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What Employers Now Expect From Brokers:
Cost Containment That Holds Up Under Real-World Pressure

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Contents

1	Executive Summary
2	I. Introduction: The Broker Role Has Moved Beyond Savings
3	II. The New Employer Expectation
4	III. Why Traditional Cost Containment Falls Short
5	IV. The Real Broker Risk: Savings That Cannot Be Protected
6	V. What a Stronger Cost-Containment Strategy Requires
7	VI. aequum as the Broker's Solution
8	VII. What Sets aequum Apart
8	VIII. Conclusion: Broker Value Is Now Measured by Defensibility
9	Disclaimer
9	About the Author
10	About aequum LLC

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Executive Summary

Employers are applying greater scrutiny to healthcare investments as rising costs, expanding vendor portfolios and administrative demands place pressure on benefits programs. A recommendation can no longer be evaluated solely by the savings it projects. Employers also need to know whether the approach addresses the plan's priorities, can be implemented effectively and includes a credible response to provider resistance.

This expectation is expanding the broker's role from identifying opportunities to evaluating their full viability.

aequum **helps brokers meet that responsibility by giving employers a cost-containment model supported by reimbursement expertise, participant advocacy and legal protection.** The result is a stronger strategy for preserving plan value when out-of-network payment decisions are contested.



I. Introduction: The Broker Role Has Moved Beyond Savings

Employer benefit programs have accumulated specialized vendors addressing navigation, chronic conditions, pharmacy costs, behavioral health, high-cost claims and other priorities. Individual solutions may respond to legitimate needs, yet a larger vendor portfolio also requires more contracting, coordination, communication and performance evaluation. Employers are consequently taking a closer look at what each investment contributes.

UnitedHealthcare describes this process as the need to rationalize benefits spend. The discussion has moved beyond whether a program promises savings. Employers want evidence of value, clarity about how results will be measured and confidence that a new solution will advance broader benefits objectives without duplicating existing services or creating unnecessary complexity.

That shift places brokers in a more strategic position. Their value increasingly depends on helping employers distinguish between an attractive proposal and a workable program.

Financial projections remain important but they are now one part of a broader evaluation that includes organizational fit, implementation and accountability.



II. The New Employer Expectation

The financial environment is accelerating this change. Employers projected a median health care cost trend of 9% for 2026 before plan design changes, declining to 7.6% after those changes. Overall healthcare costs and affordability for employers and employees were identified as leading priorities.

Against this backdrop, employers need guidance that extends beyond comparing vendors. They expect brokers to determine whether an alternative model addresses the plan's actual cost drivers, explain how the financial assumptions were developed and identify the operational changes required for implementation. The report specifically calls on consulting partners to assess and explain alternative health plan and pharmacy benefit models, measure their financial implications and develop change-management approaches that reduce concerns about participant disruption.

Cost containment raises the same considerations. Before recommending an approach, the broker must evaluate whether the reimbursement methodology is appropriate for the employer and whether the expected financial effect justifies the administrative and participant implications. The assessment must account for the plan's ability to execute the model consistently, not simply the calculation used to estimate savings.

In some arrangements, this responsibility includes helping employers establish processes through which high-cost and out-of-network claims can be reviewed, validated and negotiated before payment when appropriate. **Broker advice is therefore moving beyond solution selection toward a more complete determination of feasibility.**



The broker must evaluate whether the reimbursement methodology is appropriate for the employer and whether the expected financial effect justifies the administrative and participant implications.

III. Why Traditional Cost Containment Falls Short

Traditional claims workflows are primarily designed to receive, adjudicate, reprice and pay claims. Point solutions can improve efficiency within that process by applying a payment methodology or automating a defined administrative function. Their limitations become visible when a provider contests the reimbursement decision.

Repricing establishes the amount a plan intends to pay. It doesn't determine whether a disagreement qualifies for a particular resolution process, assemble the information needed to substantiate the plan's position or manage the procedural steps that follow. Those responsibilities require capabilities beyond claims calculation.

The federal IDR process demonstrates the distinction. For certain out-of-network services subject to the NSA, an initial payment or denial may be followed by a 30 day open negotiation period. If the parties don't agree, either may initiate IDR within the applicable timeframe. The parties then submit payment offers and supporting information to a certified IDR entity, which selects one of the offers. Not every out-of-network claim is eligible for the federal process and state law may govern certain disputes.

This is not a marginal administrative issue. During the first year of the federal IDR program, parties submitted 489,000 disputes, 14 times the number federal regulators had expected for an entire calendar year. By January 31, 2026, more than 5.1 million disputes had been submitted for review.

Claims repricing remains one component of cost containment. It is not a complete response to the negotiation, documentation, regulatory and legal work created by a contested payment.



IV. The Real Broker Risk: Savings That Cannot Be Protected

The financial value of a reimbursement model depends on what happens after the plan calculates and issues payment. This is particularly important in RBP arrangements, which reimburse covered services according to a defined benchmark or methodology instead of a negotiated network rate.

If a provider rejects the amount, the disagreement may reach the participant. The American Hospital Association explains that under RBP, a dissatisfied provider may bill the patient for the unpaid portion of the claim. Whether such billing is legally permitted depends on the service, applicable federal and state protections, plan terms and the circumstances surrounding the claim. The NSA restricts balance billing for specified categories of out-of-network care but it does not apply to every claim.

Once a participant receives an additional bill or collection notice, the matter extends beyond reimbursement. The employee may not understand why the provider is seeking payment or where to obtain assistance. Human resources may be drawn into an issue it is not equipped to resolve. Additional payments, settlements, administrative work or legal expenses can reduce the anticipated financial result.

The broker also faces a relationship risk. Employers may evaluate the recommendation according to the disruption that follows implementation, particularly if responsibility for the dispute is unclear or the participant is left to respond alone. The original calculation may have been sound, yet confidence in the model can deteriorate if no one is prepared to address provider resistance.

Brokers cannot prevent every disagreement. They can ensure that a recommended program includes a defined response before one occurs.

Employers also need to know whether the approach addresses the plan's priorities, can be implemented effectively and includes a credible response to provider resistance.

V. What a Stronger Cost-Containment Strategy Requires

A more durable cost-containment approach needs coordinated infrastructure behind the pricing methodology. Its purpose is to give the plan a consistent way to address disputed reimbursement while maintaining financial discipline and shielding participants from avoidable exposure.

That infrastructure should include:

- **Plan and Compliance Foundations:** Plan language, administrative procedures and vendor responsibilities must reflect the intended reimbursement method and account for applicable ERISA, NSA and state requirements.
- **Claims Information:** The plan needs access to claim-level data, pricing information, provider billing patterns and supporting documentation to evaluate high-cost claims and substantiate payment decisions.
- **Provider Engagement:** Experienced communication and negotiation can resolve some disagreements before they advance into formal proceedings or reach the participant.
- **Dispute Administration:** Eligible matters require accurate notices, timely responses, supporting information, payment offers, fee management and oversight of applicable deadlines.
- **Member Protection:** Participants need a clear source of assistance when they receive balance bills, collection communications or questions concerning the amount paid by the plan.
- **Legal Escalation:** Matters that cannot be resolved through administrative review or negotiation may require qualified counsel capable of defending the plan and participant.

The Federal IDR Operations Final Rule reinforces the need for this structure. The rule addresses payer-provider communications, open negotiation procedures, eligibility review, batched disputes, administrative fees and the creation of an IDR registry.

The timing of these provisions is important. Some requirements took effect with the rule or on specifically stated dates, while other operational changes will apply after the federal departments issue implementation guidance and announce that the necessary system functionality is available. **Brokers and their partners must therefore follow both current procedures and subsequent federal guidance rather than treating compliance as a one-time exercise.**

A sound reimbursement methodology establishes the financial basis for payment. The surrounding infrastructure determines whether the plan can apply that methodology consistently and respond appropriately when it is disputed.



VI. aequum as the Broker's Solution

aequum helps brokers bring employers cost-containment programs supported before, during and after a reimbursement challenge. Its approach connects claims information, RBP strategy, NSA knowledge, provider engagement and participant advocacy within a coordinated operating model.

Before a disagreement develops, aequum can use available pricing and claims information to identify high-cost providers, outliers and recurring billing patterns. These findings can inform reimbursement decisions, plan design considerations and the resources an employer may need to place around the program.

When a provider contests payment, aequum assists with communication, negotiation and dispute positioning. For matters subject to the NSA, this includes helping plans navigate applicable open negotiation and federal IDR requirements. At the participant level, aequum protects members and dependents against unreasonable out-of-network and balance billings and unfair debt collection practices.

When administrative efforts do not resolve the matter, aequum coordinates the appropriate escalation. The company also performs post-payment review and works with self-funded plans and insurers to recover overpayments from medical providers where appropriate.

By placing these responsibilities within a defined operating structure, aequum gives brokers a practical way to move from recommendation to execution. Employers gain greater clarity about how reimbursement issues will be managed and participants know where to turn if a provider seeks additional payment.



> ***This expectation is expanding the broker's role from identifying opportunities to evaluating their full viability.***

VII. What Sets aequum Apart

aequum differs from vendors that stop at claims processing in two important ways.

The first is its information and reporting infrastructure. The company is supported by a proprietary, customized and fully relational database that integrates with document automation, contact management and calendaring software. This allows the team to manage claims, correspondence, notices, reports and litigation materials within a coordinated system.

Reporting can be customized by plan, provider, geographic region, carrier or other tracked category. Available information may include claim status, disputed and originally billed amounts, settlement values, savings and recoveries. This gives brokers and employers visibility into individual matters as well as broader patterns that may affect plan performance.

The second distinction is aequum's relationship with Koehler Fitzgerald LLC. **Through that partnership, aequum provides access to trial and appellate lawyers experienced in unreasonable medical charges, balance billing and overpayment matters.** Legal resources are therefore available to protect plans and participants when advocacy and negotiation are insufficient, including litigation and appeal when circumstances warrant.



Together, the database and legal partnership distinguish aequum from an off-the-shelf point solution. The model combines the information needed to manage reimbursement matters with access to the legal experience required when those matters escalate.

VIII. Conclusion: Broker Value Is Now Measured by Defensibility

Employers will continue to expect proof that healthcare investments produce measurable value. For broker-led cost containment, that evaluation will extend beyond the initial savings estimate to whether the recommended model remains effective after implementation.

This raises the standard for broker performance. The strongest recommendations will anticipate the operating realities surrounding out-of-network reimbursement and account for them at the beginning. That foresight gives employers greater confidence in the program and reduces the risk that an unresolved provider dispute will undermine the participant experience or the financial rationale behind the decision.

Defensibility is therefore becoming a meaningful measure of broker value. Brokers ready to strengthen that position can partner with aequum to bring employers cost-containment strategies designed for sustainable performance under real operating conditions.

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Christine Cooper, founder and CEO of aequum LLC, is a transformative leader in the healthcare industry who is recognized for her pioneering spirit, dedication to positively move the needle for constituents in the self-insured community and assist and defend plans and patients. Cooper continues to bring technological advancements to the market space and has assembled a tech-driven team that effectively partners with TPAs, insurers, medical cost management companies and stop-loss carriers throughout the country.

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About aequum LLC

aequum LLC is an advocacy firm that partners with a national law firm, both of which specialize in No Surprises Act compliance and IDR defense for employers, plan sponsors, and TPAs. We combine litigation strategy, regulatory expertise, and data analytics to reduce exposure, improve outcomes, and promote systemic integrity.

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