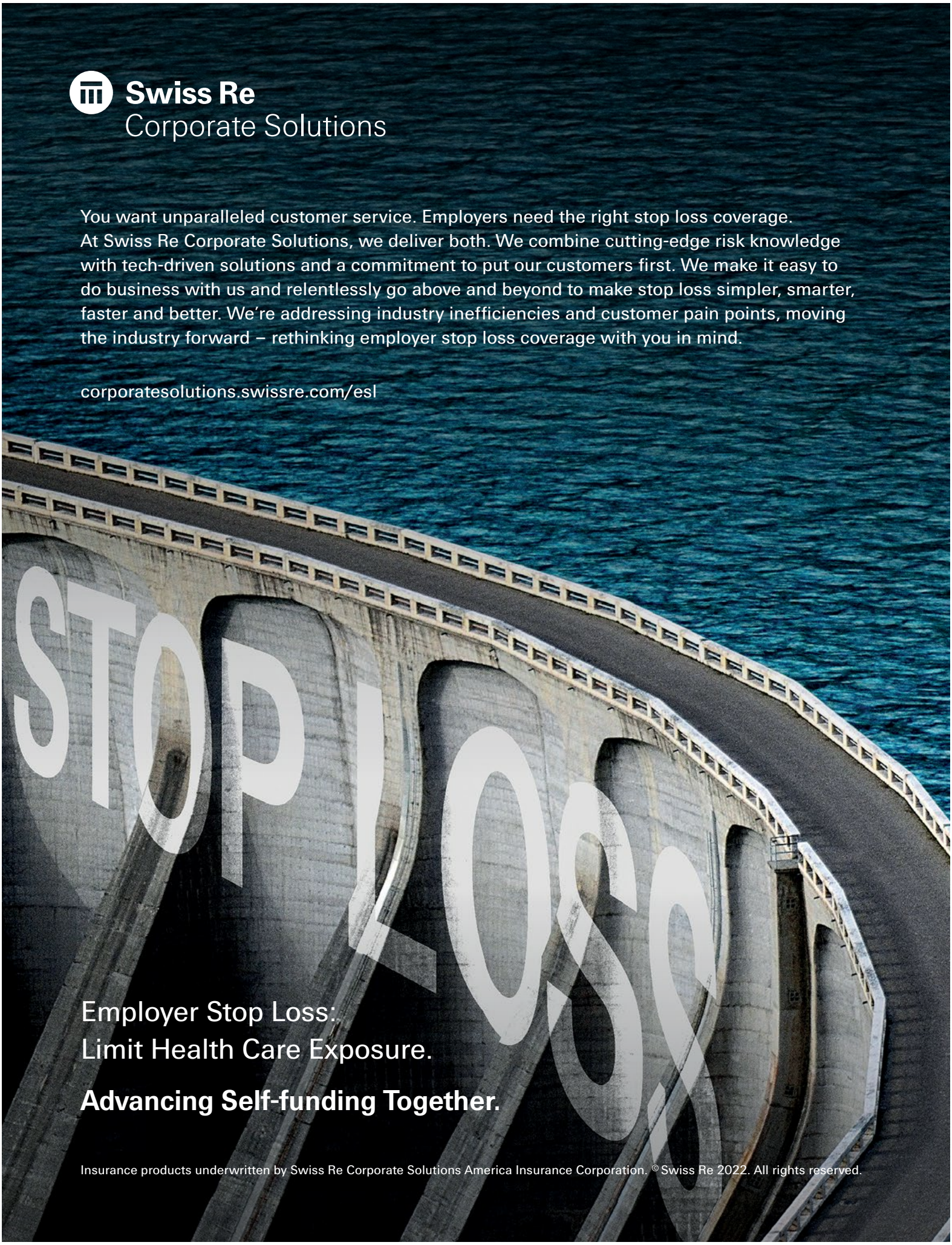
Considering that the reinsurance space is valued at about $35 billion to $36 billion, with double-digit annual growth being reported, Bolgar noted that M&A activity is heating up. Notable developments include private equity investment from big players like Sequoia and the Carlisle Group, as well as acquisitions by Blackstone and KKR. The sector is also drawing additional sources of capital other than private equity, he added, noting that the organic growth of this market stimulates interest in investment.

While reinsurance continues to generate interest among major investors, Bolgar said it represents a tiny slice of a much broader market estimated at $4.5 trillion, with about 18% of gross domestic product being spent on healthcare – an amount that's projected to reach $7 trillion by 2030.

"We work in an extraordinarily inefficient sector," he observed, noting that private equity loves opportunities to turn around poorly run operations. While the impact of this influx of capital into the market has yet to be determined, he said it's an attempt to create greater efficiency and competition through better data quality.

Captive insurance, an alternative risk transfer arrangement that has gained traction in recent years, finds its way into about half of all conversations in the self-insurance market, observed Thomas Leonardo, global head of accident and health for SiriusPoint America Insurance Company. Typically, he sees a partnership approach wherein captives issue a policy with reinsurance behind it.

"We've seen that from time to time, though probably not as prevalent as an MGU taking risk on their captive or finding a strategic partner in their work stream that is interested in participating in the risk and seeking additional revenue on the same premium base," he reported.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Leonardo said collateralization is critically important, noting that letters of credit are very common and used in some combination with buying reinsurance on the top end. "There are things the carrier can do to protect themselves that allows them to then take credit for that reinsurance on our balance sheet," he explained.

The importance of this issue was spotlighted in the past year or so when he noted that a financial technology company issued $4 billion in letters of credit in the property and casualty market that were later discovered to be fraudulent, and therefore, attempts were made to replace that collateral. An ability to protect downstream policyholders is critical when working with a captive solution, he added.

Leonardo looks for longevity, integrity and discipline in new business opportunities. "A very smart man once told me that he likes chaos, which drives market opportunity, and I think that is going to be tested here in the next few years," he opined.

Those words rang true for fellow panelists. "When something catastrophic happens, I always consider it an opportunity," said Paul Skrtich, senior vice president of accident and health at Odyssey Reinsurance Company.

One such area that has generated growing interest involves cell and gene therapy, whose sky-high cost he believes ultimately will be built into reinsurance coverage with access to a network of specialists to make it more affordable vs. carving it out, which was done with organ transplants years earlier.

THE CASE FOR IMPROVING ACCESS TO BEHAVIORAL HEALTHCARE

Four years after pandemic lockdowns seeded social isolation and loneliness, the effects of a national behavioral health epidemic are still being felt. Sandra Stein, M.D., chief medical officer of Banner Health Plans, cited the emergence of rising levels of anxiety, depression and substance abuse associated with an opioid crisis, as well as greater awareness of social determinants of health. Since then, she has been working closely with employers to remove obstacles to care for people suffering from mental illness and substance use disorder and eliminate the stigma associated with seeking treatment.

With COVID-19, MINES and Associates CEO Daniél Kimlinger, Ph.D., noted several care-access challenges tied to provider shortages, especially in rural areas, and industry consolidation. Since providers drop in and out of networks all the time and administrative overhead can be significant, she said it's important to know how networks connect patients with providers, as well as measure the effectiveness of treatment.

Sometimes behavioral health services aren't connected, and patients are confused about where to seek care, which Kimlinger said can be a missed opportunity. She suggested that health plans do whatever they can to integrate care networks and keep care barriers low by charging low co-pays or no out-of-pocket costs. With so many working Americans living paycheck to paycheck, she said it's challenging to afford $150 per session for treating behavioral health conditions in the face of rising out-of-pocket costs.

Another concern is that there are no guardrails on what facilities charge for behavioral health claims, which vary widely, nor is there any transparency on that pricing information, explained Ira Weintraub, M.D., chief medical officer for WellRithms, Inc.

In searching online for luxury rehab centers in California, for instance, he found that cash customers may expect to pay $54,000 for a month's stay, whereas the price tag may be $141,000 for those with insurance coverage. Patients have the option of anything from a private villa to a shared room. In evaluating another inpatient facility, he noted that the American Hospital Directory suggested an average cost per day of $693, though charges can be as high as $3,000 to $5,000.

"What's the right number?" he asked. "No one even knows what they get because you can't get an itemized bill like you could get for hospital care. These prices, like everything else in medicine, have gone overboard."

As a physician, Weintraub believes doctors should be paid fairly, but it's difficult to determine how – and for what – patients are being treated based on the billing. This is why he said it's important to include in the summary plan description exactly what will be covered. The most difficult obstacle he sees is that behavioral health facilities are loath to provide medical records.

Nowadays, consumers are becoming more sophisticated about these conditions. Many of Kimlinger's clients started watching Tik-Tok videos, which she described as "incredibly digestible," and became more knowledgeable about trauma, eye movement desensitization and reprocessing of distressing experiences and specialty networks, some of which sought to remove care barriers for marginalized communities.

With the pandemic shining a spotlight on the importance of mental health treatment, some unconventional approaches have shown promise. One such example involves the use of ketamine, which the Drug Enforcement Administration describes as "a dissociative anesthetic that has some hallucinogenic effects."

Nearly 200,000 members of Enthea, which provides access to safe and affordable psychedelic-assisted therapy, reported significant reductions in anxiety, depression and PTSD after a year

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of ketamine therapy, according to Enthea CEO Sherry Rais. She said clinical trials among prestigious universities have reported similar results, while ketamine also has shown promise with smoking cessation programs.

However, there are certain obstacles that may stand in the way of any progress. She noted, for instance, that there's a stigma associated with the use of psychedelics for certain ethnic and blue-collar groups. Her recommendation for overcoming this challenge is twofold: educate employees about treatments that are being provided and promote a healthy culture at work.

Depression alone cost U.S. employers $200 billion in lost productivity last year, which Rais said raises concern about the direct and indirect cost of untreated mental health. "The more interesting story comes from looking at improvements in employee absenteeism, engagement, productivity and retention," she added.

Although telehealth has revolutionized care delivery, especially on the behavioral health side, where privacy is deeply valued, not everyone is comfortable receiving virtual care. Last year, Kimlinger noticed that 52% of her clients elected in-person care, which all employee assistance program providers she works with are also experiencing. Another point to consider is that people in rural areas may have poor access to wi-fi or live in crowded homes with little to no privacy.

Western and Northeast states have had the largest rise in telehealth, while it's about the same in the South and the Midwest has decreased slightly, according to Weintraub. He said as many as 65% of those virtual visits involve mental health conditions. Telehealth commanded a higher payment than in-office visits, with the biggest price tag in the Northeast and lowest in the West. "These kinds of statistics make you understand that the numbers coming in are really astronomical," he noted.


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Telehealth increases capacity for psychotherapy and psychiatric services, as well as assessment of medication, Stein added. Her company also uses urgent care centers to decrease the need for crisis intervention in the E.R., as well as primary care physicians who are educated about behavioral health – mindful that those visits can help reduce the stigma around these conditions.

NQTLS SEEN AS COMPLICATING PUSH FOR MENTAL HEALTH PARITY

While the Department of Labor ramps up its mental health parity compliance audits, a panel of experts noted that the self-insurance community continues to struggle with developing non-quantitative treatment limitations (NQTLs) analyses.

Recently issued regulations require the collection of specified data and a detailed evaluation to assess the impact of NQTLs on behavioral health benefits relative to medical/surgical benefits covered under the plan along the road to achieving parity.

The issue dates back 28 years ago with the passage of the Mental Health Parity Act of 1996, which prohibited large group health plans from imposing annual or lifetime dollar limits on mental health benefits that were less favorable than those on the med/surg side. It was followed by the Mental Health Parity and Addiction Equity Act of 2008, which extended those protections to health plan members being treated for substance use disorder. A final regulation implementing that law was published in 2013, while new final rules that amended certain provisions of the regulations and added others were released on September 9, 2024.

Compliance with NQTLs is being staggered over the next few years, the panel noted. For example, employers must certify for 2025 that an expert was hired to do an NQTL analysis. Also, a new data evaluation requirement and nondiscrimination component as part of the NQTL analysis, as well as determining any material differences between behavioral health and med-surg benefits, have been delayed until 2026.

"What I'm finding from these types of audits is the regs, and department interactions are sometimes subjective, and it's very difficult to understand what the departments are believing from a client perspective where you and your counsel, or your client, believe you are complying and putting together a comparative analysis that required by these rules," SIIA General Counsel Chris Condeluci said.

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There's a lot of word salad with the NQTL requirement with regard to what constitutes a "meaningful" benefit, explained Lisa Campbell, a principal at Groom Law Group. Since definitions that served as the framework for NQTL analysis have changed, she said it poses a compliance challenge for employers.

The hope is that additional guidance will be forthcoming, along with more of a standard framework for relevant data. Plan sponsors need to consult with their counsel about what plan information they currently have and what's expected to comply with these requirements, she added.

Noting that the documentation requirement is very serious, Campbell said more than 150 NQTLs were requested to audit in the first year. "The departments are being aggressive, and I don't think that's going to stop," she cautioned.

Another complication is that Condeluci believes the recently overturned Chevron-deference judicial precedent that courts have followed for decades will open up the floodgates on litigating all regulations. Specific to the mental health parity regs, he said, there could be an argument that the government exceeded its authority by challenging definitions of material differences between behavioral health and med-surg benefits.

The rub on compliance is that employers rely almost entirely on their service provider for guidance. He says that means they'll need to be more diligent about ensuring compliance with the law when designing a suite of benefits and provider networks.

Condeluci added that provider network accuracy is a core issue when it comes to access to behavioral health services. Some providers aren't being reimbursed at a fair and reasonable rate, which he said is an issue to consider, and it may not be a resolvable problem unless payers are willing to increase those reimbursements.

At least one of the panelists expressed optimism about the final rules, believing they offered some blessings in disguise. Jordan Smith, chief compliance officer for Healthcare Reporting, said they provide plan sponsors a hands-on approach that gives them more control over benefits design. "For someone who is making decisions for a self-insured plan, this was meant to be a wake-up call," he said. "The fiduciary certification was a really important place to start."

In offering context about the complexity of these rules, Smith noted that "we have to take a step back and realize that this is a really difficult thing to write regulations on because there is a tightrope around navigating the concept of ERISA preemption for self-insured plans and requirements of the ACA."

One impactful area that Smith said is hidden in the regs is that if a health plan is found to be noncompliant, there are real financial consequences in that behavioral health claims that were denied will need to be reprocessed.

Campbell said federal agencies also can require plan sponsors not to impose prior-authorization requirements on behavioral health benefits if there's a determination that their data is insufficient for complying with the NQTL analysis.

Smith warned that receiving an insufficient ruling on the NQTL analysis could be a P.R. problem for employers with their employees that can undermine a company's reputation and affect retention.

That is because benefit plan participants must be notified if the Department of Labor determines that their employer conducted what it considers an insufficient comparative analysis, Condeluci reported.

Looking ahead, Smith believes NQTL analysis should be something that's reviewed annually during open enrollment, and with vendors updating their data each year, mental health parity should be on every employer's annual benefits-compliance checklist.

It's also important that health plan data is buttoned up for HIPAA compliance and that plan sponsors are mindful of the need to protect personally identifiable information given that this type of data is targeted daily by hackers, added Colbey Reagan, a partner with Holland & Knight LLP. He said there should be separate security agreements made with vendors to protect large amounts of data, which should never be stored in a repository where it's not encrypted to lessen the risk of a breach of such information.

"It's important to verify who you are giving your data to because that data there is worth billions of dollars throughout the year," he said.

If these newest mental health parity requirements are seen as overly onerous and costly over time, then Campbell warned that they could produce unintended consequences. Amid the well-intentioned quest for mental health parity, she said employers may decide not to offer behavioral health coverage for fear of running afoul of the law since these benefits are not required.

STOP-LOSS CAPTIVES SEEN AS BUSINESS-DEVELOPMENT OPPORTUNITY

Medical stop-loss group captive programs represent the fastest-growing segment within the self-insurance marketplace, serving as an important business development opportunity for TPAs, brokers and numerous specialty service providers. However, a panel of experts pointed out that their complexity poses challenges that make it important to understand how these programs operate before they're positioned and priced for self-insured employers. Any collaboration seeded within these partnerships ultimately will help avoid landmines along the rocky road to risk mitigation.

SIIA's recent captive survey shows four-times growth from 2021 to 2023, reported Kari Niblack, president of Blackwell

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Captive Solutions. "We see a complete migration over to this solution, which shows no sign of slowing down," she said, noting that a captive pulls out the middle-layer risk and there's no group too small or large to implement this solution.

"The group captive model gives underwriters something they can lean on in terms of credibility and like-minded employers that have the same strategy in mind," added Dale Sagen, vice president and business development leader of QBE North America.

Other industry players are also sharing in the spoils. For example, he noted that risk managers who turn captive insurance into a profit center through a superior approach to medical claims management can differentiate themselves in the market. A similar competitive edge is being realized by forward-thinking advisers who he said are embracing so-called agency captives that are owned or controlled by an insurance agency or brokerage.

While 90% of Fortune 500 companies have their own captive, Sagen noted that single-parent captive solutions are piquing the interest of smaller employers.

As service providers in the self-insurance industry are able to get their hands on more data, they'll be better able to predict and manage risk – and captives are a tool for just that, observed Anna Quarum, co-founder and president of WellRithms. These strides in data collection allow employers to become more granular when putting into place a meaningful risk-mitigation plan, she said, noting that "it's exceptionally powerful when you have tools in place like a captive that can aggregate risk."

According to Niblack, it's critical in the captive space to measure savings based on data analytics. She said six-figure savings in organ transplants, for example, can help seed a captive program surplus. And any surplus that a captive captures from its claims-management experience can be earmarked toward reserves or reinvested to improve the benefits package, she added.

In order to reap the full benefits of a captive, transparency is imperative. Whatever partner that's connected with this ecosystem has to be willing to share both good and bad news because of the risks involved, according to Quarum. The more employers are able to get excited about risk assessment, the more she said they're able to drill down into a captive solution.

Echoing an often-repeated line that "if you've seen you've seen one captive, you've seen one captive," Quarum lauded these vehicles for providing self-insured employers an ability to think creatively without being locked into a cookie-cutter solution. However, standard practices are also necessary. A summary plan description, for instance, serves as a manual for risk mitigation by featuring strong language and guidelines on what exactly the captive will and will not cover, Quarum said.

There's a migration to customized solutions with specialty areas driving high-cost claims, Niblack observed. Being open to complete innovation without boxing oneself into a single solution can help leverage the power of a captive, which she said helps make benefit plans more competitive – and as such – can be used as a talent-management tool.

Sagen described captives as a more efficient and stable experience in managing group health plan risk, which is why so many employers are embracing them. What a captive can do very well for an adviser or TPA, he added, is streamline solutions and enable advisers to grow their book of business, removing variability from the market.

While direct primary care (DPC) is a trend that provides better access to healthcare on a daily basis, Sagen noted that there's not much credible data on the merits of this approach. He said captive insurance, however, can help build out the DPC model. He's also working on a few RFPs for an 11,000-life group that will use captive

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insurance without stop-loss to smooth out the volatility of cell and gene therapies and assume their own risk.

Noting a tenfold growth in captive regulator involvement, Niblack explained that reserve requirements and regulator receptiveness to these vehicles differ from one state to the next. Therefore, she said it's important to vet these terms with various state insurance departments when deciding where to domicile a captive.

NON-TRADITIONAL STRATEGIES TO CONSIDER FOR PHARMACY SPEND

The prevalence of "diabesity," a combination of diabetes and obesity, is clearly driving the prescription drug market. Since as many as 70% of U.S. adults are considered overweight or morbidly obese, virtually all employers cover drugs for diabetes, and about 30% do for weight loss, David Blair, CEO of LucyRx, noted in a panel discussion about non-traditional strategies self-insured employers can consider reining in their group health plan's pharmacy spend.

He said GLP-1 receptors, which were created in 2005 for diabetes before pivoting to weight loss and are now the nation's top drug category, have the potential to deliver tremendous health benefits to millions of patients.

"I can tell you a tsunami of drug costs are coming," he reported, noting that 16 drug manufacturers are working on GLP-1 scripts. He also referenced Rx developments to treat stroke, substance abuse, liver and kidney disease and believes a new pill form of this burgeoning drug category that's being developed will be a game changer for millions of Americans on injectables.

According to Blair, there are two strategies that should be employed to contain GLP-1 costs. One is a rigorous three-month prior authorization window. The second is required behavior modification such as nutrition and exercise. He said patients must play a role in helping contain these costs, noting that it's not a drug that can just be shipped out. Clients that have adopted this approach have reaped 56% savings over the past two years.

Blair said a memorable quote in the corporate office of a Catholic hospital system client, "No margin, no mission," applies to GLP-1s. These drugs "play a critical role in our mission to deliver outstanding care to our employees and their families. But together, we need to be financially responsible," he added.

Another promising approach for Rx cost-containment involves patient-assisted programs (PAPs), also known as manufacturer assistance programs, which allow drugs to be offered free to patients based on income eligibility up to double the median household income. Michael Jordan, chief business officer of Payer Matrix, noted that a rigorous application and approval process are involved, including physician engagement. The motivation for big pharma to offer a PAP is that it widens market access, reduces their tax liability, earns corporate goodwill, and improves public perception about their company, he opined.

For plan sponsors, Jordan said the chief issues involve affordability of prescription drugs, health plan sustainability, wage impact and risk protection. An avalanche of litigation is expected to shape the future of this industry, he opined, especially since drug costs are rising.

A third area for helping bend the Rx cost curve involves 340B programs, a federal subsidy set up in 1992 to support hospitals that care for a disproportionate number of low-income patients by discounting outpatient drugs by as much as 20% to 50% off the list price.

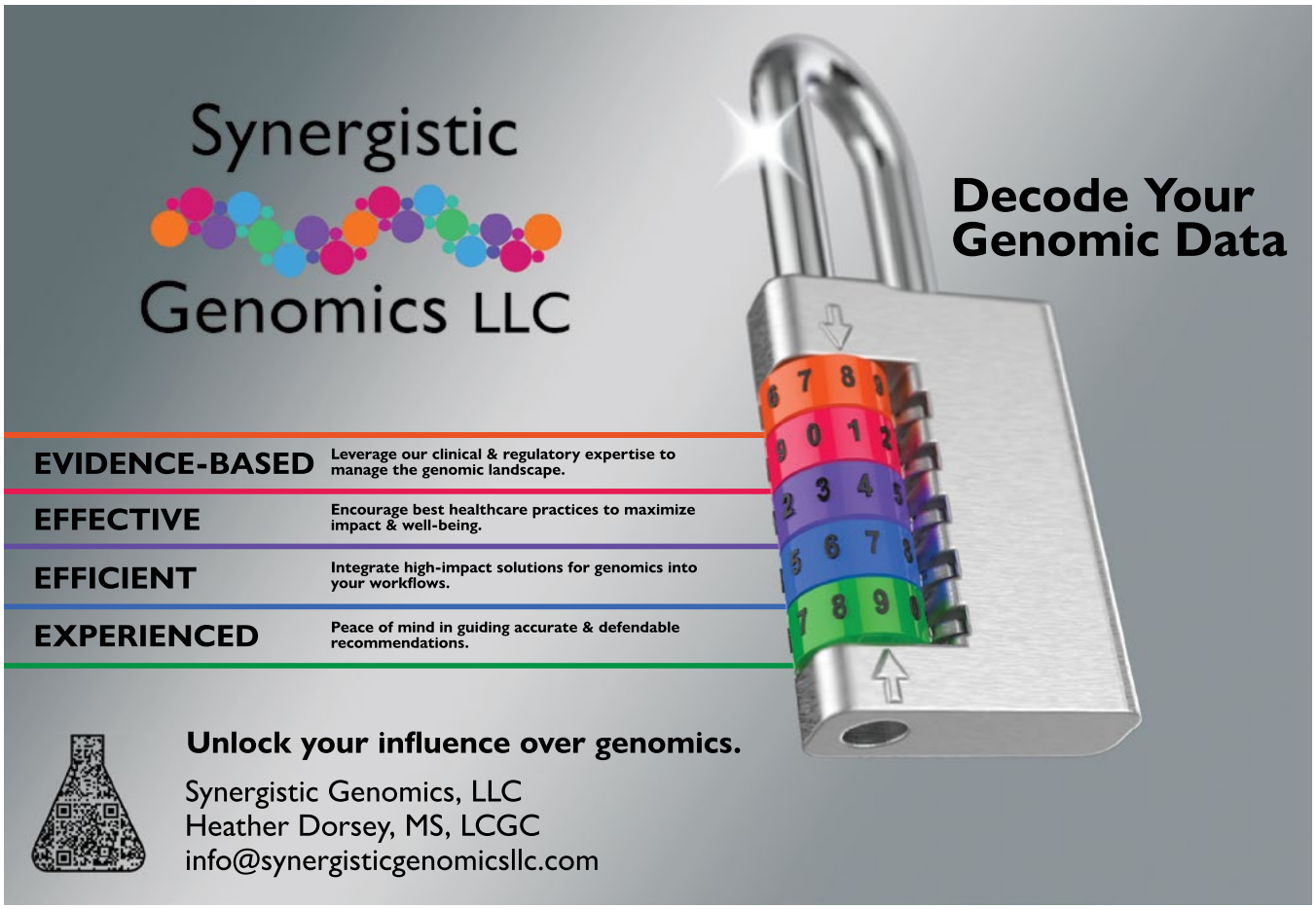
Safety-net hospitals or clinics were the ones that initially were supposed to derive value from offering 340B programs, explained Kerri Tanner, PharmD, chief pharmacy officer of PayerAlly. Nowadays, 340B is the second-largest federal prescription drug program behind Medicare Part D – and with good reason.

She said pharmacies became involved and would share in that value with specialty pharmacies – allowing hospitals access to their claims data for an administrative cost. PBMs also wanted access to the claims information and leverage it – also for a price, she added. A tug of war has since ensued between pharmaceutical manufacturers miffed about lost profits and safety-net hospitals wanting to preserve a lifeline for cash-strapped facilities.

A fourth approach for helping lower Rx spending involves drug importation, which can be a breeding ground for confusion. Indeed, there are several myths about importing drugs from other countries, explained Andrew Miller, chief delivery officer of RxFree4me. For example, he said there's no Food and Drug Administration prohibition against personal importation of drugs, which can help significantly reduce their price tag, nor does it violate the terms of a pharmacy benefits management contract. As powerful as PBMs are, he noted that they cannot control the flow of drugs. Also, he said concern about the efficacy of drugs flowing into the U.S. from other nations is unfounded because the same ingredients are being used.

At one point, about 80% of his clients that imported drugs were government entities, but it has since caught on among self-insured employers in the private sector.

Miller told attendees a humorous story to illustrate that it is not illegal to import a drug from abroad to save money or for an employer to incentivize a health plan member to import their drugs. His wife's grandfather remarried several months after his spouse passed away, and knowing he worked in the Rx field, asked him for a prescription of Viagra. So, Miller called in a favor for a script to be overnighted in his name.



FedEx sent the package, and it had an obnoxious neon green tape wrapped around the package. The tape indicated that it was opened and inspected by U.S. Customs and Border Patrol, which he said is fine as long as a copy of the prescription and any necessary paperwork is included.

HOW PUBLICLY AVAILABLE PRICING DATA CAN HELP SAVE ON COST

As more medical pricing data becomes publicly available through federal and state initiatives, self-insured health plans will seek to use this data in provider contract negotiations and as a tool to help lower healthcare spending. A panel of experts weighed in on this issue and shared their collective insight into how plan sponsors can leverage that information.

The expectation was that making available public pricing data to healthcare consumers under the No Surprises Act and Transparency in Coverage rule would be transformative, but SIIA General Counsel and panel moderator Chris Condeluci said that's not the case.

Trying to find a complete set of data is a whack-a-mole game, observed Peter Schultz, vice president of actuarial and underwriting services for Marsh McLennan Agency.

Gathering a trillion medical records a month whose information is cluttered can be overwhelming, noted Matthew Robben, co-founder and chief technology officer for Serif Health. He said having access to the right filters, such as national claims access, can result in useful records for consumers. He believes carriers will face pressure to provide more useful information as publicly available data doesn't square with what's being shared.

An employer coalition or employers banding together in some way to create a meaningful data repository to obtain better quality pricing data would create "a super powerful asset" that Robben sees as enriching for the self-insured community.

Cheryl Matochik, managing director of market analytics for Third Horizon Strategies, has found that using publicly available pricing information in very specific ways is quite useful. For example, it's being used to create a bundled payment for maternity benefits for a large Midwest employer and to contextualize some of the pricing that was set up for that program. Her firm is also helping a third-party administrator price a section of their network on specialty care so that they can cut episode-based contracts with those provider groups.

There's a lot of filtering and cleaning on the front end of the data processing that must be

done, according to Matochik. Examples include an outlier protection methodology, provider-type exclusions, a Medicare benchmark, modifier treatments and modeling per diems for apples-to-apples comparisons. She said that what's missing are optimal files for ambulatory surgical centers and imaging and radiology facilities, which complicate the ability to perform network performance analyses or network selection.

Matochik described the pricing data as extremely sophisticated and requires a lot of nuances that even a jumbo employer doesn't have the internal resources on hand to make sense of this data set. While there are various solutions coming online, she cautioned that they're not yet at a point where the information can be trusted. This is why finding good consulting and a deep understanding of the data is key.

Schultz hopes that as healthcare claim files improve, employers will hold carriers more accountable by demanding that the information actually represents claims experience. "There's a lot of good work that still can be done to have more enforceable requirements," he said, adding that "significant change is on the horizon."

He's also hopeful that more publicly available pricing data will continue to inform what provider discounts will look like and how employers can steer their covered lives to the highest discount. For all their flaws, he said discounts are still "the best representation of relative network outcomes because the data that we have currently cover enough of the plain data set that makes up an employer spend because the data that we have currently cover enough of the plain data set that makes up an employer spend."

Schultz predicted that publicly available pricing data would be modified in about three to five years with different versions featuring many specifications and believes that having a large all-payer claim file from multiple payers would be extremely helpful. Better calibration of the quality of this information will result in a real utility in the files that can be leveraged, he said, while knowing how much of the data is useful will help employers be confident about its value. ■

Bruce Shutan is a Portland, Oregon-based freelance writer who has closely covered the employee benefits industry for more than 35 years.