



exponential health

A FIELD GUIDE FOR CFOs AND HR LEADERS

The 5 Pillars of High-Performing Health Plans.

A more rigorous approach to managing company healthcare spend is one of the fastest ways to boost EBITDA and increase enterprise value. This is the field manual.

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EXECUTIVE SUMMARY

The performance question

Most organizations can tell you what they spent on healthcare last year. Very few can tell you how they are measuring whether that spend performed. That is not a semantics problem. It is a management problem. If you cannot define success, you cannot govern the category, so you default to renewal negotiations, broker shopping, and vendor narratives while the cost curve compounds against EBITDA.

Healthcare is one of the largest operating expense categories most employers carry. The benchmarks underline the stakes. In 2024, average annual premiums for employer-sponsored coverage reached \$8,951 for single coverage and \$25,572 for family coverage, according to KFF. Milliman estimated the total cost of healthcare for a family of four at \$32,066 in 2024. PwC projects group medical trend remaining elevated at 8.5 percent for 2026.

Healthcare is often managed with less rigor than fleet, facilities, or property and casualty insurance, because the system is complex and vendor-driven. The result is a category that compounds in cost, drains executive time, and erodes enterprise value year after year.

This whitepaper does two things.

First, it names the five most expensive failure modes we see in employer health plans. These are the patterns that drag EBITDA, frustrate employees, and compound risk over a multi-year horizon.

Second, it defines what high-performing employers do instead. Five pillars that, when achieved together, let you credibly claim you are getting strong return on healthcare spend.

The framing question

How are you measuring the **performance** (return) on your company healthcare spend?

Typical answers sound like:

- "We go to market each year."
- "We check what our broker recommends."
- "We try to keep the renewal increase low."

Those are not performance measures. They are procurement activities. The goal of this whitepaper is to give you a measurable, multi-year performance model that protects EBITDA and enterprise value.

WHY THIS MATTERS TO THE CFO

Benefits is an enterprise value lever.

Every CFO has three structural priorities: strengthen financial resilience, drive profitable growth, and increase operational efficiency. Benefits touches all three. It is financially material, it compounds over time, and it either runs as a controlled operating system or it drains time, creates errors, and weakens reporting. The most direct way to translate healthcare savings into business performance is the math below. Use it before any benefits decision to surface the real stakes.

Profit-equivalent revenue

Revenue needed to equal healthcare savings = **Savings ÷ Net margin**

Example: \$500,000 in healthcare savings at a 10 percent net margin equals the bottom-line impact of \$5,000,000 in new revenue.

Units-sold equivalent

Units needed = **Savings ÷ (Average selling price × Net margin)**

Translates the savings into a number your sales team would understand: how many cars, units, contracts, or services would have to be sold to drop the same dollars to the bottom line.

Enterprise value equivalent

Enterprise value impact ≈ **EBITDA improvement × EBITDA multiple**

If your business trades at a 10x EBITDA multiple, every dollar of recurring healthcare savings is worth roughly ten dollars of enterprise value at exit.

THE REFRAME

Healthcare savings are not just an HR win. They are a revenue equivalent, a units-sold equivalent, and an enterprise value equivalent. Until benefits gets translated into the language the CFO already speaks, it stays a renewal conversation instead of a margin conversation.

PART ONE

The diagnosis.

The 5 costliest mistakes employers make with employee benefits.

These five mistakes share a common root cause. Benefits is being managed as an annual event and a collection of vendors instead of a measurable performance system. Each mistake is an expensive failure mode that shows up in cost, employee experience, or enterprise value drag. Read each section asking the same question: where is this showing up in our plan today?

MISTAKE 1 OF 5

They confuse communication with education.

They broadcast information, then act surprised when employees do not value the benefits.

What it looks like

- Open enrollment is the only real communication season.
- PDFs, carrier jargon, and "here are the plans" emails do the heavy lifting.
- Employees still do not know what to do when something happens (new prescription, surgery, pregnancy, mental health, denied claim).
- HR becomes the translator and the unofficial help desk.

Why it is costly

- Employees cannot use what they do not understand, so they default to expensive behavior and frustrating experiences.
- Benefits spend does not convert into trust, retention, or smart utilization, so ROI is diluted.
- Low adoption of high-value resources because employees do not know where to start.

THE PROVOCATION

You can spend millions on benefits and still have employees believe they are not that great, because value perception is driven by literacy and confidence, not information volume.

What high-performing employers do instead

- Run a year-round benefits education strategy tied to moments that matter, not just open enrollment.
- Measure benefits literacy quarterly, not email open rates.
- Design communications to build confidence: "Start here. Do this next."

MISTAKE 2 OF 5

They have a lazy approach to cost containment.

They manage healthcare one renewal at a time, while the five-year cost curve compounds against EBITDA.

What it looks like

- Success is defined as getting through renewal with the smallest increase.
- The funding model (Fully Insured, Self-Funded, ICHRA) is inherited, not defensible.
- No five-year view of cost trajectory or volatility exposure.
- Levers live as ideas, not as an execution roadmap.

Why it is costly

- Compounding wins: a one-year mindset guarantees long-run margin erosion.
- Volatility surprises (claims shocks, pharmacy spikes) undermine forecast confidence and leadership trust.
- Modern levers are missed because the organization is reacting to an event, not running a system.

THE PROVOCATION

If you cannot answer "Can you defend your funding decision with data?" you are not running a cost containment strategy. You are guessing on one of your largest expenses.

What high-performing employers do instead

- Treat benefits like finance: a five-year cost curve plus a volatility band with a real cadence.
- Make the funding model a data-defensible decision, revisited regularly.
- Build a 12 to 18 month lever roadmap with stated tradeoffs and measurable outcomes.

MISTAKE 3 OF 5

They tolerate manual chaos in benefits administration.

So they pay in leakage, cleanup time, and reporting they cannot trust.

What it looks like

- Benefits runs across disconnected systems (payroll/HCM, ben admin, carrier portals, COBRA, FSA/HSA vendors, spreadsheets).
- Every employee change triggers a chain of manual steps across vendors and systems.
- Carrier feeds break or are not monitored; exceptions pile up.
- Payroll deductions drift from elections; carrier bills drift from eligibility.
- Finance discovers problems after the bill spikes, or when an employee is denied at the point of care.

Why it is costly

- Leakage: paying for ineligible people, wrong tiers, delayed terminations, missed refunds, retro corrections.
- Cleanup time: HR and payroll get trapped in reconciliation and exception handling instead of strategic work.
- Employee harm: denied claims, coverage gaps, and payroll headaches even when the employee did everything right.
- Bad reporting: delayed or inaccurate data makes rigorous financial management of the category nearly impossible.

THE PROVOCATION

You cannot manage healthcare spend like a financial strategy if the underlying admin machine runs on manual workflows and broken data flows. If Finance cannot trust the numbers, you are not managing spend. You are reacting to surprises.

What high-performing employers do instead

- Anchor the system to a single source of truth, often payroll/HCM.
- Integrate and monitor data flows; manage exceptions deliberately.
- Reconcile carrier invoices against enrollments and payroll deductions on a routine cadence.
- Treat reporting integrity as a KPI: Finance should trust benefits numbers without Excel heroics.

MISTAKE 4 OF 5

They do not have a digital healthcare strategy.

So they cannot adapt as AI reshapes employee expectations, showing up in both cost and retention.

What it looks like

- They believe AI matters, but it stays conceptual: "We should explore that."
- They may even add an AI tool, then put the AI sticker on the program and assume the box is checked.
- No roadmap, no operating model, no ownership, no institutional foundation.
- Consumer-first tools (labs, wearables, personalized insights) remain outside benefits; employees pursue them on their own.
- Point solutions pile up without orchestration; adoption stays low and the experience stays fragmented.

Why it is costly

- They keep renewing benefits for a world that is changing underneath them.
- Employee expectations shift toward faster answers, clearer navigation, and personalization. Benefits feels outdated by comparison.
- Tool sprawl creates waste and low adoption; random entry into care remains expensive.
- They miss the chance to enable proactive health ownership in a way that improves experience and reduces avoidable cost over time.

THE PROVOCATION

AI is not the strategy. A list of apps is not the strategy. A single AI vendor is not the strategy. The strategy is building a digital healthcare ecosystem that compounds as fast as expectations change.

What high-performing employers do instead

- Memorialize a digital healthcare strategy: owner, roadmap, success metrics.
- Build a digital ecosystem: AI-enabled front door plus navigation, benefits Q&A, and key actions (enroll, change, manage).
- Create an integration plan so consumer-grade tools can be incorporated as they go mainstream, without turning benefits into tool sprawl.

MISTAKE 5 OF 5

They have weak compliance execution.

So they waste internal time, create avoidable exposure, and risk eroding EBITDA and enterprise value.

What it looks like

- Compliance gets done unevenly; execution depends on people and memory.
- Deadlines and requirements are managed as one-offs instead of a repeatable system.
- Responsibilities are unclear across HR, payroll, finance, broker, and vendors. Things fall between cracks.
- Vendor oversight is informal; contracts, fees, and responsibilities are not reviewed with auditability in mind.
- Documentation is thin; governance artifacts do not demonstrate a prudent process.

Why it is costly

- Internal waste: time burned on rework, chasing info, preventable exceptions.
- Execution risk: weak process increases missed notices, incorrect reporting, and avoidable problems.
- Enterprise value drag: avoidable penalties, disputes, or litigation erode EBITDA and valuation.
- The shifting compliance and fiduciary landscape increases pressure on individuals. Process and documentation matter more than many leaders realize.

THE PROVOCATION

This is the eat-your-vegetables pillar. Nobody craves it. But it is also the seatbelt: you do not think about it until the day you need it. High-performing employers do not do more compliance. They make compliance routine and automatic, so it protects value instead of draining it.

What high-performing employers do instead

- Build a compliance operating system: calendar, owners, checklists, escalation paths.
- Make routine requirements repeatable workflows, not annual reinvention.
- Align vendors and contracts so responsibilities are explicit, measurable, and auditable.
- Create governance artifacts without bureaucracy: documented cadence, vendor monitoring, defensible decisions.

FROM DIAGNOSIS TO PRESCRIPTION

The 5 mistakes are symptoms. The 5 pillars are the system.

Each mistake in Part One is the inverse of an outcome a high-performing health plan delivers. Communication theater is the inverse of employee value perception. Renewal management is the inverse of financial performance strategy. Manual chaos is the inverse of administrative efficiency. Tool sprawl is the inverse of a digital healthcare strategy. Sloppy compliance is the inverse of governance and accountability.

The pillars are not five new initiatives to add on top of everything else. They are the operating model that replaces "how did renewal go this year?" with "is the system performing?" The rest of this paper defines each pillar: what great looks like, what to measure, and how it ties to EBITDA.

THE SHIFT

If you fix the mistakes one at a time, you stay in renewal mode forever. If you build the pillars together, you get a system that compounds margin, EBITDA, and enterprise value year over year.

PART TWO

The prescription.

The 5 pillars of a high-performing health plan.

A high-performing health plan produces five outcomes. Together, they form the success criteria for healthcare spend. If you are achieving these five, you can credibly claim you are getting strong return on the category, because the program is delivering employee value, controlling the five-year cost curve, operating efficiently, evolving with a changing healthcare front door, and governing risk with a documented process.

The 5 pillars at a glance

PILLAR 01 Employee value perception. Year-round education that increases benefits literacy, trust, and confident use.

PILLAR 02 Financial performance strategy. A data-defensible funding strategy plus disciplined execution of modern levers to control the five-year curve.

PILLAR 03 Administrative and operational efficiency. A low-friction, high-integrity operating system that scales and produces CFO-grade reporting.

PILLAR 04 Digital healthcare strategy. A digital ecosystem that unifies care navigation, benefits Q&A, and key actions.

PILLAR 05 Governance and accountability. Documented oversight that aligns vendors, protects contract integrity, and makes compliance routine.

PILLAR 01 OF 5

Employee value perception.

Core idea: *Information is not education.*

Definition

Your organization's ability to drive a high-value perception of benefits in the mind of employees through a year-round communication and education strategy that increases benefits literacy, trust, and confident use at the moments that matter.

Why it matters

WTW data highlights a recurring pattern: employees can feel more informed while becoming less satisfied, which signals that communication volume is not the objective. Value perception is. MetLife has reported strong differences in workforce happiness and stability between employees who do and do not understand their benefits. Aflac has reported that many employees would consider trading pay for better benefits, which makes perceived value a real talent lever.

What great looks like

- Employees can answer, "What do I do when X happens?" (new prescription, surgery, pregnancy, denied claim).
- Benefits literacy improves measurably across the year, not just at open enrollment.
- High-value resources earn adoption (navigation, virtual care, preventive care).
- HR is not the benefits call center.

What to measure

- Quarterly benefits literacy pulse (3 questions: understand, know where to go, confident using).
- Moments-that-matter campaign engagement (life-event education, not just open enrollment).
- HR ticket volume for benefits confusion (per 100 employees per month).
- Value perception score ("My benefits are valuable" / "My employer cares").

THE DIAGNOSTIC QUESTION

Can your employees confidently answer "what do I do when something happens to me?" without calling HR?

PILLAR 02 OF 5

Financial performance strategy.

Core idea: *Can you defend your funding decision with data?*

Definition

Your organization's ability to access and execute modern levers to manage healthcare spend as a multi-year financial strategy. It starts with a data-driven funding model decision (Fully Insured, Self-Funded, or ICHRA), then executes the highest-impact levers within that model to control the five-year cost curve, reduce volatility, and protect EBITDA and enterprise value.

Why it matters

The scale and persistence of healthcare trend makes annual renewal management structurally insufficient. PwC projects 8.5 percent group medical trend for 2026, on top of multi-year compounding. A five-year lens is required to manage compounding cost, protect margin, and avoid volatility surprises.

What great looks like

- Funding strategy fit: data-driven and defensible.
- Tactical execution within the chosen model: tradeoffs and levers spelled out, not assumed.
- Five-year management system: baseline curve, drivers, sequenced lever roadmap, measurement.
- A 12 to 18 month lever roadmap that ties each lever to a measurable EBITDA impact.

What to measure

- Five-year baseline cost curve plus volatility band.
- PEPM and PEPY trend versus baseline and benchmark.
- Lever roadmap completion rate and impact realized (dollars and percentage).
- Funding model fit review cadence (defensible decision, revisited).

THE DIAGNOSTIC QUESTION

If your CFO asked tomorrow why you are funded the way you are, do you have data to back the answer?

PILLAR 03 OF 5

Administrative and operational efficiency.

Core idea: *Execution quality becomes employee experience and CFO reporting.*

Definition

Your organization's ability to run benefits administration as a low-friction, high-integrity operating system, where eligibility, life events, enrollments, payroll deductions, carrier updates, and compliance workflows are accurate, timely, and integrated. Employees get a smooth experience, HR avoids manual firefighting, and Finance can rely on accurate reporting to manage spend rigorously.

Why it matters

Enrollment and maintenance are complex enough that the industry uses standardized data exchange, the X12 834 Benefit Enrollment and Maintenance transaction. Industry sources including SHRM (referencing Aberdeen research) have highlighted material error rates in carrier invoices, which makes reconciliation and integrated processes central to cost control. Nucleus Research has reported measurable productivity and cost savings associated with benefits administration systems. Accurate employee-level data also underpins ACA reporting (Forms 1094-C and 1095-C) and time-sensitive processes such as COBRA administration.

What great looks like

- Single source of truth for eligibility and elections, often payroll/HCM.
- Routine reconciliation: carrier invoice against enrollment against payroll deductions.
- Low exception rate on carrier feeds and life events.
- Employees experience a smooth process; errors do not become employee harm (denied claims, coverage gaps, wrong deductions).
- Finance can trust benefits reporting without spreadsheet heroics.

What to measure

- Carrier feed reject and exception rate; exception backlog.
- Life-event SLA (processed within X days).
- Monthly reconciliation completion and discrepancy rate.
- Coverage disruption incidents (employee did everything right but the system failed).
- Finance close time for benefits numbers plus a confidence score.

THE DIAGNOSTIC QUESTION

When Finance pulls the benefits numbers for the close, do they trust them without a manual audit?

PILLAR 04 OF 5

Digital healthcare strategy.

Core idea: *Your benefits cannot feel like a fax machine in a flying-car world.*

Definition

Your organization's ability to build a digital healthcare ecosystem, anchored by an AI-enabled digital front door, so employees can get answers, navigate care, and manage their benefits in one connected experience. This keeps you competitive as AI reshapes healthcare and employee expectations.

Why it matters

Consumer AI health experiences are normalizing personalized, data-connected health support. As these experiences become standard, employee expectations for the benefits experience will shift, especially around speed to answers, navigation, and ease of action.

What great looks like

- A clear "start here" pathway that routes employees to the right care (digital plus human navigation).
- Benefits Q&A that resolves "is this covered, what will it cost, where do I go" without PDF hunts.
- Key actions can be completed through a unified hub (enroll, change, manage) without unnecessary handoffs.
- The ecosystem can compound, adding or integrating tools as care models and expectations change.

What to measure

- Adoption of the start-here pathway (awareness plus usage).
- Self-service resolution rates for benefits and care questions.
- Navigation usage and channel shift (where data allows).
- Employee experience: "I got the right help quickly."

THE DIAGNOSTIC QUESTION

When an employee needs healthcare answers at 9pm on a Sunday, where do they go and what do they find?

PILLAR 05 OF 5

Governance and accountability.

Core idea: *The eat-your-vegetables, seatbelt pillar.*

Definition

Your organization's ability to proactively govern the benefits program with a documented fiduciary process, ensuring vendor alignment, contract integrity, and efficient compliance, so decisions are defensible, risk is managed, and avoidable penalties or lawsuits do not erode EBITDA and enterprise value.

Why it matters

The Department of Labor's fiduciary guidance emphasizes prudence as a process standard and the importance of monitoring, documentation, and paying only reasonable plan expenses. At the same time, employer plans have faced increasing scrutiny in pharmacy and PBM-related ERISA litigation, which highlights the value of proactive governance even when it is not today's pain point. Transparency requirements such as the annual Gag Clause Prohibition Compliance Attestation are concrete examples of compliance needing to be routine, not a fire drill.

What great looks like

- Documented fiduciary process with named owners and cadence.
- Vendor and contract review with auditable artifacts (fees, services, performance).
- Compliance calendar with owners, checklists, and escalation paths.
- Pharmacy and PBM oversight with defensible methodology.
- Governance artifacts that demonstrate prudent process without bureaucracy.

What to measure

- Compliance calendar completion rate (on-time, complete, documented).
- Vendor review completion (annual or per cadence).
- Audit and finding rate (internal or external).
- Documentation quality score (decisions traceable to evidence).
- Fiduciary committee meeting cadence and minutes integrity.

THE DIAGNOSTIC QUESTION

If a regulator or plaintiff's attorney asked tomorrow to see your fiduciary process, what would you hand them?

CLOSING

From whitepaper to working blueprint.

These five mistakes share a common root cause: benefits is being managed as an annual event and a collection of vendors instead of a measurable performance system. The five pillars are the inverse: a system that you can govern, measure, and defend.

The fix is not more complexity. It is more rigor. Clearer outcomes, disciplined execution, and a multi-year financial lens that protects EBITDA and enterprise value.

The next step is to translate this framework into your numbers. That is what the High-Performing Health Plan Blueprint engagement does. It is a no-cost diagnostic and strategic planning engagement designed for employers with 250 or more employees spending at least \$2.5 million annually on healthcare. We run a structured assessment against the five pillars, then deliver a sequenced 12 to 18 month roadmap with quantified EBITDA and enterprise value impact.

Capacity is limited to four Blueprints per month.

Two ways to take the next step.

01 · RUN THE NUMBERS

Open the Profit Lever calculator

Translate your healthcare spend into a revenue equivalent, units-sold equivalent, and enterprise value impact. Move the sliders. Copy the summary. Send it to your CFO.

→ exponentialhealth.co

02 · BOOK A WORKING SESSION

Blueprint performance review

A 30-minute working session with Chris Krusiewicz to map your current plan against the five pillars, identify the highest-EBITDA-impact levers in your specific situation, and outline what a full Blueprint engagement would surface.

→ [**Book the call**](#)



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SOURCES AND REFERENCES

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This whitepaper draws on primary research, regulatory guidance, and industry studies. Direct sources are listed below for further reading.

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- Public court filings and legal analyses summarizing employer-plan pharmacy and PBM fiduciary litigation.

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