PEO INSIDER®

PUBLISHED BY THE NATIONAL ASSOCIATION OF PROFESSIONAL EMPLOYER ORGANIZATIONS®

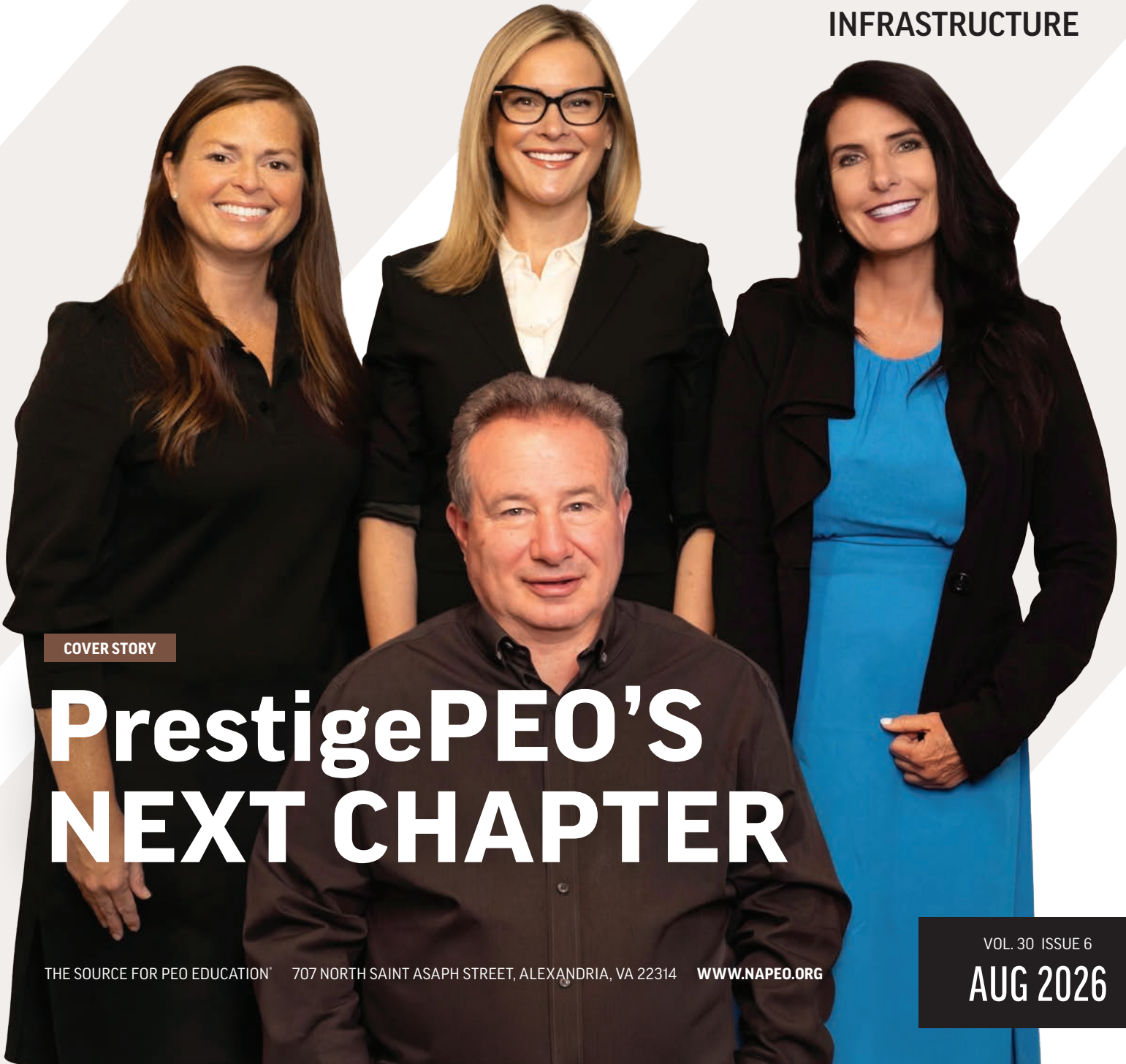
THIS MONTH'S FOCUS

HEALTHCARE

BENEFITS UTILIZATION

EMPLOYEE EXPERIENCE AND ACCESS

TECHNOLOGY AND BENEFITS INFRASTRUCTURE



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Lori Martin, Robyn Rusignuolo, Heather Keefer Saulsbury and Andy Lubash, PrestigePEO

THIS MONTH'S FOCUS: HEALTHCARE

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PRISMHR

MEETING TODAY'S CHALLENGES TOGETHER

BY BILL MANESS

For as long as I have been in this business, healthcare has always been a major factor in our ability to attract and retain clients. It is one of the most visible ways we help our clients compete and care for their people.

That has never been more important than it is today.

Employers continue to face rising costs, changing employee expectations and an increasingly complicated benefits landscape. For small businesses in particular, the challenge is not simply offering health coverage. It is understanding options, managing compliance, communicating value to employees and making decisions that support both the workforce and the bottom line. That is a lot to ask of any business owner who is also trying to serve customers, grow revenue and manage day-to-day operations.

This is where we come in.

We help clients think strategically about benefits, not just transactionally. We help employers offer competitive options, explain those options more clearly to employees and stay ahead of requirements that can change quickly.

When policy shifts, costs rise or new challenges emerge, small businesses need partners who can translate complexity into practical action. But offering and managing benefits plans is only one part of the PEO value proposition. We are trusted partners across the full employment relationship.

That will be on full display at this year's Annual Conference and Marketplace, September 16–18, in Marco Island, Florida.

Every year, the Annual Conference brings our industry together at an important moment. It gives us the chance to step away from our offices to compare notes with peers, hear from experts, meet with partners and think more broadly about where our businesses and the industry are headed.

Just as important, the conference reminds us that we are part of something larger than our own organizations. The conversations that happen in hallways, sessions, receptions and marketplace booths help strengthen the relationships that move this industry forward. We learn from one another. We challenge one another. We leave with ideas we can put to work for our clients, our teams and our businesses.

We are trusted partners across the full employment relationship. That will be on full display at this year's Annual Conference and Marketplace, September 16-18, in Marco Island, Florida.

As NAPEO board chair, I believe one of the association's greatest strengths is its ability to bring people together around shared challenges and shared opportunities. Healthcare is certainly one of those challenges. It is also one of our industry's great opportunities to demonstrate the value of the PEO model.

I hope to see many of you at the Annual Conference and Marketplace in September (register at napeo.org/events). It will be a chance to reconnect, recharge and recommit to the work we do every day on behalf of small and mid-sized businesses across the country. ■

BILL MANESS
2025-2026
NAPEO Chair
CEO
Syndeo

ADVOCACY

NAPEO HOSTS ADVOCACY DAYS IN NY AND DE

NAPEO members recently gathered in New York and Delaware for Advocacy Days focused on advancing a positive legislative and regulatory agenda for the PEO industry. We thank our members for taking the time to engage with state officials and look forward to continuing to build relationships with policy-makers across the country as we advocate for the PEO industry.

LEADERSHIP

KEENA PEO SERVICES APPOINTS ROBERT MILLARE AS CHIEF FINANCIAL OFFICER

NAPEO member KEENA PEO Services has appointed Robert Millare as chief financial officer. Bringing more than 20 years of leadership experience in the PEO, ASO and HRO industries, Millare joins KEENA at a pivotal time as the organization continues to expand its services, strengthen operations and invest in long-term growth. "What excites me about KEENA is the passion our employees have for serving clients and their commitment to the Real Relationships. Real Solutions. philosophy," said Millare. "I'm energized by the opportunity to help support that mission, strengthen the organization, and contribute to its continued success as we grow."

INNOVATION

VENSURE EMPLOYER SOLUTIONS LAUNCHES COMMUNICATION HUB

NAPEO member Vensure Employer Solutions has launched Communication Hub, a unified, AI-powered workforce communication platform that enables businesses to deliver employee communications across every channel from a single system. Communication Hub uses AI to help organizations create, refine and translate communications quickly and consistently, including payroll reminders, benefits deadlines, policy updates and more. "By combining HR data, multichannel delivery and AI-assisted message creation, our clients can communicate just once and confidently reach the right employees at the right time," said Alex Campos, chief executive officer of Vensure Employer Solutions.

QUICK HITS

KUDOS

INSPERITY EARNS 2026 GREAT PLACE TO WORK CERTIFICATION™

NAPEO member Insperity has earned a 2026 Great Place to Work Certification™ for the third year in a row. The recognition is based on employee feedback about their experience working at the company. "The Great Place to Work Certification reflects our commitment to a people-first culture at Insperity," said Paul Sarvadi, chairman and chief executive officer of Insperity. "Our values guide how we support our employees, champion wellbeing, and make a meaningful impact in the communities where we live and work. That same commitment extends to how we support our clients—we want to help every client to be an 'employer of choice.'"

LEADERSHIP

ISOLVED APPOINTS MICHAEL HASKE CEO

NAPEO member isolved has appointed Michael Haske as its new chief executive officer. Haske brings experience scaling platforms at Paylocity, ADP and Paychex, along with recent CEO experience in agentic AI. "I am honored to lead isolved at this pivotal moment in the HCM industry," said Haske. "Our next phase moves past the traditional SaaS model to establish isolved as a true 'Platform of Action.' By integrating Agentic AI and advanced orchestration protocols, we will empower our customers to bridge the gap between human intent and organizational output, fundamentally changing how work gets done."

INSIGHTS

NEW RESEARCH ON RETIREMENT SAVINGS CRISIS

The 2026 Retirement Confidence Survey finds that worker confidence in retirement readiness is declining, with only 61% of employees confident they will have enough savings for a comfortable retirement, down from 67% last year. Rising healthcare and housing costs, along with growing debt burdens, are making it more difficult for workers to save.

M&A

ONEDIGITAL ACQUIRES MP WIRED FOR HR

NAPEO member OneDigital has acquired MP Wired for HR (MP), a Massachusetts-based payroll and human capital management technology firm delivering integrated HR services. The acquisition brings MP's payroll systems, HR technology and compliance advisory services into OneDigital's broader offering of benefits, financial services and workforce consulting. "Ultimately, we decided to partner with OneDigital because in addition to their culture and values being closely aligned with MP, we believe their platform offers value to our clients," said Jason Maxwell, founder and chief executive officer of MP.

LEADERSHIP

G&A PARTNERS ANNOUNCES CEO TRANSITION

NAPEO member G&A Partners has announced that John W. Allen, co-founder and chief executive officer, will retire after more than 30 years leading the company. The Board of Directors has appointed Jeff Williams as incoming CEO. "I'm proud G&A has grown into an organization that positively impacts thousands of companies and hundreds of thousands of workers across the country," said Allen. "I'm humbled by what we've built together and excited about the company's future under Jeff's proven and mission-aligned leadership."

CONGRATULATIONS

FRANKCRUM HONORED AS SILVER STEVIE AWARD WINNER

NAPEO member FrankCrum has been named a Silver Stevie® Award winner in the Human Resources Team of the Year category of the 24th Annual American Business Awards®, shining a national spotlight on FrankAdvice, the company's dedicated HR consulting team. "People are at the center of every business decision, and the companies we serve deserve HR guidance that reflects that," said David Peasall, senior vice president of human resources at FrankCrum. "FrankAdvice has consistently delivered expert, personalized support that helps our clients build stronger, more resilient workplaces. This award is a meaningful acknowledgment of the dedication this team brings to that mission every day."

LEADERSHIP

COADVANTAGE APPOINTS NEW LEADERSHIP

NAPEO member CoAdvantage has appointed Jim Neve as chairman and chief executive officer and Brian Meharry as chief operating officer. Together, the two executives, alongside a handpicked group of seasoned leaders, will lead CoAdvantage into its next phase of strategic growth. "We have a comprehensive, integrated suite of HR, payroll, benefits, and compliance solutions, along with the talent and infrastructure to deliver at scale," said Neve. "Our focus is seamless execution, strategic innovation, and making CoAdvantage the partner of choice for businesses that want to grow with confidence."

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Benefits Utilization

The Benefits COMMUNICATION PROBLEM No One Talks About

BY DANIEL CLINE

Most PEOs think they have a benefits problem. What they actually have is a communication problem.

The benefits are there, the coverage is solid, but none of it matters if employees don't understand what they're buying. Utilization stays flat, employers grow skeptical of the value they're paying for, and the PEO ends up defending products that were never really given a fair shot. The fix isn't a better benefits package. It's a better communication strategy, one that treats employee education as a year-round function rather than a once-a-year scramble.

Here's what that looks like in practice.

START WITH THE EMPLOYEE, NOT THE PRODUCT

Most benefits communication is written from the inside out. It starts with what the PEO offers, lists the features, and then hopes employees can figure out what's relevant to them. They rarely do.

Effective communication starts with the employee's situation. A 28-year-old in good health is not thinking about their deductible. They're thinking about whether they can afford their student loans while still putting something away for retirement. A 45-year-old with two kids and a chronic condition is not scanning the dental summary of benefits. They're trying to figure out whether their current doctors are in-network and what their out-of-pocket exposure looks like if something goes wrong.

Before you communicate anything, understand who you're communicating to. PEOs serve dozens of client companies across wildly different industries, demographics and geographies. That variety is useful. You already have the raw material for messaging that speaks to a 25-year-old warehouse worker differently than a 50-year-old office manager.

SIMPLIFY THE LANGUAGE, DON'T OVERSIMPLIFY THE STAKES

There's a version of "plain language" that strips benefits communication down so far it loses meaning. Employees don't need benefits jargon replaced with cheerful platitudes. They need honest, clear explanations of how their choices will affect their wallet and their health.

The goal is to make the stakes legible, not invisible. When someone is choosing between a high-deductible health plan and a PPO, they need to understand what that actually means for them in a real scenario. Not just what the monthly premium difference is, but what happens if they have an unexpected surgery, or a new baby or a mental health crisis. Walk through examples. Use actual dollar figures. Show them what utilization looks like, not just what coverage looks like on paper.

A glossary of common terms helps. So does a plain-language summary of each plan. The real goal is helping employees understand the choice in front of them, not just the menu of options.

TREAT OPEN ENROLLMENT AS A DESTINATION

One of the most costly mistakes in benefits communication is treating open enrollment as the moment employees learn about their benefits. By that point, they're already overwhelmed, the window is narrow, and most will default to whatever they chose last year.

Year-round communication changes that calculus. When employees encounter their benefits outside of a high-pressure enrollment window, they can absorb information at their own pace. They start to associate their benefits with real moments in their lives: a new gym membership, a prescription refill, a life insurance conversation after the birth of a child. By the time enrollment opens, employees already know what an FSA is and whether their gym qualifies. That's the difference.

Practically, this means building a communication calendar. Share content on preventive care in January when health resolutions are top of mind. Cover mental health benefits in May. Touch on FSA and HSA deadlines in Q4. The topics don't need to be complicated. They just need to show up consistently.

USE EVERY CHANNEL THAT REACHES YOUR AUDIENCE

There is no single channel that works for all employees. A warehouse worker on a shift schedule doesn't check the company

intranet. A remote knowledge worker might tune out a benefits webinar but read a two-minute email summary during their commute.

The PEOs that drive the highest utilization tend to use layered communication strategies: a core email series, short-form video for key concepts, printed one-pagers for client companies with limited digital access and manager toolkits so frontline supervisors can answer basic questions. None of this is expensive. All of it requires actually thinking about who you're talking to before you hit send.

Don't underestimate the manager as a communication channel. Employees are far more likely to engage with benefits information when it comes from someone they trust and interact with daily. Giving managers simple talking points and a FAQ document can extend your reach significantly with almost no incremental effort.

MAKE DECISION SUPPORT PART OF THE INFRASTRUCTURE

The best benefits communication actually helps employees make a call. This is where the tools have actually caught up to the problem. Tools that allow employees to compare plans side by side based on their own projected utilization, household size or financial situation move the needle in ways that static materials simply can't.

This doesn't replace a real conversation. It just means someone can run the numbers at 10pm on their couch instead of waiting for a benefits fair. When giving them a way to explore their options in that specific moment, without having to wait for an HR contact or a benefits fair, the decisions they make tend to be noticeably better.

Employees don't need benefits jargon replaced with cheerful platitudes. They need honest, clear explanations of how their choices will affect their wallet and their health.

MEASURE WHAT'S ACTUALLY WORKING

Most PEOs track enrollment rates. Far fewer track utilization, plan switching behavior, or whether employees are accessing the benefits, like mental health coverage or financial wellness tools, that are most likely to affect their long-term health and financial security.

Measuring communication effectiveness doesn't require a sophisticated analytics stack. Simple surveys after open enrollment, utilization data from carriers, and qualitative conversations with a handful of client HR contacts can tell you a lot about where employees are confused or disengaged. Use that information to improve the communication strategy each year. The PEOs that treat this as a continuous improvement process consistently outperform those that dust off the same PDF every fall.

THE BOTTOM LINE

Benefits communication is not a support function. It's a core part of the value a PEO delivers. When employees understand and use their benefits, employers see lower turnover, better health outcomes and a clearer return on their benefits investment. When they don't, even the most c ompetitive benefits package quietly underperforms.

DANIEL CLINE

Tech Partnerships & PEO Practice Leader
Nayya
New York, NY

Beyond Open Enrollment: HOW PEOS CAN HELP CLIENTS IMPROVE BENEFITS COMMUNICATION

BY RONDA MCCULLOUGH

PEOs already play a critical role in helping clients navigate healthcare benefits. But as employee expectations continue to evolve, there is a meaningful opportunity to expand that role beyond plan administration and open enrollment support.

Offering strong benefits is only part of the equation. Employees also need to understand what is available, why it matters, and how to use those benefits when they need them most.

Too often, benefits communication is treated as an annual event. Employees receive a large volume of information during open enrollment, make quick decisions, and then are expected to remember the details months later when a question, life change or healthcare need arises.

That approach leaves too much value on the table. When PEOs help clients communicate benefits more clearly, consistently and personally, they strengthen the employee experience and reinforce their own role as strategic advisors.

COMMUNICATION MATTERS

Employees increasingly expect communication that reflects their needs, timing, and circumstances. According to MetLife's Employee Benefit Trends Study,

cited by Milliman, more than 55 percent of employees said they wish they received more personalized benefit recommendations. Nearly half said they would feel more cared for if their employer improved benefits communications.

That is an important signal for employers and the PEOs who support them. Employees are not simply asking for more information. They are asking for better guidance: communication that is timely, relevant, easy to understand and connected to the decisions they are actually making.

For PEOs, this creates a practical opportunity to add value beyond administration and compliance. When employees understand and use their benefits, employers are more likely to see the return on one of their largest workforce investments.

PEOs can help clients build year-round communication plans that educate employees before decisions become urgent.

ONE SIZE DOESN'T FIT ALL

Many organizations still rely on broad reminders sent to the entire workforce. While those messages may be efficient, they are not always effective. Employees have different needs depending on their life stage, benefit elections, location, family situation, tenure and current level of engagement.

PEOs can help clients move from one-size-fits-all messaging toward more segmented communication strategies. Segmentation does not have to be overly complicated to be useful. Even simple audience groups can make communication more relevant and actionable.

Segmentation opportunities may include: Employee life stage, benefit eligibility, geographic location, new hire status, enrollment activity, timing throughout the employee experience and specific benefit participation.

New hires may benefit from onboarding communications that explain available benefits, enrollment deadlines, and where to find support. Employees enrolled in health savings accounts may appreciate reminders about contribution limits and educational content that helps them maximize their accounts. Remote employees may benefit from information about telehealth services and virtual care options.

Employees with dependents may need reminders about dependent care resources and available support programs. Employees approaching retirement may benefit from targeted education related to future healthcare planning considerations.

The goal is not simply to communicate more often. It is to communicate more meaningfully. When communication reflects employees' actual circumstances, it becomes easier to understand, easier to act on, and more valuable to the employee.

BEYOND OPEN ENROLLMENT

Benefits communication should not begin and end with open enrollment. Employees make healthcare decisions throughout the year. Questions come up when they experience a major life event, seek medical care, welcome a new dependent, evaluate mental health support or try to understand how a benefit applies to their situation.

PEOs can help clients build year-round communication plans that educate employees before decisions become urgent. This helps benefits feel less like a once-a-year transaction and more like an ongoing resource for employee well-being.

Year-round communication touchpoints may include:

- Preventive care reminders early in the calendar year
- Flexible Spending Account contribution reminders before key deadlines
- Mental health resources promoted during Mental Health Awareness Month
- Wellness program updates and participation opportunities throughout the year
- Dependent care benefit reminders before back-to-school periods
- Telehealth education during cold and flu season
- Open enrollment preparation communications several weeks before enrollment begins

Consistent communication helps employees make informed decisions

before needs become urgent. It also reinforces that benefits are not just enrollment options; they are resources designed to support employees and their families throughout the year.

CONSISTENCY COUNTS

PEOs can also help clients use technology to make benefits communication more consistent and more relevant. Automated workflows, targeted lists and scheduled campaigns can ensure important messages are delivered at the right time, without requiring HR teams to manually manage every touchpoint.

For example, automated reminders for employees who have not completed open enrollment, or onboarding workflows that introduce new hires to available benefits over their first several weeks of employment. Follow-up communications that reinforce important enrollment deadlines and targeted educational campaigns focused on underutilized benefits such as employee assistance programs, wellness initiatives or telehealth services are also potential use cases.

Automation should support, not replace, the human element. Employees still need opportunities to ask questions and seek clarification, especially when they are making healthcare decisions that affect themselves or their families.

Technology is most effective when it makes communication more timely and relevant while preserving the personal guidance employees value.

ENROLLMENT ISN'T ENOUGH

Successful benefits communication extends beyond ensuring employees complete enrollment forms on time. PEOs can encourage clients to look beyond enrollment numbers and evaluate whether employees understand, use, and value the benefits available to them.

Useful indicators may include:

- Participation rates in wellness programs
- Utilization of Employee Assistance Programs
- Engagement with preventive care services
- Employee feedback regarding understanding of available benefits

These insights can help clients identify communication gaps and improve their approach over time. If employees r emain unaware of valuable resources or underutilize available programs, it may signal that the benefits are not being communicated in a way that is clear, timely or relevant enough.

THE ADVISOR ADVANTAGE

Healthcare benefits represent one of the most significant investments employers make in their workforce. Yet employees cannot fully appreciate that investment if they are unsure what resources are available, how to access them, or when to use them.

Clear, proactive and personalized communication helps employees feel informed and supported. It reduces confusion, builds confidence in healthcare decisions, and reinforces an employer's commitment to employee well-being.

The same MetLife study found that nearly half of employees said they would feel more cared for if their employer improved benefits communications. When employees receive timely, relevant information that aligns with their needs, benefits become more than a transaction. They become a tangible demonstration that their employer cares.

For PEOs, helping clients close the gap between offering benefits and helping employees understand them creates a powerful opportunity to strengthen employee experiences and demonstrate value that extends beyond benefits administration.

For PEOs, helping clients close the gap between offering benefits and helping employees understand them creates a powerful opportunity to strengthen employee experiences.

The goal is not simply to increase awareness. It is to help employees understand the value of their benefits, take appropriate action and feel supported throughout their employment journey.

By guiding clients toward more segmented, proactive and year-round communication strategies, PEOs can help improve benefits understanding and utilization while strengthening their role as trusted advisors.

RONDA MCCULLOUGH

Business Development Executive
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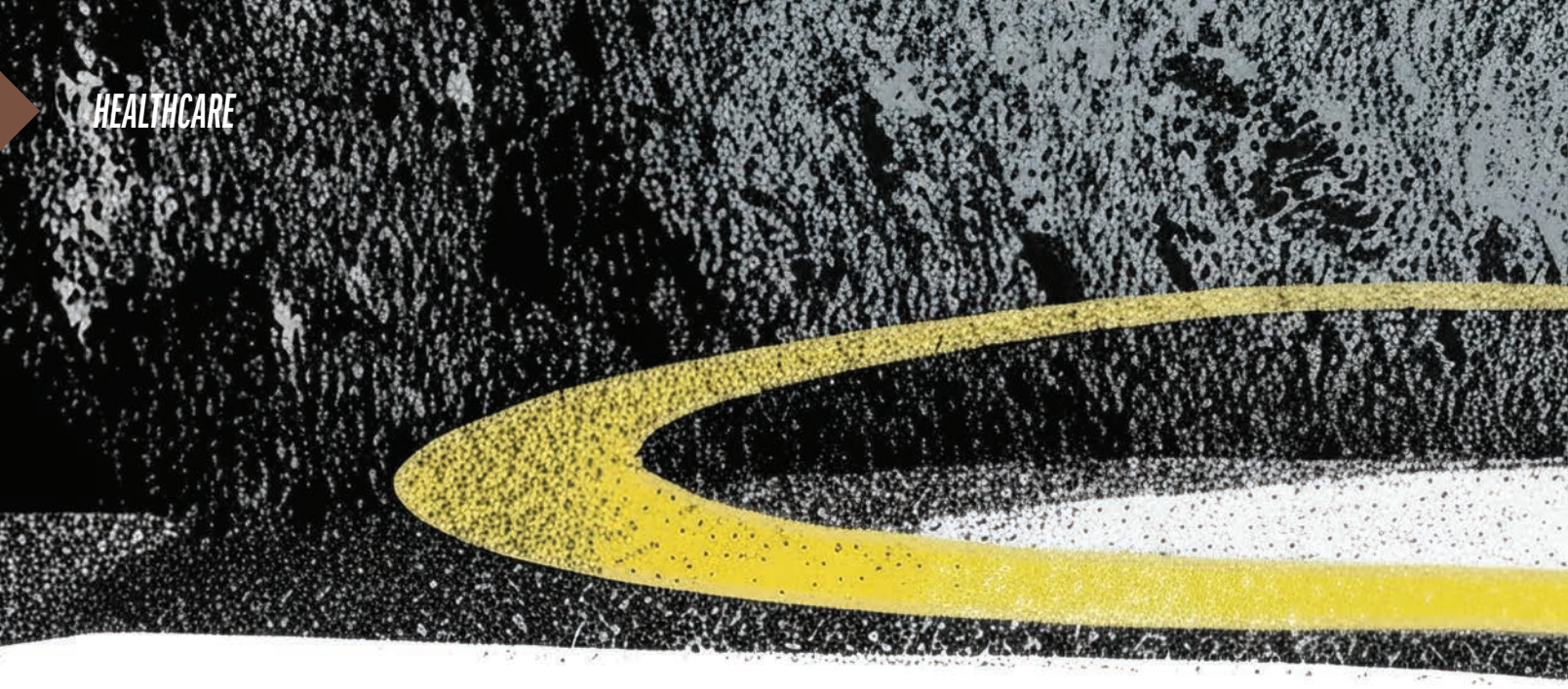

The New Imperative in Benefits Strategy: THE CUSTOMER EXPERIENCE AND JOURNEY

BY DAVID IACINO

For years, benefits strategy was defined primarily by coverage, cost and compliance. Today, that is no longer enough. Employees increasingly judge the value of health benefits by a different standard: how easy they are to understand, how simple they are to use and how confident they feel when making healthcare decisions. That shift has major implications for professional employer organizations (PEOs) and other benefits leaders. In a market shaped by rising costs, digital expectations and growing complexity, the healthcare experience itself is becoming one of the clearest sources of differentiation.

Modeling best-in-class consumer experiences from outside of healthcare and moving from a transaction-oriented model to a consumer solutions orientation with improved navigation and personalization will become the new standard.

CUSTOMER EXPERIENCE AS A STRATEGIC ADVANTAGE

As benefits strategies evolve, organizations have an opportunity to focus on the value of how customers understand, access and experience their benefits. Employees gain the most when carriers, provider networks, pharmacy programs, point solutions and employer communications work together in ways that feel clear and supportive. At Aetna, we are seeing that play out through tools and services that offer members with diabetes, joint issues or maternity needs a personalized view of their benefits and access to a dedicated care team. When the benefits experience is designed thoughtfully, it can strengthen engagement, support timely care and help employees make more confident decisions.

External research continues to show that trust, access and navigation are central to how consumers evaluate healthcare today. For organizations providing and managing benefits, the

Employee Experience and Access

consumer experience is a powerful lever for loyalty, retention and brand strength.

SIMPLICITY AS THE NEW STANDARD OF VALUE

Employees value guidance that makes their benefits easier to navigate. The most effective strategies create a smoother path to finding care, understanding coverage, comparing options and taking action. This is where benefits leaders, including PEOs, can create disproportionate value. A stronger experience comes from bringing programs and resources together in ways that feel intuitive and connected as part of one cohesive journey. That kind of simplification includes efforts such as Aetna standardizing 88% of prior authorization volume, approving more than 95% within 24 hours, and processing 83% in real time—steps that have already eliminated more than 1 million provider phone calls. Navigation becomes not just a support function, but a core design principle.

Digital tools are essential to that vision when they are organized around the user. Employees increasingly value personalized recommendations, easier access and support that feels timely and relevant. Conversational AI built into the app and website helps answer members' questions in plain language, explains benefit details and cost breakdowns, and guides them to next steps without requiring them to understand complex insurance terminology. When digital capabilities are brought together thoughtfully, they can create a more seamless and engaging experience across the full benefits journey. The organizations that stand out will be those that use digital enablement to unify the experience and make benefits more useful year-round. Recent market analyses point to personalization and year-round guidance as critical levers for improving how employees use and value their benefits.

INTEGRATION CAN POWER A MORE CONNECTED EXPERIENCE

A more connected healthcare experience begins when systems are integrated and work together more effectively. As benefits administration, carriers, pharmacy, advocacy and care delivery become better aligned, employees can move through the system with greater ease and continuity.

Integration is increasingly important not only as a technical capability, but as an experience enabler. When information flows more smoothly across touchpoints, the result is stronger coordination and a more coherent journey for the person seeking care or benefits support. As artificial intelligence (AI) and digital navigation mature, integration is becoming a key foundation for delivering the full potential of the consumer experience.

AI CAN ELEVATE THE BENEFITS EXPERIENCE

AI offers meaningful opportunities to create practical value for employees and benefits organizations. AI offers great potential in making the experience more responsive: answering routine questions, surfacing the next best action, personalizing recommendations and helping people navigate care with greater ease.

Benefits carriers are already applying AI in ways that support those goals. For example, Aetna is utilizing conversational tools that help members get clear answers about benefits and costs, as well as AI-enabled support that gives care managers back more than 90 minutes a day so they can spend more one-on-one time with members who need it most.

Recent research suggests that consumers are increasingly open to AI-enabled health experiences, especially when those tools are transparent, reviewed by clinicians or experts and clearly improve convenience or decision-making. For benefits leaders, the opportunity is to use AI as a force multiplier for trust, relevance and responsiveness.

ENGAGEMENT GROWS WHEN EMPLOYEES FEEL CONFIDENT AND SUPPORTED

Comprehensive benefits communications help employees feel informed, supported and ready to act. Clarity and timing play a vital role in helping people know where to start, what matters most and what to do next. That means communication that is plain-language and tailored to help shape decisions, from open enrollment to chronic condition support to care selection. The most effective experiences build confidence over time and make it easier for employees to engage in ways that feel manageable and personal.

Research reinforces the same point: people respond best when access is easier, communication is clearer, and support feels relevant to their needs.

DESIGN FOR THE ENTIRE JOURNEY

The future of the healthcare consumer experience will be shaped by stronger collaboration across providers, payers, pharmacies, technology companies and benefits intermediaries. Each plays a significant role in simplifying the experience and in creating a consumer journey that is more simplified, connected, supportive, seamless and effective. That work includes initiatives such as bundled prior authorization for certain conditions, which combines medical and pharmacy reviews into a single step, reducing paperwork and helping members and providers move through the system more efficiently.

This is a marked shift from the industry's more typical transactional approach to healthcare, to now build one that is journey-based and holistic.

Organizations that lead in the next era of benefits strategy will be those that focus on orchestrating all players focused on designing for the entire consumer journey.

Employees value guidance that makes their benefits easier to navigate. The most effective strategies create a smoother path to finding care, understanding coverage, comparing options and taking action.

DAVID IACINO

VP, Aetna PEO President
Aetna, a CVS Health Company
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The Pharmacy Counter Test: WHY REAL-TIME DATA IS THE ULTIMATE PEO RENTENTION TOOL

BY ANDREW ANTCZAK

In the PEO industry, success is often measured by the ability to remove friction from the lives of business owners. PEOs deliver streamlined payroll, compliant HR, and robust, Fortune 500-level benefit packages. However, the true test of a PEO's value does not happen during the initial sales pitch or even during the open enrollment period.

The ultimate test happens at the pharmacy counter, or the doctor's office checkout window; wherever a member first learns whether their coverage actually works.

Benefits are only valuable if they can be utilized. When a worksite employee (WSE) attempts to use their health coverage and faces a roadblock, it exposes the hidden cracks in a PEO's operational infrastructure. Solving this problem requires looking beyond the benefits package itself and examining the data pipelines that support it.

THE ANATOMY OF A FRUSTRATING FRIDAY NIGHT

Imagine a new WSE trying to pick up a prescription for a sick child on a Friday evening. The pharmacist runs the insurance card, only to tell the parent that no active coverage is found in the system.

The employee knows they enrolled. The client knows they submitted the onboarding paperwork on time. Yet the carrier system shows absolutely nothing.

This disconnect usually stems from a reliance on manual administration or legacy batch files. When employee data sits in a queue waiting for a weekly EDI file transfer, or worse, waiting for a benefits specialist to manually key the information into a carrier portal, a dangerous gap is created. That gap represents the time between when coverage is legally effective and when it actually becomes accessible to the member.

HOW DATA LAG BECOMES A RETENTION CRISIS

A denied prescription is not just an administrative hiccup. It is a highly stressful, emotional event for the employee that quickly escalates into a business problem.

The frustrated employee immediately complains to their manager or the business owner. The business owner, who pays the PEO a premium administrative fee for a seamless and professional experience, is suddenly dragged back into the very HR chaos they paid to avoid. They have to spend their Monday morning making angry phone calls to their PEO account manager to resolve a coverage issue.

In a highly competitive market, clients rarely leave a PEO because they dislike the software interface. They leave because trust is broken. Every time a WSE faces friction accessing the care they were promised, the PEO's core value proposition is undermined. What begins as a minor IT data lag rapidly transforms into a major client retention crisis.

By automating the pipeline, PEOs completely remove the human bottleneck and the batch-file delay. This ensures that WSEs can access their healthcare the exact moment their coverage is supposed to begin.

THE SHIFT TO REAL-TIME CONNECTIVITY

To eliminate the pharmacy counter crisis, PEOs must modernize their technology stacks to support real-time or near-real-time data integration.

The traditional approach to benefits administration relies heavily on scheduled flat-file transfers that might only run once a week. If a file fails due to a formatting error, another week might pass before the carrier successfully processes the enrollment.

Modern data integration replaces this fragile process with direct API connectivity and automated EDI pipelines. When an HRIS or payroll platform is connected directly to carrier systems, the traditional waiting period disappears. An enrollment entered and approved on a Tuesday morning is validated and reflected in the carrier's system shortly after.

By automating the pipeline, PEOs completely remove the human bottleneck and the batch-file delay. This ensures that WSEs can access their healthcare the exact moment their coverage is supposed to begin.

STRENGTHENING THE CO-EMPLOYMENT PROMISE

Real-time data integration does more than just speed up administrative workflows. It actively strengthens the co-employment relationship.

When a PEO acts as the plan sponsor, it holds a profound responsibility to the worksite employees relying on those master policies. Delivering a flawless benefits experience proves to the client that their workforce is in capable hands. It reduces inbound support tickets, lowers client noise and restores faith in the PEO as a seamless, unified solution.

For PEO operators, ensuring seamless access to care is no longer just an IT or operational initiative. It is a fundamental client retention strategy. By investing in integrated data pipelines, PEOs can stop apologizing for delayed files and start delivering on the true promise of the co-employment model: total peace of mind for the client and uninterrupted care for their employees.

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FROM RISK ASSESSORS TO STRATEGIC PARTNERS:

The Evolution of the Underwriter's Role in PEO Master Medical Plans

BY TIM MAROZ

Underwriting has long served as the backbone of financial stability for PEO master-medical plans. At its core, underwriting is the process of assessing risk—evaluating the expected healthcare costs of a group and determining appropriate pricing and coverage strategies. For PEOs, which aggregate diverse employer groups into a single risk pool, underwriting is not just a pricing exercise; it's a critical discipline that ensures the long-term viability and competitiveness of the master health plan.

As the PEO industry continues to evolve amid rising healthcare costs, growing data complexity, and increasing competitive pressure, so too must the role of the

and Benefits Infrastructure

underwriter. What was historically a judgment-heavy, labor-intensive process is rapidly transforming into a technology-enabled function powered by advanced analytics and artificial intelligence (AI). This shift is redefining how underwriting teams operate and where they deliver the most value.

UNDERSTANDING THE UNDERWRITING FUNCTION

Underwriting teams in the PEO ecosystem can take several forms. Some organizations maintain in-house underwriting capabilities, while others leverage outsourced or hybrid models supported by external partners and centralized underwriting centers of excellence. In most cases, underwriting teams rely on structured models—either proprietary tools or leased platforms—to evaluate risk, ensure consistency and support pricing decisions.

These models increasingly integrate a wide range of inputs, including demographic data, plan-design attributes and prospective-health-risk indicators. Leading platforms are evolving into end-to-end underwriting ecosystems that connect data ingestion, risk scoring, pricing, and reporting into a unified framework, delivering greater transparency, consistency, and scalability across markets.

THE THREE PHASES OF UNDERWRITING—AND HOW THEY ARE CHANGING

While underwriting processes vary across organizations, they generally follow three core steps: data collection, risk evaluation and proposal development. Each of these phases is undergoing a fundamental transformation.

1. Data Collection Becoming Data Integrity Management. Historically, data collection focused on assembling census information, benefit designs, and supporting documentation. Underwriters often spent hours validating inputs manually, correcting errors and reconciling inconsistencies.

Going forward, this phase will evolve into a more sophisticated discipline centered on data-integrity management. Agentic AI and automation tools will ingest, structure, and validate large volumes of data in real time—identifying anomalies, flagging potential manipulation and ensuring completeness before analysis begins.

This shift is critical because high-quality inputs are foundational to accurate risk assessment. Even the most advanced models will produce suboptimal outcomes if fed incomplete or inconsistent data. As a result, future underwriters will play a key role as data stewards—overseeing the integrity of inputs, investigating discrepancies and ensuring that only high-confidence data enters the underwriting engine.

In addition, this phase will increasingly support prospect segmentation. By leveraging advanced analytics, underwriters can help identify which employer groups are well suited for the PEO master plan and which may introduce disproportionate risk, enabling more strategic placement from the outset.

2. Risk Evaluation Becoming Model-Guided Decisioning. Risk evaluation has traditionally been the most time-intensive component of underwriting.

Underwriters applied professional judgment to interpret data, assess medical and pharmacy risk factors, and ultimately determine pricing recommendations.

With the rise of AI-driven predictive analytics, this step is undergoing the most significant transformation. Modern underwriting models are capable of analyzing vast datasets—including demographic, medical and pharmacy indicators—to generate highly refined risk scores and cost projections. These models can identify patterns and correlations that are often invisible to human analysis, improving both accuracy and consistency.

As confidence in these models grows, the role of the underwriter will shift from primary decision-maker to model reviewer. Rather than re-underwriting each case, underwriters will focus on validating outputs for reasonability, monitoring model performance and escalating exceptions where necessary. Declination decisions, in particular, will increasingly be driven by model thresholds rather than subjective judgment.

This transition requires a cultural shift. Trusting the model—rather than second-guessing it—will be essential to unlocking the full value of advanced analytics. At the same time, underwriters will maintain an important governance role, ensuring that models are applied appropriately and that outcomes align with broader business objectives.

3. Proposal Development Becoming Strategic Solution Design. In the traditional underwriting process, proposal development was often a downstream activity—translating underwriting outputs into client-facing pricing and plan options.

In the future state, this phase will become a core value driver. With risk evaluation increasingly automated, underwriters will dedicate more time and expertise to designing tailored solutions in collaboration with sales teams.

This includes developing alternative offerings, applying parity adjustments based on incumbent coverage, and aligning proposed plans with market dynamics, carrier strategies and client objectives. Rather than presenting an exhaustive list of options, underwriters will help curate recommendations—delivering targeted, high-impact solutions.

This evolution positions underwriters as strategic partners to sales, supporting faster decision making and improving win rates through more thoughtful and differentiated proposals.

Rather than presenting an exhaustive list of options, underwriters will help curate recommendations—delivering targeted, high-impact solutions. This evolution positions underwriters as strategic partners to sales, supporting faster decision making and improving win rates through more thoughtful and differentiated proposals.

THE BUSINESS IMPACT: SPEED, ACCURACY AND ALIGNMENT

The combined effect of these changes is a more efficient and effective underwriting function. Automation and AI reduce turnaround times, enabling PEOs to compete more aggressively in fast-moving sales environments. Enhanced data integrity and predictive analytics improve pricing accuracy, supporting stronger loss ratio performance and long-term plan stability.

Equally important, the evolving role of the underwriter strengthens alignment across functions. By focusing on data quality, portfolio strategy and solution design, underwriters become integral contributors to both risk management and business growth.

THE FUTURE UNDERWRITER: ENABLED, NOT REPLACED

The rise of AI in underwriting does not eliminate the need for human expertise—it amplifies it. Future underwriters will be "superpowered" by technology, leveraging advanced tools to work faster, more accurately and at greater scale.

Their responsibilities will shift away from manual, repetitive tasks and toward higher-value activities: safeguarding data integrity, guiding portfolio strategy, and crafting client-centric solutions. In doing so, underwriters will move beyond the perception of "sales prevention" and emerge as true partners in driving profitable growth.

For PEO master medical plans, this evolution is not optional—it's essential. As the industry continues to grow in complexity and competition, the organizations that successfully integrate AI into their underwriting processes, while redefining the human role around it, will be best positioned to deliver sustainable value.

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AI FOR PEOS: Save Time and Drive Growth by Rethinking Benefits Communications

BY RANDY WOOD

It's hard to go a day without seeing something about AI. Between ever-evolving tools and a growing list of vendors who offer them, the real question becomes: where do you even start?

For PEOs, the opportunity isn't just adopting AI. It's using it to save time, operate faster and scale your services without adding overhead. In other words, how can AI help you work more efficiently, deliver more value to your clients and ultimately grow your business?

THE BIGGEST AI OPPORTUNITY FOR PEOS

According to SHRM, 43% of organizations now leverage AI in HR tasks. At the same time, Willis Towers Watson's 2026 Artificial Intelligence in Health and Benefits Survey reported that employers' top AI-in-benefits priorities are communication (68%),

analytics (59%), and personalized support (57%).

What this tells us is clear: benefits communication and enrollment support represent one of the most immediate, high-impact opportunities for PEOs to apply AI. Not only are employers increasingly expecting these capabilities, but they also provide a way for PEOs to expand their offerings while saving time and reducing the burden on internal teams.

Research reinforces this shift. Willis Towers Watson notes that generative AI can significantly reduce the time and effort required to create benefits communication materials, from enrollment guides to employee education resources—helping teams move faster while maintaining accuracy and consistency.

INTEGRATING AI TOOLS INTO BENEFITS COMMUNICATION AND ENROLLMENT

As a PEO, you're managing multiple employers with different needs and communication preferences, all while delivering clear, accurate benefits education under tight timelines and limited resources.

AI can help address that complexity in a few ways.

Simplifying complex benefits information. AI can read and summarize detailed plan documents such as summaries of benefits, plan designs, and cost structures, and convert them into clear, easy-to-understand formats like digital guides or microsites.

Delivering 24/7 support. AI-powered virtual assistants can guide employees through enrollment, answer questions in real time and provide ongoing support across channels such as text, phone or email.

Personalizing communication at scale. AI enables campaigns to be tailored to specific employee groups and triggered based on real-life events or behaviors. For example: segmenting employees by demographics or enrollment status; automating outreach during onboarding, open enrollment, and throughout the year; and, triggering communications based on life events like marriage or a new child.

This allows PEOs to deliver more relevant messaging without increasing manual workload.

Turning static communication into dynamic engagement. AI-driven tools can move benefits communication from one-time distribution to ongoing engagement. For example: automated email and text campaigns that keep employees informed year-round; personalized recommendations based on available data inputs; and, scenario modeling that helps employees better understand costs and plan options.

This shift helps employees make more confident decisions and ultimately drives higher participation and better outcomes.

Reducing administrative burden while improving accuracy. AI tools can streamline repetitive tasks, reduce manual errors and free up time for more strategic work. For example: automates content creation and updates; keeps materials current as plans change; and, enables PEO teams to focus on client support and strategy.

AI can be difficult to keep up with, but the good news is PEOs don't have to do everything at once. By starting small and incorporating time-saving AI tools into your communications strategy, you can make meaningful progress.

AI can be difficult to keep up with, but the good news is PEOs don't have to do everything at once. By starting small and incorporating time-saving AI tools into your communications strategy, you can make meaningful progress. Whether you implement one or several of the approaches outlined above, your team becomes more agile, your PEO becomes more competitive, and your clients see the value.

The most effective approach is pairing the right technology with the right partner—one who acts as an extension of your team and helps you apply AI in a way that strengthens your overall offering. AI tools combined with real-person support set your PEO up for success.

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PrestigePEO'S NEXT CHAPTER

BY CHRIS CHANEY

For Andy Lubash, the path to the PEO industry began with a client's question.

Trained as a research analyst, he built a career in finance after college and eventually opened his own broker-dealer and securities firm. Clients began asking about more than investments as time went by. They wanted help understanding their medical insurance, especially as premiums climbed and employee benefits became a more urgent concern for employers.

At first, Lubash referred those questions to a benefits agency in his office building. But when he saw that those referrals were turning into meaningful business, he did what research analysts do: he studied the market.

"I can learn anything. Instead of reading a financial statement, I can learn a benefits booklet," Lubash thought.

He did more than learn it. He built a benefits agency, serving clients ranging from very small businesses to companies with thousands of employees. As the business grew, so did the scope of the questions clients brought to him. COBRA. Maternity leave. Employment issues. HR questions. Legal questions. The benefits conversation had become something larger.

Lubash and his partner considered hiring a labor attorney and a vice president of HR to support their clients and differentiate the agency. A friend in Florida told them there was already a name for what they were describing: a PEO. He pointed them to NAPEO and the rest is history.

Lubash launched PrestigePEO in 1998. Nearly 30 years later, the company has grown into a large PEO with a national footprint, an expanding executive team, a successful acquisition strategy and a culture its leaders describe as intensely personal. For all that has changed, Lubash insists the foundation has not.

"This is still a people business," he says.

A BROKER-CHANNEL BET

PrestigePEO's early growth was shaped by a strategic decision to build the company around the broker channel.

At the time PrestigePEO was founded, the internet was beginning to change the way insurance carriers and employers interacted. Carriers were starting to explore selling group benefits online, and Lubash saw a threat to the traditional benefits broker model. If employers could buy benefits directly, he reasoned, brokers needed a new way to remain relevant and valuable.

PrestigePEO became that solution.

Rather than compete with brokers for client relationships, PrestigePEO positioned itself as a partner. Brokers could bring clients to PrestigePEO while maintaining their relationships and continuing to provide value. The model worked because it was built on alignment. Brokers brought opportunities they believed were a true fit, and PrestigePEO became accountable not only to the client but also to the broker.

That dual accountability, Lubash says, has helped drive strong retention. If PrestigePEO fails a client, it risks losing the broker relationship as well. That makes service more than a promise; it becomes the core of the business model.

The approach helped PrestigePEO grow for decades largely through organic growth. That changed about five years ago, when Lubash's partners decided to retire and the company began evaluating options. After exploring several paths, PrestigePEO partnered with a private equity sponsor to support its next stage of growth.

Since then, PrestigePEO has continued to grow organically and pursue PEO acquisitions. The company is interested in growth, but not at the expense of fit.

"We want people that fit," Lubash says. "This is one large family."

GROWTH WITHOUT LOSING THE FEEL

Robyn Rusignuolo joined PrestigePEO in 2023 after 15 years in the PEO industry, with experience spanning legal and operations roles. The opportunity to join PrestigePEO was attractive because of the company and culture that Lubash had built, she says.

PrestigePEO team members at the annual summer event.

"I was drawn to Prestige's culture of accountability and performance, as well as the opportunity to work with a fun, dynamic team," Rusignuolo says.

She describes PrestigePEO as a rare combination: a 30-year-old company still founder-led, still growing and private equity-backed. That combination has created exciting opportunities to pursue organic growth, M&A transactions and new market entry.

PrestigePEO's executive team reflects that evolution. Leaders have joined from different parts of the industry and through different paths, including acquisition. Rusignuolo sees that as part of Lubash's commitment to building a best-in-class team that can help the company continue scaling without losing what made it successful. In addition to Lubash (CEO) and Rusignuolo (COO), Lori Martin joined PrestigePEO as its chief financial officer after a decade leading finance operations at a large national competitor. Industry veteran Heather Keefer Saulsbury joined the executive team through an acquisition and now serves as the company's chief strategy officer rounding out the executive leadership team.

The leadership team represents varied experiences within the PEO industry which combine to create a dynamic group of leaders focused on propelling the company into its next chapter.

Central to that effort is PrestigePEO's M&A approach. The company is not looking to buy businesses, strip them down and impose a rigid model. It looks for strong regional operators, management teams, products, services and processes that can make the broader organization stronger.

Rusignuolo notes the company's acquisition strategy has allowed PrestigePEO to enter strategic regional markets and gain local expertise while preserving what made acquired companies valuable in the first place.

"It's truly a partnership," she says. "We're interested in leveraging Prestige's capabilities to build upon what they do well."

That requires discipline. PrestigePEO has built a formal integration playbook, supported by an integration team, with a process that begins before a transaction closes. That process is designed around communication, transparency, project planning, and collaboration with acquired-company leadership.

The goal is not simply to migrate systems and consolidate operations. It is to create a positive outcome for everyone involved.

"Values alignment" is essential, Rusignuolo says. Sellers should acknowledge what outcomes they are seeking through a transaction, and buyers and sellers need open communication so there are no surprises before or after closing.

Lubash is equally direct about the challenges of the M&A process. He knows due diligence can be exhausting. He has been through the spreadsheets, the questions, the fatigue and the feeling that the process will never end. That experience shapes how PrestigePEO approaches sellers today. The company seeks to run an efficient, transparent process and identify material issues as early as possible.

For Lubash, acquisitions are not just financial transactions. They are relationships. He prefers operators who want to stay, contribute and continue building.

BOUTIQUE SERVICE AT SCALE

PrestigePEO's leaders repeatedly return to one theme: service. The company has grown, but Lubash says it still operates with what he calls a "large PEO with a boutique model" mindset.

One example is the company's accessibility. Lubash describes a commitment to answering phones and returning calls quickly. He is blunt about why that matters. Clients do not want to fight through automated systems when they need help with a payroll, HR, benefits, compliance or employee issue.

PrestigePEO's service model is built around teams that include an HR business partner, benefits specialist, payroll specialist, risk manager and retirement plan specialist. Importantly, those experts are accessible not only to the employer but also to employees. The goal is to get questions answered quickly by the person best equipped to answer them.

That model requires careful consideration to scale successfully, but Lubash says PrestigePEO has been able to preserve the feel of a smaller PEO while delivering the resources and capabilities of a larger one. Clients are provided with direct access to dedicated service professionals rather than relying primarily on a traditional call-center model.

Rusignuolo says that commitment to client experience has been consistent from the company's earliest days. Technology, benefits, and service methods continue to evolve, but the "why" remains the same: deliver a great product and a great client experience.

That philosophy is now shaping how PrestigePEO thinks about AI.

AI AS AN ENHANCER, NOT A REPLACEMENT

Like every business, PrestigePEO is looking closely at AI. Lubash and Rusignuolo both see enormous potential, but both emphasize that AI must support the company's service model rather than replace it.

Lubash sees AI as a tool for efficiency and speed. PrestigePEO has already begun deploying AI-supported tools to significantly improve the speed and consistency of its proposal process. He expects AI to help the company increase capacity, improve responsiveness and support continued growth without compromising service quality. But he does not view AI as a replacement for human expertise.

"You still need someone to pick up the phone when an employer has a problem with an employee," he says.

Rusignuolo frames the issue similarly. PrestigePEO's executive team is executing its AI strategic plan, assessing opportunity across departments, prioritizing and implementing use cases, and focusing on practical wins. The company wants to move quickly enough to remain an innovator, but not so quickly that it moves blindly.

For Rusignuolo, the right AI strategy must align with PrestigePEO's values. It should improve speed to service, speed to sale, quality of work and employee job satisfaction.

"It's not a job eliminator," she says. "It's a job enhancer."

The company is also watching how AI may affect broader workplace dynamics. Interest in blue- and gray-collar work is rising as employees and employers think differently about the future of work. PrestigePEO has responded in part with PrestigeBLUE, a curated service offering focused on blue- and gray-collar clients. The model tailors service, underwriting and support to businesses whose needs may differ from PrestigePEO's traditional base of white-collar clients.

For PrestigePEO, that offering reflects a broader strategy: expand into new markets and segments while leveraging the expertise already present across the organization, including experience gained through acquisitions.

"PrestigeBLUE is a wonderful example of acquisition success. The model was born through varying sales model prioritization. We appeal to the referral sources in property and casualty, in addition to our benefit partners," Chief Strategy Officer Heather Saulsbury explains.

"We will continue to prioritize this unique strategy of embracing the "one size does not fit all" growth model," she adds.

CULTURE THAT TRAVELS

As PrestigePEO grows across geographies, culture becomes both more important and harder to maintain. Lubash and Rusignuolo both describe the company as a family. They connect that culture to accountability, performance, service and fit.

"We work to empower our employees to drive the client experience. Our culture is one that is led by example. The leadership team is hands on, present and energized for our next phase of growth," Chief Financial Officer Lori Martin adds.

Lubash points to employee tenure as evidence. Some employees have been with PrestigePEO for over two decades. He also points to company events designed to bring people together across locations, including a summer event hosted in New York. For this event, employees convene for a day filled with team building exercises including the highly competitive water ballon toss. It's a chance for employees, including those from acquired entities, to engage with individuals they may not work directly with to build stronger relationships across the organization. Ultimately, it's a reflection of Lubash's founding principle: this is a people business. Taking care of employees and clients alike is the company's north star.

"Happy employees help create and retain happy clients. Take care of your people," Saulsbury believes.

That culture extends beyond the workplace. PrestigePEO has a long-standing commitment to community involvement, supporting nonprofits, client organizations and causes across Long Island, New York, and beyond. Employees participate in volunteer days, charitable walks, and community events. Lubash is personally involved with organizations supporting Alzheimer's and dementia causes.

Community engagement, Rusignuolo says, is not a side project. It is a foundational value.

THE NEXT CHAPTER

PrestigePEO's growth story mirrors the industry's broader trajectory. The company has evolved from a benefits-driven idea into a large, sophisticated PEO. It has expanded through organic growth and acquisitions. It is investing in AI, new markets, specialized service offerings and executive leadership. Yet its leaders say the same principles still drive the company: relationships, service, accountability, culture and trust.

For Lubash, the future will bring new technology, new compliance challenges, new acquisition opportunities and new ways to serve clients. But the heart of the business will remain familiar.

People still need advice. Employers still need someone to call. Employees still need answers. Business owners still need partners who understand the weight of what they are carrying.

That is what brought Lubash into the PEO industry in the first place. And nearly three decades later, it is still what drives PrestigePEO forward. ■

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MAKING EVERY MILE MATTER

BY JENNA MARCEAU

Some barriers are easy to see. Others are parked in a maintenance garage.

At Our Daily Bread Food Pantry, there is no shortage of compassion. Volunteers show up ready to serve. Community partners generously donate food. Families know where to turn when they need help. Yet one of the greatest challenges facing the pantry today isn't collecting food, it's delivering it. That's why NAPEO Gives Back is proud to partner with Our Daily Bread Food Pantry as our 2026 charitable organization.

For those who may be unfamiliar with NAPEO Gives Back, it is our opportunity each year to come together in support of a nonprofit serving the community that hosts the Annual Conference and Marketplace. At its core, NAPEO Gives Back is built on the power of many. When members from across the country combine their generosity, time, talents, and resources, we create an impact far greater than any one company or individual could make alone. This year, that collective effort will help keep food moving throughout Marco Island and Collier County.

On Marco Island, hunger doesn't always look the way people imagine. Sometimes it's a child quietly slipping extra apples into a backpack because the weekend is long. Sometimes it's an older adult choosing between groceries and medication. Sometimes it's a family waiting for the mobile pantry because reliable transportation simply isn't available.

For years, Our Daily Bread Food Pantry has been a lifeline for families throughout the community. Their impact extends far beyond the walls of a traditional food pantry. Last year alone, the organization packed more than 20,000 weekend backpacks for students, served 1,019 households through Saturday pantry events, and delivered food to 66,744 households through its mobile pantry program.

Those numbers represent more than meals. They represent children who can focus in school, parents who can stretch a paycheck a little further, and seniors who don't have to choose between filling a prescription and filling the refrigerator.

The pantry has more than 250 dedicated volunteers ready to serve. Food donations continue to arrive from generous community partners. The need is clear, and the commitment is unwavering. The challenge is getting that food to the people waiting for it.

An aging truck has reached the end of its service. Another delivery van requires frequent repairs under the Florida sun. Every breakdown means fewer deliveries, fewer families served, and fewer opportunities to provide fresh, nutritious food to neighbors who depend on the pantry's outreach.

One of the things I appreciate most about the PEO community is that when we see a need, we don't simply acknowledge it, we come together to solve it. Every day, PEOs help businesses remove barriers so employers and employees can succeed. Through NAPEO Gives Back, we have an opportunity to remove a different kind of barrier, one that stands between families and the food they need.

Throughout the 2026 Annual Conference and Marketplace, attendees will have multiple opportunities to support Our Daily Bread through our annual silent auction, sponsorship opportunities, and direct giving campaign. Together, we hope to help fund the vehicles and transportation needs that keep food moving throughout the community, including a van for community outreach and food drives,

THE IMPACT:

- Every mile those vehicles travel means another family served.
- Every supermarket pickup rescues food that might otherwise go to waste.
- Every backpack delivered helps ensure a child has something to eat over the weekend.
- Sometimes making a difference isn't about creating something new. It's about removing the obstacle standing in the way.

a truck for supermarket pickups, and critica repairs that will keep the pantry's fleet on the road.

The power of many begins with one act of generosity. One donation. One silent auction item. One sponsorship. Together, those individual contributions become the miles that carry food to families throughout the community.

Before we leave Marco Island, we have an opportunity to leave something behind that will continue serving families long after the conference ends. Long after the exhibit hall closes. Long after we all return home. Every contribution helps keep food moving. Every mile driven represents hope delivered.

Throughout the 2026 Annual Conference and Marketplace, attendees will have multiple opportunities to support Our Daily Bread through our annual silent auction, sponsorship opportunities, and direct giving campaign.

I invite every member of our PEO community to join us in supporting Our Daily Bread Food Pantry. Whether you donate, contribute an item to the silent auction, become a sponsor, or simply help share their story, your generosity will help ensure that transportation never becomes the reason a family goes hungry.

Together, we can make every mile matter. ■

JENNA MARCEAU

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THE LATEST TRENDS IN YOUR FAVORITE TOPIC: HEALTHCARE

BY T. ERIC FOSTER

If you're frustrated with healthcare these days, you're not alone. That value-added service PEOs either insure or administer has continued to grow in cost and complexity. In this article, we'll cover top trends as seen through the lens of benefits consulting. Specifically, we'll deal with cost dynamics and how PEOs can chart new paths to sustainable growth.

ECONOMIC IMPACT

The US spends 18% of GDP on healthcare. That's astounding considering we have the highest GDP in the world at $33 trillion (T) annually. 18% of $33T is $5.9T. That's our spend on healthcare. Germany has the world's third-largest economy and comes in second with spending only 12% of GDP (a ratio 1/3 less than us). To put their 12% in context, Germany's entire GDP is $5.5T annually, or less than what the US spends on healthcare alone!

Yes, we spend a lot. About 50% of what we spend is on publicly funded programs like Medicare, Medicaid and military and veterans' benefits. The other 50% are dollars we put into privately funded solutions through employers and the individual market. Over 80% of the privately funded healthcare is provided through employer-sponsored benefits, or about 40% of all money allocated to healthcare in the US. That's approximately $2.5T, or large enough to exceed the annual GDP of countries like Russia and Mexico. That's just the value of healthcare benefits provided through US employers. That's heady stuff.

You wouldn't be surprised to learn that growth in our healthcare costs is expected to outpace growth in our GDP. By 2034, healthcare spending is forecasted to reach nearly 21% of GDP or $9T. That's over a 50% increase in just 8 more years.

There are numerous factors at play. Before we talk about how technology is driving cost, let's discuss how changes in workforce are driving consumption.

WORKFORCE CHANGES

According to the US census bureau, the fastest-growing age group in the labor force is workers aged 55 and older (a group to which I, admittedly, belong). Workers in that age segment are approximately 25% of the workforce, growing at a rate 50% higher than average. Our data suggest that workers in that segment consume healthcare at a rate 2x that of workers 35–54 and nearly 4x that of workers under 34. Chronic diseases like diabetes, heart disease and neurological disorders manifest more frequently in that group because lifestyle and genetic factors have had ample time to express themselves. Increased age also brings increased exposure to cancer and autoimmune conditions. So, suffice it to say that condition-based demand for healthcare is rising apart from manufactured demand via new technology and advertising.

Let's now cover where money is being spent on healthcare delivery. Viewing in broad categories, inpatient hospital care is 15%–20% of total spend but declining. Outpatient hospital care is growing quickly at 25%–30% of total spend with many expensive drug therapies being administered in that setting. Hospital ER adds another 5%, bringing hospital-based care to 45%–55% of expenditure. Physician and surgical costs are another 20–25% of total spend, and retail Rx is the single fastest growing segment of cost at 20-25% and increasing rapidly. It's easiest to think of roughly half of the cost concentrated in hospital-based services and half in the combination of physician and retail RX. The two fastest growing segments are outpatient hospital and retail Rx.

Hospital consolidation and renegotiation of insurance contracts are driving higher hospital fees while advancements in care continue to shift hospital services to an outpatient setting. Hospitals are acquiring physician services and steering more patients to hospital outpatient. Specialty pharmaceuticals are commonly administered in a hospital-outpatient setting for treatment of cancer, autoimmune diseases and genetic illnesses.

Meanwhile, the development of new, specialty-retail drugs is driving a wave of consumption through new, highly effective treatments for rheumatoid arthritis, plaque psoriasis, psoriatic arthritis, Crohn's disease, MS, lupus, cystic fibrosis and a host of other genetic illnesses. Cancer treatments have also advanced with new oral medications that change the way the human body confronts the disease. The emergence of new treatments offers incredible promise of more effective care across the spectrum, but that comes with an increased price tag.

THE 2 PERCENT

We routinely run analyses of how members enrolled through PEO plans use healthcare. Those analyses reveal

consistently reliable statistics. One of the key findings is that a very small number of covered members drives an increasingly high % of total consumption. Simplistically, 2 of every 100 covered members generate half of the insurance claims by cost. The remaining 98 generate the other half. To compare those ratios, they would be 50/2 = 25 for the high-utilizing 2 members, and 50/98 = 0.51 for the balance. That means the high-cost population is roughly 50 times more expensive than the rest (25/0.51=49). That means insurance plans, even very large ones, are susceptible to wide swings in performance from just a small change in how the high utilizers impact a policy year. Those 2 members spread throughout a worksite-employer population have a different impact.

For example, 4 employers with 25 members each, 100 in total, would have 2 members generating half of their medical cost (2 of 100). If those 2 members fell across 2 different worksite employers, half of the employers in the sample (2 of 4) would be underfunded. So, just 2 of 100 members could create underfunding with half of the worksites! When viewing that phenomenon across a large sample, approximately 30% of employers contribute 70% of total cost (underfunded worksites), while 70% of employers contribute the remaining 30%. From a ratio standpoint, that's 70/30 = 2.33 compared to 30/70 = 0.43, with the high-consuming employers manifesting nearly 5.5x the claims of the others (2.33/0.43=5.4). That means the 30% of worksites with the highest claims average about 5-6x the cost of the rest of the population.

Further, the "50% from 2%" phenomenon also appears within Rx data. Specialty Rx, treating the rare diseases referenced earlier, comprise only 2% of scripts filled in retail Rx. Because of the high cost associated with those drugs, they generate 50% of total retail Rx spending. Those claims and attendant costs will only grow in significance with the release of additional specialty drugs. The 50/2 and 70/30 ratios appear commonly in our data sets and they often inform how plan performance is evaluated at renewal.

> *You wouldn't be surprised to learn that growth in our healthcare costs is expected to outpace growth in our GDP.*

In looking a bit deeper, our data show that retail Rx treatment of autoimmune disorders is the most commonly occurring claim that exceeds $50,000 ($50k) in a 12-month period. Examples of drugs in that class include Skyrizi, Stelara, Cosentyx, Tremfya, Dupixent and Humira. Some are available in a less-costly biosimilar, but still at significant cost. The average cost of those drugs in our data is $100k/yr. They represent 66% of all retail Rx claims over $50k in a year, and those drugs have emerged significantly post COVID. Unlike certain types of drug treatments, they are largely not delaying or eliminating costly hospitalization and are simply adding to spending. Retail Rx for cancer comes in second at just 6% of claims over $50k in 12 months. All retail-Rx claims in the cancer category averaged $150k annually and that doesn't capture more expensive IV cancer drugs administered in an outpatient setting. Advanced therapies like antineoplastic immunotherapy are easier on the body than traditional chemotherapy but come at an average annual cost of $500k- billed as medical claims and not Rx. Retail Rx treatment of liver and kidney disease average $150k/yr, with treatment of endocrine disorders and MS averaging just under $100k/yr. Blood disorders represented only 1% of high-cost Rx but averaged $500k/yr in treatment cost for the drugs only. To reiterate, these costs are for the retail Rx scripts only and include no other treatment costs.

The costs from retail Rx alone are staggering and, although some can be predicted from risk-management models, the most common-occurring claims often appear without warning: the high-cost Rx is the first notable treatment someone receives after testing. Aside from high-cost Rx, GLP-1s, not high-dollar claims themselves, are being prescribed often enough to add approximately 10% to total Rx spending or 2% to overall plan costs. All of this is driving annual forecasts of medical/rx trend to a consensus of 9%/yr but with significant volatility related to high-dollar claims. Inside the 9% trend is an approximate 8% medical trend coupled with an approximate 12% Rx trend. Also, there's a hidden stat within the 50/2 ratio mentioned earlier: 1 in 1,000 covered members generate 10% of claims cost. Those claimants carry a cost index of 10/0.1 = 100 compared to the 25 cost index for high utilizers in general and 0.51 for everyone else. A very slight variance in the 1-in-a-1000 group has a very measurable impact to annual plan performance. One notable story within our data set was a baby born with a genetic illness carrying unfortunate, grave, complications. The baby received a newly approved treatment for the illness and, after intravenous therapy and a protracted hospitalization, was cured- not stabilized but cured. That's amazing. We live in amazing times. The claim was $4 million (M).

The trend in healthcare cost appears to not be cyclical but structural and compounding. We need to appreciate that

significant investment is being made in treatment of conditions that are classically defined as "rare." The National Organization for Rare Disorders defines a rare disease as one affecting less than 200,000 people in the US. The broader rare-disease community defines it more loosely as less than 1.5M people. With a US population of 350M, even 1.5M people with an illness represent just 0.4% of the population. Using that broader definition, the number of catalogued diseases sits at approximately 10,000. That's right, 10,000 distinct rare diseases. Given the sheer number of diseases, the odds of someone in the US having at least one of the diseases considered "rare" is 1 in 10. That doesn't seem very rare. The point is simply that there is ample opportunity for new investors to pour billions into the development of treatments for a fractional number of eligible patients, driving up the cost per treatment. Given there are so many rare conditions eligible for treatment, you can appreciate the challenge we all face.

To recap, we have an aging workforce, hospital and physician-group consolidation with price inflation, growing specialty drugs, increased treatment of rare conditions (often chronic), increased cancer diagnosis with advanced treatments and more significant high-dollar claims. Some argue that healthcare use is up in general in the years following COVID simply because of delayed diagnosis and treatment, possibly combined with suboptimal habits during COVID. Our data shows that claim trend has roundly outpaced post-renewal premium yield, putting policyholders on the back foot when it comes to negotiating renewals. Many health policies are early in the process of achieving suitable premium given new claims, and overall performance reflects that. That issue is impacting all health-insurance markets and all carriers. So, how does all this impact PEOs offering access to health insurance?

Our enterprise-wide data substantiate that smaller groups represent the safest growth path for now.

THE PEO IMPACT

Risk-prediction models used in health underwriting are directionally useful and, based upon testing and actuarial feedback, are most effective at making near-term cost predictions for actively treated chronic conditions. Generally, there is a tremendous amount of uncertainty in the months following point-in-time predictions. That comes from a combination of a few things. First, data is lagged. Timing is always an issue. Second, data is often incomplete. Models using aggregator data for new-business evaluation could be missing a few pieces (from inaccurate member data and low data robustness), and renewal models contend with an increasing number of masked conditions (conditions too concerning to be revealed by insurers even with appropriate protections and documentation). Third, the data set itself is insufficient, defined by ICD-10s, CPI-4s and NDCs. Those are the codes showing diagnoses, procedures and drugs. The data set was created to reimburse providers for services and was adapted for clinical intervention and cost prediction. The data set is missing electronic medical and health records that capture a much larger picture of member health. We can see a test was run, but we can't see the results. We need to wait for any ensuing treatment to forecast near-term cost using lagged data, so far from ideal. We are missing lab results, vitals, clinical notes, and physician observations and treatment recommendations. The absence of complete data stymies significant predictive gains from AI, too. AI can improve how people evaluate options and buy insurance. AI in underwriting can and will improve data integrity, speed, clarity, reporting, guided decision making and user interface. But AI will struggle to markedly improve cost prediction until we expand the data set. Fourth, precursors to many claims are not present in the data. People can have little to no expensive treatment before being treated with an Rx at $100k/yr. High-cost claims can pop up with little warning. Lastly, predictive models were developed from large data sets to then apply to large data sets. We can predict average incidence and condition cost for an entire health plan, but we are applying models to small groups where the forecasting is directionally useful but subject to substantial volatility in the months after prediction.

Let's revisit one earlier point about prediction models being best at predicting cost for immediate, high-cost risk from actively treated chronic conditions. They cannot assure us that groups presenting well will continue well. The traditional approach of assigning groups most-favored status based upon point-in-time risk metrics no longer meshes with emerging data on actual performance. Data suggest that, within an entire health plan, the best assumption we can make is that most clients will present with average risk. Given that average cost is higher now than in years past, average premium needs to keep pace. Benefits consultants are squarely focused on identifying strategies to increase premium.

One last important consideration is determining the best markets for health insurance. Our data suggest that member costs across groups, defined by enrollment count, are relatively homogenous.

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If anything, there is a slight bias toward higher claims per member within the largest worksites. That's based on larger groups, given their size, carrying a greater statistical likelihood of picking up high-dollar claims, and the fact that a subset of high-dollar claims will be very high, even by large-group standards. More high dollar claims increases the possibility of an extremely high claim, and competition for larger groups typically drives their premium lower: a double whammy. Our data suggest that the best opportunity to achieve competitive, yet appropriate, premium lies with small groups (under 50 eligible employees in most states), including groups new to benefits. Our enterprise-wide data substantiate that smaller groups represent the safest growth path for now. That conclusion runs counter to traditional thinking about safety in numbers, but reveals an important maxim that safety often comes from seeking shelter rather than trusting yourself to consistently predict the weather.

How do PEOs seek shelter while charting paths to sustainable growth? We believe that comes from carefully defining company objectives, accepting realities in the healthcare market today, and setting strategies for achieving quality growth despite market challenges. That would impact both how PEOs issue their new-business proposals and how they retain their current clients. It also comes from recontextualizing benefits and the role that masters play in a much larger benefits arena. We need to meet worksite employers where they are with flexible, cost-effective, dynamic, and appropriate insurance solutions. That likely means supplementing masters with complementary options and, for PEOs without masters, leaning into diversification. Benefits consultants can help.

I'm fond of asking our PEO clients, in the context of health benefits, how they define "winning." That's a deceptively difficult question to answer. I urge you to consider how you define winning and pressure test that answer with data. With reflection, we often find we know more than we appreciate but less than we should. Accepting our new reality is key to success, and as we change the way we approach healthcare solutions, we can adapt and overcome. We got this. ■

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HEALTH PLAN SERVICE PROVIDER INVESTIGATIONS, ICHRAS AND ASSOCIATION HEALTH PLANS: WHERE IS DOL HEADED?

BY AMBER RIVERS, ESQ.

In addition to providing clients with full-service HR support—payroll, employee benefits administration, and risk management—PEOs are responsible for helping ensure that the benefits provided to their clients comply with the law. Given their role in the provision and administration of employee benefits, PEOs should be closely tracking what is happening at the Department of Labor's Employee Benefits Security Administration (or EBSA), the primary enforcement agency for employer-sponsored benefits.

EBSA, is responsible for issuing regulations and enforcing the requirements that the Employee Retirement Income Security Act, or ERISA, imposes on employee benefit plans. Over time, the agency has assumed an increasingly active role in its oversight of those plans. Under the current administration, EBSA has undergone a number of changes—in resources and staffing as well as regulatory and enforcement priorities—all of which affect how the agency will interact with employee benefit plans, including those offered by PEOs.

At first glance, a smaller EBSA under an administration focused on deregulation and with a newly appointed assistant secretary that is supportive of employers in sponsoring employee benefit plans would suggest a hall pass for most employers and plan sponsors. However, given EBSA's view of PEOs as having a dual role as both plan sponsors and commercial service providers, PEOs should not expect a moratorium on agency action. Instead, PEOs should expect a more intentional EBSA in search of opportunities to leverage thin resources. PEOs—as entities that oversee plans covering dozens to hundreds of client employers, should watch closely what initiatives the agency prioritizes and where it directs its resources.

RESOURCE AND STAFFING CHANGES

EBSA's historical staffing levels hovered at approximately 900 full-time employees, and the agency routinely reported that it had one investigator for approximately every 14,000 benefit plans it had enforcement jurisdiction over. The first year of the current administration emphasized government efficiency, including by streamlining staffing across agencies. Employees across the government, including at EBSA, were offered early retirement, or for those not eligible, were offered an opportunity to resign while remaining on paid administrative leave through the end of the fiscal year. EBSA lost a significant portion of its workforce through these initiatives and natural attrition, reporting staffing levels around 580 full-time employees earlier this year. A staffing loss of this scale directly affects the agency's ability to carry out its mission, including its ability to issue regulations and conduct investigations.

More recently, EBSA has worked to rebuild its workforce, but in a strategic manner that PEOs should pay close attention to. The agency has undertaken a campaign to hire large numbers of benefits advisors—the front-line staff responsible for assisting individuals with complaints. This targeted hiring matters because the agency initiates most investigations through public complaints. With more benefit advisors available to intake and review client worksite employee (WSE) inquiries/complaints regarding PEO-sponsored master plans, it is plausible that PEOs may in fact see more (not less) investigations of their master plans and related actions—even in a lighter-touch enforcement environment. It will be worth watching how this staffing shapes the number and types of investigations the agency ultimately pursues. PEOs may want to review its process for handling WSE benefits-related complaints to ensure that viable complaints are addressed and other concerns are responded to with sufficient explanation.

ENFORCEMENT PRIORITY SHIFTS

Earlier this year, the agency announced its enforcement priorities, highlighting where it will focus limited resources to drive broad-based plan compliance and address abusive practices and bad actors. Although not a national project, EBSA indicated that it will continue its longstanding commitment to identifying abusive multiple employer welfare arrangements, or MEWAs, and to preventing fraudulent MEWA operators from opening new arrangements in other states.

Many PEOs take the position that a PEO-sponsored health plan is not a MEWA (but instead a single employer plan). However, EBSA has, in certain prior statements and enforcement actions characterized PEO-sponsored plans as MEWAs. MEWA status would trigger

> *…given EBSA's view of PEOs as having a dual role as both plan sponsors and commercial service providers, PEOs should not expect a moratorium on agency action.*

Form M-1 filing obligations and a patchwork of state oversight on top of ERISA. Against this backdrop, the agency's renewed focus on investigating MEWAs signals that it will continue to review and enforce ERISA's requirements on plans sponsored by multiple employers. Accordingly, PEOs would be wise to evaluate how they view their plans and ensure that plan administration as it relates to ERISA's requirements (e.g. COBRA) and regulatory filings (such as the Form 5500 and Form M-1) are consistent. Additionally, PEOs should anticipate continued EBSA interest in their PEO-sponsored plans regardless.

The 2026 national enforcement project update also highlighted barriers to mental health and substance use disorder benefits and surprise billing as projects. Under the mental health project, the agency will target the most serious violations by plans and service providers that block individuals from accessing their promised benefits. While not framed as a mental health parity initiative, the project builds on EBSA's parity enforcement work. The surprise billing project focuses on ensuring that plans comply with the protections that were enacted under the No Surprises Act. Both are health care priorities that reach plans that PEOs administer, and both are being pursued, where possible, at the service-provider level to achieve correction across many plans at once.

While the national project update focuses on what the agency will prioritize in enforcement, the agency issued a field assistance bulletin (FAB 2026-01) outlining its approach to enforcement generally. The bulletin lays out four guiding principles for all enforcement activity:

- Focusing enforcement on the most egregious conduct and significant harm.
- Ensuring whenever possible that EBSA is not regulating by enforcement, guaranteeing fairness, prior notice, and clarity to the regulated community.
- Performing a proper review by senior agency officials of all critical enforcement initiatives.
- Committing that EBSA's enforcement will be timely and responsive.

Taken together, these principles suggest that EBSA will focus its efforts on bad actors who lack a reasonable process in administering their plans. Even though the agency has spotlighted a number of enforcement priority areas, the bulletin suggests that enforcement actions should focus on clearly communicated violations of the law. The priorities and bulletin also suggest that EBSA will focus on service provider investigations rather than plan sponsor-level investigations as a mechanism to both leverage limited resources and achieve widespread corrective action. PEOs should document their processes, including plan administration decisions and vendor selection, in order to demonstrate a reasonable process consistent with FAB 2026-01.

EBSA'S REGULATORY AGENDA

Despite the strain on resources, EBSA has an aggressive regulatory agenda. Transparency and health care disclosure continue to be a major focus under this administration, as a cornerstone of their

approach to lowering health care costs and promoting choice and competition. In practice, this means that plan sponsors are likely to receive more information than ever before about their coverage from their service providers—which raises a question for PEOs and their clients: what must a plan sponsor actually do with that information to discharge its responsibilities under ERISA? Receiving more data without a process to evaluate and act on it could potentially create exposure.

EBSA is also likely to revisit other priorities that were established during the first Trump administration. As with its renewed efforts to strengthen the transparency regulations, the agency will likely renew efforts to increase choice in coverage options, including by revamping ideas introduced under the first Trump administration such as Individual Coverage Health Reimbursement Arrangements, or ICHRAs, and Association Health Plans, or AHPs. PEOs will especially want to pay attention to any regulatory activity on association health plans to ensure that there are no unintended spillover effects for the plans that PEOs sponsor.

KEY TAKEAWAYS

While this administration has emphasized deregulation and scaled-back enforcement, given their dual role as plan sponsor and commercial service provider, PEOs should expect EBSA—an enforcement agency at its core—to continue to regulate and enforce ERISA's requirements. The agency's issuances to date signal an intent to continue carrying out its mission—developing effective regulations; assisting and educating workers, plan sponsors, fiduciaries, and service providers; and enforcing the law. In the near term, plans may feel a modest reprieve as the agency absorbs staffing losses and recalibrates its priorities. However, as staffing levels recover and administration priorities take effect, plans are likely to feel a renewed—though redirected—impact from EBSA's enforcement and regulatory efforts. ■

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ELEVATING SUBJECT MATTER EXPERTISE: THE ESSENTIAL ADVISORY ROLE OF PEOS

BY MELISSA REMILLARD, FPC

As the employee benefits landscape becomes increasingly intricate—driven by rising healthcare costs, evolving regulations, and changing workforce expectations—PEOs must transform into strategic benefits advisors. Simply administering plans is no longer sufficient; clients now seek actionable insights and guidance to make informed decisions and achieve tangible business outcomes.

To meet these demands, PEOs must strengthen internal expertise and offer comprehensive, year-round advisory services that align benefits with talent strategy, financial management and organizational health. Below are key strategies for PEOs aiming to evolve into trusted partners that deliver substantial, actionable value.

ENHANCING SUBJECT MATTER EXPERTISE

Establishing Centers of Excellence.

PEOs should develop centers of excellence (COEs) focused on critical areas like group health, compliance and workforcewell-being. These COEs serve as specialized hubs where experts can consolidate knowledge and best practices. By creating dedicated teams for areas such as health benefits, regulatory compliance and employee wellness, PEOs can ensure that clients receive accurate, timely and nuanced guidance. This structure not only enhances the quality of advice but also fosters a culture of continuous improvement and innovation within the organization.

Investing in Continuous Professional Development.

The benefits landscape is ever-changing, making ongoing education crucial. PEOs should encourage team members to pursue professional credentials such as Certified Employee Benefit Specialist (CEBS) or Society for Human Resource Management Senior Certified Professional (SHRM-SCP). These certifications enhance organizational credibility and ensure advisors understand both technical requirements and strategic implications. Additionally, implementing a structured internal curriculum that covers emerging legislation, innovative plan designs, claims trends and real-world case studies keeps expertise current and relevant, allowing PEOs to adapt quickly to changes in the industry.

Within our benefits knowledge function specifically, this role-based learning model has driven strong interest in advanced credentials. Today, more than

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half of our internal benefits team is actively pursuing the Certified Employee Benefit Specialist (CEBS) designation.

This level of participation reflects both the effectiveness of our structured learning programs and our commitment to cultivating deep subject matter expertise. By investing in targeted education and professional certification, we ensure our team is equipped to deliver informed, compliant and strategically relevant benefits guidance to our clients.

Creating a Cross-Functional Advisory Council

Benefits do not exist in isolation. Integrating payroll, HR policies and risk management with benefits strategy is essential. Establishing a cross-functional advisory council that includes leaders from various departments—such as HR, finance, and risk management—fosters alignment and delivers cohesive guidance to clients. This collaborative approach ensures that the PEO's messaging is consistent and strategic, allowing for a comprehensive understanding of how benefits intersect with overall business objectives. Regular meetings and workshops can facilitate knowledge sharing and engagement among departments, leading to more innovative solutions for clients.

DELIVERING COMPREHENSIVE YEAR-ROUND ADVISORY SERVICES

Transitioning to Strategic Benefits Planning

Traditional PEO benefits teams often focus on annual renewals and logistics. In contrast, holistic advisors engage in multi-year planning that incorporates workforce analytics, demographic insights and organizational goals. This transformation shifts the conversation from merely presenting plan options to discussing how benefits strategies can enhance employee retention, control costs, and boost productivity over time. By utilizing data-driven insights, PEOs can create tailored benefits strategies that align with clients' long-term objectives, fostering a more proactive and strategic partnership.

> *PEOs must strengthen internal expertise and offer comprehensive, year-round advisory services that align benefits with talent strategy, financial management and organizational health.*

Ensuring Continuous Advisory Engagement

To distinguish themselves, PEOs must provide value beyond the renewal season. Regular check-ins, mid-year claims analyses, and proactive recommendations keep clients informed and confident. By scheduling quarterly reviews and providing updates on industry trends, claims performance, and emerging best practices, PEOs can ensure clients feel supported throughout the year. This ongoing engagement not only mitigates surprises at renewal but also strengthens relationships through transparency and trust, positioning the PEO as a valued partner rather than just a service provider.

Enhancing Employee Education and Engagement

Knowledgeable employees make better benefits decisions. PEOs can add value by offering diverse educational resources, including virtual workshops, micro-learning videos and interactive benefits libraries for new hires. These resources should be designed to simplify complex concepts and encourage engagement, ensuring employees understand their options fully. Regular communication campaigns, such as newsletters or social media updates, can reinforce education throughout the year, leading to better utilization of benefits, lower employee stress and improved outcomes for clients.

Aligning Benefits with Broader Organizational Goals

Benefits should reinforce a company's strategic objectives. By analyzing turnover patterns, recruitment challenges, employee feedback and productivity metrics, PEOs can recommend solutions that directly support retention and workforce well-being. This alignment positions PEOs as key contributors to clients' overall people strategies, allowing them to influence organizational culture positively. Moreover, by showcasing how tailored benefits can enhance employee satisfaction and alignment with company values, PEOs can help clients attract and retain top talent.

We support a diverse range of small businesses across our region that may not individually have the scale or resources to offer competitive, comprehensive benefits. By partnering with us as their PEO, these organizations gain access to benefit programs typically reserved for much larger employers—allowing them to better compete for talent while staying focused on their core business objectives.

A key component of our approach is intentional alignment between benefits

strategy and organizational goals. Through ongoing client education and consultation, we help employers understand available benefit options (earned wage access, pay cards and traditional benefit plans), emerging market trends, and how specific programs influence workforce outcomes such as attraction, retention, engagement and productivity. By tailoring recommendations to each client's business goals, employee demographics, and budget considerations, we enable informed decision making that strengthens both employee well being and long term organizational success.

STRENGTHENING ADVISORY THROUGH TECHNOLOGY AND PARTNERSHIPS

Utilizing Data-Driven Technology Solutions

To provide sophisticated analysis, PEOs must leverage technology systems that offer real-time insights into claims, costs and employee engagement. Implementing modern dashboards and predictive analytics tools enables advisors to identify trends early, address cost drivers and communicate value clearly to business leaders. By utilizing data analytics, PEOs can enhance decision-making, optimize benefits offerings and demonstrate their impact on organizational performance.

Strategic Vendor Partnerships

Collaborating with carriers, wellness vendors and mental health providers allows PEOs to enhance their service offerings. These partnerships expand available resources and bring specialized expertise to clients during renewals and workforce planning discussions. By establishing strong relationships with key vendors, PEOs can negotiate better rates, access innovative solutions, and provide clients with a comprehensive suite of services that address diverse employee needs.

PEOs that transition from transactional support to strategic partnerships build stronger relationships, enhance client retention and differentiate themselves in a competitive marketplace.

By consolidating our master PEO ancillary benefits from multiple carriers to a single strategic carrier partner, we have significantly enhanced both program value and employee experience. This consolidation enables us to offer more competitive, employee focused plan designs while ensuring seamless integration with our payroll system. The result is improved data accuracy, streamlined administration and a more cohesive benefits experience for both employers and employees.

In parallel, we migrated all flexible spending account–type programs to a single vendor solution. This platform provides employees with centralized access to account information, the ability to connect benefit carrier data, and entry to a pre tax spending marketplace—delivered through a secure single sign on experience. This integration simplifies benefits management, improves transparency, and empowers employees to more easily understand and utilize their benefits.

STANDARDIZING ADVISORY PRACTICES

To ensure consistent client experience, PEOs should formalize their advisory framework. Standardizing service levels—such as communication timelines, data reporting, and advisory deliverables—ensures every client receives high-quality guidance. Developing shared resources, templates, and messaging frameworks not only strengthens alignment across departments but also reduces silos, allowing for a more integrated approach to client service.

BECOMING A STRATEGIC PARTNER

Ultimately, elevating benefits advisory is about adopting a consultative mindset. This involves asking insightful questions, deeply understanding client goals, and connecting benefits decisions to broader business outcomes. PEOs that transition from transactional support to strategic partnerships build stronger relationships, enhance client retention, and differentiate themselves in a competitive marketplace. By focusing on value creation and long-term collaboration, PEOs can position themselves as essential partners in their clients' success.

By cultivating subject matter expertise and providing comprehensive, forward-thinking advisory services, PEOs can create meaningful impact—helping clients navigate complex benefits ecosystems with clarity and confidence while reinforcing their value as indispensable business partners. ■

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HOW PEOS CAN LEVERAGE DENTAL INSURANCE AS A STRATEGIC COST CONTAINMENT TOOL

BY ANGELA ST. PAUL

For PEOs, managing a robust benefits strategy is a delicate balance. PEOs want to remain competitive, protect clients and manage rising costs without reducing benefits in ways that could hurt recruitment, retention or satisfaction. The benefits carriers they work with should have deep expertise in customizing plan designs, and a track record of customer satisfaction.

PEOs know dental insurance is more than an add-on benefit. Dental benefits support preventive care and reduce downstream costs. But the right dental program can contribute to a more sustainable total benefits strategy that significantly impacts overall health and healthcare expenses.

Recent inflation data reinforces why plan strategy matters. From January 2022 to September 2025, dental CPI outpaced medical CPI (18.4% compared with 11.3%, respectively). For PEOs, this cost pressure reinforces the need to evaluate dental coverage by how well the plan supports access, utilization network use and long-term value across a diverse worksite employee population.

THE BUSINESS CASE FOR DENTAL BENEFITS

Dental benefits often take a back seat to medical coverage, but poor oral health can affect overall health, productivity and medical utilization. Untreated dental issues may lead to pain, missed work, emergency care and delayed treatment that becomes more expensive over time.

Dental claims pressure is also being shaped by more than inflation alone. Higher procedure volume per member, shifts toward higher-cost services, elevated provider costs and chronic disease are all contributing to rising plan costs. That makes dental plan design part of benefits cost management.

The connection between oral health and overall health is especially important for worksite employees managing chronic conditions. Studies have found that preventive dental care is associated with significant medical cost savings for individuals with conditions such as diabetes and coronary artery disease. While each population is different, the broader message is that dental benefits can play a role in reducing avoidable costs when worksite employees are encouraged and enabled to use care appropriately.

For PEOs, a dental strategy that improves access, supports prevention, and aligns with the needs of a broad worksite employee population can help strengthen the overall benefits offering while supporting more sustainable program costs.

MAKE SURE PLANS MEET NEEDS

Cost containment does not have to mean cutting benefits. For PEOs, it means making sure the dental offerings are aligned with worksite employees' needs.

Offering a larger annual maximum benefit is a popular response to increasing dental service costs. But a right-sized maximum is based on benefits utilization, demographics and claims patterns. Higher limits may sound attractive, but if few worksite employees use the additional benefit, the PEO may be paying for richness that does not produce a meaningful return. A higher maximum may be appropriate if members delay necessary treatment because their benefits are exhausted too quickly. The key is making sure the plan avoids both over-insuring and under-insuring by aligning coverage with real population needs.

Cost containment does not have to mean cutting benefits. For PEOs, it means making sure the dental offerings are aligned with worksite employees' needs.

Coverage should also align with generational needs. A younger workforce with low major-service utilization may not need the same design as a workforce with older individuals, families or higher restorative claims. Plans that do not account for industry, geography, income level or provider access may create unnecessary costs without improving outcomes.

Procedure tiering also deserves careful attention. If important services are placed in coverage categories that create high out-of-pocket costs, individuals may delay care. Chronic or recurring needs, such as periodontal care, may warrant different plan treatment than more acute or less frequent services. Thoughtful tiering should balance affordability, access, utilization patterns and total plan cost.

Network strategy is essential to managing costs. Network value depends on both the discount available and whether members use network providers. A well-designed plan can lose value when worksite employees do not understand why staying in-network matters. Thoughtful benefits education with in vs. out-of-network cost examples shows the impact of network savings, and how lower network costs preserve more of the benefit maximum.

Regular market checks are also important. PEOs should periodically compare plan pricing, network strength utilization trends and benefit design against current market data to ensure the dental offering remains competitive, appropriately priced and aligned with needs.

USE DATA TO CUSTOMIZE THE STRATEGY

PEOs can work with their carrier partners to evaluate what their PEO worksite employee population needs are rather than relying on generic plan designs. That process should include demographic insights, regional cost differences, provider availability, claims experience, utilization patterns and workforce characteristics.

Utilization reporting can help identify waste, gaps and opportunities. Are worksite employees using preventive care? Are Major procedures increasing? Are members going out of network? Are annual maximums being reached? These questions can guide plan changes that are more precise and defensible. The goal is to make dental benefits more intentional, not more complicated.

MAKE EDUCATION PART OF THE DENTAL STRATEGY

Education is one of the most practical cost containment tools available to PEOs. Worksite employees should understand what preventive services are available, why those visits matter and how early care can help avoid more complex treatment later. Research sponsored by

the National Association of Dental Plans found that preventive dental care was associated with lower overall medical costs among adults with several conditions. PEOs can communicate that preventive dental care supports both oral health and broader health management.

Benefits literacy is equally important. Individuals often do not fully understand deductibles, coinsurance, annual maximums, networks or the difference between preventive, basic and major services. When worksite employees do not understand these features, they may bypass enrollment, avoid care, choose higher-cost providers or be surprised by out-of-pocket expenses. This is where the right carrier partner can add value. A carrier that specializes in dental and vision can offer expertise during open enrollment and year-round to help educate worksite employees.

Pretreatment estimates are another valuable education opportunity. Encouraging individuals to request carrier-based estimates for more expensive procedures can reduce confusion, limit financial surprises and improve trust in the benefits program. As worksite employees better understand and appreciate their benefits, they will have a better experience and see the value of coverage. And clients are more likely to see the connection between PEO guidance and the employee experience.

POSITION DENTAL AS A STRATEGIC BENEFIT

Dental insurance may not be the largest component of the benefits budget, but it can be one of the most practical areas for strategic improvement. As PEOs face rising health care costs and competitive labor market pressures, they can differentiate themselves by bringing more discipline to every part of the benefits package. Dental coverage is a meaningful place to start. ■

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HELPING CLIENTS GET THE MOST OUT OF THEIR BENEFITS PACKAGE

BY GABRIEL CUELLAR

Employers invest significant time and money in building competitive benefits packages for their employees, offerings that both attract and retain talent. However, if employees are unaware of, or fail to utilize the comprehensive benefits their employer generously provided, both parties as well as their PEO partner lose out. The resulting gap can be costly. Benefits go underutilized. Employees miss out on leveraging valuable resources and employers fail to see a return on one of the most significant investments in their workforce. And from the PEO perspective, benefits underutilization can cause business leaders to question whether they chose the right HR partner.

THE COST OF POOR BENEFITS COMMUNICATION

Many of today's employees are navigating expanded plan options, new digital tools and more information than ever before. With so much data to process, it's easy to see why some benefits offerings fall through the cracks.

In reality, many employees may not be aware of all that might be featured in their plans including preventative care, PTO for community service, continuing education assistance, wellness opportunities, along with mental health and other well-being resources. Then there are the voluntary benefits that complement core coverage. Each portion of the total package represents real value that employees will hopefully appreciate and strongly consider when competing job opportunities arise.

A well-structured employee benefits communication strategy—designed in partnership with their HR services provider - ensures that workers see the true worth of their full employment package and recognize the tremendous value of a competitive salary combined with comprehensive benefits. This recognition from staff often leads to heightened morale, improved engagement, a stronger employer-employee relationship and long-term satisfaction. It can also result in increased PEO partner trust and ultimately help extend service agreements.

INITIATING A YEAR-ROUND BENEFITS DISCUSSION

One of the most common mistakes employers make is treating benefits communications as a once-a-year event, exclusively tied to open enrollment. If the only period in time when employees receive meaningful information about their benefits is during the busy and frequently stressful annual sign-up window, they are likely to miss critical details or forget all the many services they have access to when opportunities to use them arise.

Establishing an internal communications plan complete with scheduled benefits updates throughout the year is one of the most effective strategies an employer can implement. That engagement calendar should dictate which benefits will be highlighted on a monthly, bimonthly or quarterly basis, with special attention given to unique underutilized resources. A PEO partner with comprehensive client services can not only help design but also execute that calendar, taking the burden off internal HR staff members that may already be stretched thin.

> *Too often, benefits communications focus almost exclusively on health insurance while failing to highlight the broader ecosystem of offerings.*

USING DATA TO IDENTIFY USAGE GAPS

Forward thinking PEOs are becoming more advanced than ever before thanks to the availability of AI and other technology tools that let them easily access helpful information. Even if that is not the case, all HR partners can certainly measure the rates at which employees are utilizing their benefits. Routine PEO-led data analysis can reveal where employees may need more information or targeted

outreach. If a wellness program has a 5% utilization rate, that is a sign that employees either do not know about it or do not understand how to access it. Over time, low utilization numbers can also be a signal that some adjustments in available benefits offerings may be needed.

Communicate About the Full Benefits Picture. Too often, benefits communications focus almost exclusively on health insurance while failing to highlight the broader ecosystem of offerings. Employees should regularly receive clear information about what benefits are available, how they work together, how to access continuing education, wellness and mental health resources, and how voluntary benefits can complement their core coverage. Framing the full package helps employees understand the total value of what their employer is offering.

Maximizing a Client's Benefits Awareness. As a general agency that helps brokers match companies with the right PEO, we are obsessed with making sure businesses have access to the benefits they need with high utilization rates. This is made possible by a good PEO match and a well-informed workforce. That means making internal communication a priority, helping employers see that a great benefits package is only as valuable as the awareness employees have of it.

PEOs are in a powerful position to drive this awareness, with the infrastructure, knowledge and resources to manage staff outreach and the expertise to identify benefits utilization gaps, bolstered by strong client relationships and trust. A well-matched PEO partner can transform benefits season from a once-a-year enrollment period into a year-round educational journey. ■

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BENEFITS COMMUNICATION: A PEO'S TIME TO CONNECT DIRECTLY WITH ITS EMPLOYEES

BY KRISTEN BARTOLOTTA AND DOREEN HEROLD

One of the most valuable services a PEO provides to its clients is access to welfare benefits. Communication surrounding these benefits also represents some of the most impactful opportunities for a PEO to interact directly with covered employees. Key moments such as open enrollment, new hire enrollment and qualifying life events create meaningful touchpoints that enable employees to build relationships with the PEO's client service and benefits teams. The quality of these communications can strongly affect an employee's perception of both the PEO and their employer.

For the average person navigating benefits enrollment, it can feel like learning a new language. To fully realize the value, clients and employees must understand the range of benefits available and how those offerings support their workforce. At the same time, the wide range of benefit options can be overwhelming, often leading to decision paralysis and numerous questions during open enrollment. It is the responsibility of the PEO's benefits team to communicate effectively with employees about their options and to provide the required guidance for well-informed decision-making.

Clear, timely and consistent communication is essential throughout the benefits lifecycle. When both clients and employees understand the value and practical details of their benefits offerings, everyone is better positioned to appreciate the complete compensation package, utilize available resources, and recognize the strategic value of the PEO partnership. Effective communication supports satisfaction, retention, and overall well-being for all parties.

Bridging these two perspectives, clients who make benefit decisions and employees who rely on those benefits require a coordinated communication strategy.

COMMUNICATING WITH CLIENTS

Each open enrollment cycle presents an opportunity to educate clients on the full value of the PEO's benefits offerings. It is an ideal time to reinforce the advantages of a PEO's purchasing power, which enables small businesses to access high-quality, competitive benefits that would often be unavailable or cost-prohibitive on the open market. Open enrollment discussions should not be viewed simply as a renewal process, but as a strategic conversation about employee attraction, retention, and satisfaction.

Renewal communications should provide clients with a comprehensive overview of any plan changes, premium adjustments, carrier updates, compliance considerations, and key enrollment timelines. Delivering this information well in advance gives clients time to understand upcoming changes and prepare for employee questions, helping support a smoother enrollment experience.

KEY COMPONENTS OF CLIENT COMMUNICATIONS

Effective client renewal communications should provide a clear, detailed summary of the upcoming plan year and help clients understand both what is changing and why it matters.

Key components should include: a summary of current and upcoming benefit offerings; an explanation of premium and employer contribution changes; key dates and enrollment deadlines; updates regarding carriers, networks, or plan design changes; compliance reminders and required notices; enrollment support resources available to employees; and, frequently asked questions and anticipated employee concerns.

Main Client Concerns

- Increases in medical, dental, vision, or ancillary benefit costs
- Impact of benefit changes on employee satisfaction and retention
- Budgeting for employer contributions in the upcoming plan year
- Understanding carrier or network changes
- Administrative workload associated with enrollment
- Compliance requirements and employer responsibilities
- How benefits compare to competitors in their industry
- Employee participation and engagement levels

Key Messages to Emphasize

- The purchasing power and negotiating leverage of the PEO
- The overall value of the benefits package, not just premium costs
- Market trends affecting healthcare costs and renewals
- Available plan options designed to meet diverse employee needs
- Enrollment support provided by the PEO benefits team
- Employee education resources and decision-support tools
- Compliance expertise and risk mitigation provided by the PEO
- Benefits as a tool for recruitment and employee retention

Open enrollment conversations are pivotal opportunities for PEOs to showcase their value. By helping clients clearly understand the benefits being offered, the reasons behind cost changes, and the broad support available, a PEO positions itself as a trusted strategic partner instead of just a benefits administrator.

COMMUNICATING WITH EMPLOYEES

Effective benefits communication for employees goes beyond distributing plan documents or holding annual meetings. A deliberate, ongoing focus on education empowers employees to make informed decisions, recognize the value of their compensation package, and take full advantage of available resources. This mirrors the importance of clear communication with clients, ensuring that both groups are equipped to maximize their benefits.

Why Employee Education Matters

Employee benefits have become increasingly complex, with options spanning health plans, wellness programs, voluntary benefits, and more.

Without proper education, employees may find it difficult to navigate their options and fully utilize the benefits available to them. Insufficient education can lead to multiple challenges, including underutilization of valuable benefits, such as preventive care, wellness programs, and Employee Assistance Programs; poor plan choices may result in financial stress or inadequate coverage; increased confusion and frustration during enrollment; and, the perceived value of benefits, and overall job satisfaction, may decline.

Renewal communications should provide clients with a comprehensive overview of any plan changes, premium adjustments, carrier updates, compliance considerations, and key enrollment timelines.

Education ensures that benefits are not just offered, but understood, appreciated, and used. Traditional benefits communication is often one-directional, relying on emails, brochures, websites, or enrollment portals that simply provide information. Employee education takes a more forward-looking approach through emphasizing comprehension, engagement, and knowledgeable decision-making throughout the entire benefits lifecycle. This approach should be continuous, including new-hire onboarding, qualifying life events, reminders throughout the plan year, and regular opportunities for learning and interaction.

Ultimately, employee benefits are only valuable if employees understand how to use them. Education transforms a benefits package from a passive offering into an active, meaningful resource that supports employees' health, financial well-being, and overall job satisfaction.

SIMPLIFYING COMPLEX INFORMATION

Benefits terminology can be confusing, particularly for employees who have limited experience navigating health insurance and other benefits.

Terms such as deductibles, coinsurance, copayments, out-of-pocket maximums, and Health Savings Accounts (HSAs) can be overwhelming. An effective education approach should use plain language instead of technical jargon; incorporate real-life scenarios, such as comparing the costs of a primary care visit, an emergency room visit, or a prescription refill under different plan options; and, break complex topics into smaller, easy-to-understand pieces that can be communicated over time rather than all at once.

Simplifying complex information helps employees feel more confident and capable when making important decisions.

HOW TO EDUCATE EMPLOYEES

Because employees absorb information in different ways, making a diverse communication strategy is essential to effective benefit education.

By delivering information using multiple channels and formats, PEOs and employers can accommodate diverse learning preferences, reinforce key concepts, and ensure employees have access to the resources they need throughout the benefits lifecycle.

An effective education strategy should incorporate multiple communication channels, including live webinars and workshops; on-demand videos and FAQs; interactive tools and decision-support calculators; mobile-friendly platforms; and, one-on-one counseling or guidance.

A multi-channel approach ensures that employees can access information in the

way that works best for them, strengthening engagement and retention.

MAKING BENEFIT INFORMATION EASY TO ACCESS

Even the best efforts can fall short if benefit information is difficult to find or navigate. Accessibility is an essential part of effective benefit communication, employees must be able to quickly locate, understand, and act on information when they need it.

Employees often make benefits decisions under pressure, or during important life events. If information is buried in complex portals or scattered across multiple platforms, they may make uninformed or rushed decisions; miss key opportunities or deadlines; or, become frustrated and disengaged.

Delivering a centralized, intuitive, and mobile-friendly benefits experience helps employees apply what they have learned when it matters most. Self-service portals, searchable knowledge bases, educational videos, and decision-support tools should be designed to make information easy to access and understand, reducing confusion while improving the overall employee experience.

Unified, strategic communication across both clients and employees is the foundation of effective benefits management. PEOs that invest in ongoing, engaging education and clear messaging for every audience drive better benefit utilization, enhance satisfaction and well-being, and reinforce the unique value of the PEO model.

By simplifying complex information, providing decision-support tools, and ensuring consistent, high-quality guidance for both clients and employees, a PEO can transform benefits communication from a transactional process into an experience that supports retention, satisfaction, and long-term partnership. ■

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BEHAVIOR-BASED SAFETY: A COMPETITIVE ADVANTAGE FOR PEOS

BY MAK CHOWDHURY

The safest organizations in the world don't necessarily have the most policies, they have the fewest incidents. And the gap between those two things, policies on paper and behavior in practice, is exactly where most PEOs have an opportunity.

For years, workplace safety in the PEO world has been defined by compliance: the right forms, the right training modules and the right completion rates. That work is necessary, but it is increasingly not the same thing as actually keeping people safe.

What the best organizations have figured out, and what forward-thinking PEOs are beginning to offer their clients, is that safety culture is built through behavior, not documentation. The question is not who completed the course. It is what people actually learn to do when the pressure is on, the shortcut is tempting, and nobody is watching.

That shift in thinking has a name. It is called behavior-based safety. And for PEOs willing to lead with it, it is one of the clearest competitive advantages available today.

THE COST OF GETTING SAFETY WRONG

The scale of workplace safety failures in the United States is significant. According to the 2025 Liberty Mutual Workplace Safety Index, U.S. employers paid more than $1 billion per week in direct workers' compensation costs for disabling, non-fatal workplace injuries alone. The National Safety Council estimates the average workplace injury costs around $40,000 in direct expenses. And that's before accounting for lost productivity, litigation and reputational damage.

For the small and mid-sized businesses that make up the core of most PEO client bases, a single serious incident can be devastating. These are organizations without large safety departments, without dedicated risk managers, and without financial cushion to absorb the fallout from a preventable event.

Most of them are also, at this moment, relying on exactly the kind of safety program that leaves them most exposed: a compliance-first model built around documentation rather than behavior change.

WHAT BEHAVIOR-BASED SAFETY ACTUALLY MEANS

Behavior-Based Safety, or BBS, is a proactive approach to safety management that focuses on observing, understanding, and eliminating the behaviors that lead to incidents, rather than simply responding to incidents after they occur.

At its core, BBS rests on a straightforward insight: the vast majority of workplace injuries are not caused by faulty equipment or unforeseeable events. Research consistently shows that human behavior is a contributing factor in 80 to 95 percent of all workplace accidents. People take shortcuts under pressure even when they know better. They skip a step because they are tired, or in a rush. They rationalize a risk because they have taken it a hundred times before without consequence.

A behavior-based safety program addresses this directly. Rather than asking "did the employee complete the training," it asks "what does this employee actually do when nobody is watching, when time is short, and when the easier path creates risk?"

WHY THIS IS A PEO CONVERSATION

Most PEOs are deeply familiar with the compliance side of workplace safety. They help clients navigate OSHA requirements, manage workers' compensation, and ensure that mandatory training gets documented. That is valuable and necessary work, but it is increasingly not enough to protect the business.

The PEOs that are building the strongest, stickiest client relationships in 2026 are the ones that have moved beyond compliance administration into genuine risk partnership. Behavior-based safety is one of the clearest and most important

expressions of that shift. And it's really not that hard to implement.

Consider what a PEO can offer a client through a BBS lens that a standard HR software platform simply cannot:

Cross-client pattern recognition. A PEO serving dozens of similar businesses can identify which behaviors and environments correlate with higher incident rates, and share those insights across its book of business.

Pre-incident intervention. Rather than responding to claims, a BBS-informed PEO can identify and address behavioral risk before it results in injury, complaint, litigation or even death.

Measurable outcomes. Clients increasingly want to see evidence that their investment in safety is working. BBS provides the data to show behavioral movement over time, not just course completions.

What the best organizations have figured out, and what forward-thinking PEOs are beginning to offer their clients, is that safety culture is built through behavior, not documentation.

According to the 2025 State of Employee Safety Report, 56 percent of employees admit they do not feel completely safe at work, and 39 percent of those who reported a safety concern experienced some form of retaliation. These are not statistics that improve by adding another mandatory module. They improve when organizations build a safety culture where people trust the system, speak up, and genuinely believe their behavior matters.

That culture is built through sustained behavioral work, not through documentation.

WHAT PEOS CAN DO NEXT

For PEOs looking to move in this direction, the starting point is a straightforward one: help clients understand the difference between compliance and safety culture, and why that difference matters to their bottom line.

A few practical steps worth considering:

Start with a behavioral risk assessment. Before deploying any safety program, understand where the actual behavioral risk lives in a client's organization. Which roles, which environments, and which situations are generating the most exposure? Generic programs assigned to everyone rarely address the specific gaps that matter.

Train managers, not just employees. Most workplace safety programs focus on frontline workers. But research consistently shows that manager behavior is the single strongest predictor of safety culture. A supervisor who takes shortcuts signals to the entire team that shortcuts are acceptable. Leadership modeling is not a soft benefit—it is a core safety intervention.

Measure behavioral change, not just completion. Build reporting practices that go beyond documenting who finished a course. Track observable behavior changes, near-miss reporting rates, and leading indicators of cultural health. These numbers tell a story that completion dashboards cannot.

Position safety as a retention and recruitment story. Research shows that 56 percent of employees consider workplace safety a significant factor when evaluating an employer. For clients struggling with turnover—which is most of them—a genuine safety culture is not just a risk management tool. It is a talent strategy.

A NEW KIND OF SAFETY PARTNERSHIP

Behavior-based safety is one of the most powerful tools available for that work. It is also one of the clearest signals a PEO can send to its clients: that it sees them not as accounts to be managed, but as organizations worth protecting.

That distinction, over time, is worth more than any content library. ■

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PAY IS BECOMING MORE THAN A PAYCHECK

BY STEPHEN FAUST

For years, payroll lived quietly in the background. Its purpose was straightforward—to ensure employees were paid accurately and on time. If that happened, the job was considered done.

That used to be enough.

Today, the conversation around payroll has expanded beyond processing checks. Employees are navigating rising financial pressures, while employers are searching for practical ways to support their workforce and strengthen retention. According to PwC's 2026 Employee Financial Wellness Survey, 59% of employees report feeling financially stressed, with many citing negative impacts on productivity and engagement.

As financial well-being becomes a larger workforce concern, attention is shifting to one of the most frequent interactions employees have with their employer: getting paid. For PEOs, that shift creates a new opportunity to deliver value.

PAY IS BECOMING PART OF THE EMPLOYEE EXPERIENCE

When financial challenges arise between pay cycles, the most important question is not whether employees have earned their wages, but how easily they can access and use them to manage everyday needs. As a result, pay is becoming a more visible part of the overall employee journey. Decisions about how wages are delivered, accessed, and managed can have an impact far beyond payday itself.

For PEOs, this creates an opportunity to deliver value in new ways. As financial well-being becomes a growing workforce concern, the paycheck is emerging as another touchpoint through which employers can help employees build greater financial stability.

BEYOND WAGE DELIVERY

As employers look for ways to support employee financial well-being, the paycheck is taking on a broader role than simply delivering wages. While compensation remains important, employees value tools that help them access, manage, and make the most of their earnings between paydays.

The paycheck is becoming more than a transaction. It is a tool through which employers can help employees gain greater control over their financial lives. As a result, organizations are changing how they think about payroll. It's not simply an administrative function, but it's an opportunity to support employees in practical and meaningful ways.

For PEOs, understanding this shift is important. As workforce expectations continue to change, new approaches to payroll and pay delivery are becoming an important part of helping employers support financial well-being.

MODERN PAY EXPERIENCES ARE EXPANDING EMPLOYEE EXPECTATIONS

For many employees, pay no longer begins and ends with a paycheck. As digital financial tools become part of everyday life, expectations around accessing and managing earnings are evolving as well.

Today, a modern pay experience extends far beyond wage delivery. Employees may expect access to earned wages before payday or real-time tip distribution. They may also value digital wallets, peer-to-peer money movement, remittance capabilities, mobile self-service tools, and personalized experiences that accommodate different languages and workforce preferences. Together, these capabilities reflect a broader shift in employee expectations.

The growing demand for modern pay solutions is reshaping how employers and PEOs think about how pay can contribute to strategic business goals. Research suggests pay flexibility can support retention. Among employers offering earned wage access, 93% report it has helped strengthen retention efforts.

WHAT THIS SHIFT MEANS FOR PEOS

This shift is not about replacing traditional benefits or overhauling payroll operations. It reflects a broader change in how employees think about financial well-being and the role employers can play in supporting it.

PEOs are uniquely positioned to help clients respond to these changing expectations. Modern pay solutions that provide greater flexibility, convenience, and control over earnings can complement existing workforce strategies while addressing challenges employees face every day.

As pay becomes more connected to financial well-being, PEOs have an opportunity to expand the value they deliver to clients and their workforces. Those that embrace this shift can strengthen their role as strategic partners while helping clients improve retention, support employees, and differentiate themselves in a competitive labor market. ■

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THE MASTER PLAN TRAP: WHY THE EXPLOSION OF FUNDING STRATEGIES WILL REWARD FLEXIBLE PEOS

BY GARRETT VIGGERS

Most PEOs sell one health plan, the master, and treat it as the main value proposition. That single choice quietly caps how much of the small group market a PEO can reach, and how far brokers will trust it. That is the master plan trap, and the market is about to make it expensive.

When I came into the small group health space in 2002 in Northern California, the options were less complex. Brokers lined up a handful of traditional PPO and HMO quotes, compared the rates and benefit grids, and looked for the best option with a competitive network. Then consumer-driven health (CDH) with HRAs and HSAs arrived, and the spreadsheet had to adapt to a different funding model. Brokers were slow to adopt, given HRA reimbursement friction and the compensation hit on high deductible plans. Today, the friction has been addressed and this once-novel model is mainstream: as of December 31, 2025, HSAs hold nearly $174 billion across 41.7 million accounts.

In 2026, we now have a myriad of funding strategies across small and large group that stack and combine with different value propositions and friction points: fully insured, PEO, level-funded, self-funded, captives, ICHRA, QSEHRA, HRA/MERP, MEC, reference-based pricing and direct primary care. This explosion of options is being driven by the unsustainable cost of employer sponsored healthcare, with per-employee cost on track to top $18,500 in 2026 on a 6.7% increase, the steepest in fifteen years.

THE UNTAPPED 2-50 MARKET

The 2-50 small group market, roughly 6 million employers, is the gateway to long-term PEO growth, and unlocking it at scale requires distribution strength in the broker channel, since brokers still own the relationships that shape most funding decisions. Under the 50 FTE threshold, these businesses are exempt from the ACA employer mandate, which is a sweet spot for benefits innovation, with a growing menu of small group funding models (PEO, level-funded, and ICHRA/QSEHRA) now competing more aggressively against traditional fully insured coverage. One signal of how fast the ground is shifting: small group ICHRA adoption grew roughly 52% from 2024 to 2025, and 83% of 2025 adopters had never offered coverage before. ICHRAs are opening new access rather than replacing plans. As more employers contemplate cancelling their group plan, I believe brokers will shift to bring more relevant group funding models to the table, including the PEO, with or without its master plan.

FRICTION AS A STRATEGY, OR FLEXIBILITY AS A STRATEGY

Whether we admit it or not, our industry has led with friction as a strategy. Siloed RFP workflows make it painful to shop and more painful to switch. Models live in their own channel with their own tech stack, so comparing across them is difficult. A client who could not easily see the alternatives could not easily leave. Friction has been a feature, not a bug: a retention mechanism. This strategy works less and less as more models go mainstream, and employers demand better-fit solutions.

Flexibility inverts it. Rather than making the client work to escape its current model, benefit consultants must drive a recommendation process that compares in the open, and earns the relationship by serving the client, rather than making it hard to leave. The consultative seat owns it, whether that's the PEO benefits consultant or a broker partner, and running these three steps with a client is defensible, rather than anchoring to a single model.

What are the right funding strategies? Start with the prospect or client's goals, not the quotes. Given what this business is trying to accomplish, whether capping a volatile cost line, competing for talent, or shedding an HR/compliance burden, which funding models are even in play? A 15-life group bleeding on a fully insured renewal but fighting to keep talent is a different puzzle than a stable 40-life group in 12 states. This narrows the field to two or three, and eliminates the risk of a prospect later asking "why didn't you bring a PEO or ICHRA solution to the table?"

Who owns each model? Map each viable model to who delivers it: the PEO partners with brokers for open-market coverage; the broker partners with PEOs, level funded plans, and ICHRA administrators.

Which is the final recommendation? Identify the model and partner that meets the needs of the client, and the reasoning behind it. It is defensible precisely because the client watched the first two steps happen.

The difference between the two strategies (friction vs. flexibility) is the difference between owning a client because they cannot leave versus owning one because they are in the best-fit funding model.

WHY FLEXIBILITY WINS IN A WORLD OF FUNDING STRATEGIES

That open comparison is why a rigid PEO loses. A master-plan-or-nothing approach can fail step one before the conversation starts, and a broker can rule it out the moment it doesn't fit. More PEOs are shifting to decouple core HR, payroll, compliance, and workers' comp from the master plan. By adopting a no-wrong-door policy, the PEO provides optionality, and when it's a fit, partners with the broker to offer the master plan. This continues to turn the PEO from a suspected competitor into an indispensable partner.

Flexibility is also the retention engine. I have watched PEO master clients walk away over a renewal that offered no viable alternate options, taking payroll and admin revenue with them, when a flexible chassis could have moved them to an open market health option. The admin core holds while the health plan adapts at each stage.

The opportunity is massive. PEO penetration sits at only about 15% even across the wider 10-499 group size, with a majority of the roughly 6 million small employers having never worked with a PEO. That ceiling is not employer demand. It is our industry's reputation as a single solution channel. The PEOs that drop the master-plan-or-nothing posture and partner with brokers on the funding strategy decision layer will own the next decade of this market. Flexibility is not a concession. It is the engine of growth. ■

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TARGETED CLIENT ACQUISITION & RETENTION LIFECYCLE STRATEGIES:

BY MATT CLAUS

As you may recall, our value proposition is very simple: "McHenry Consulting helps its customers make more money and keep more money." This series (of which this is the second article) is dedicated to providing input generated via hundreds of client interactions and intended to allow you to make more money and keep more money!

Previously, we explored how underwriting discipline, pricing architecture, operational consistency, and process design create enterprise value. Together, these disciplines support a broader objective: building a client portfolio that delivers predictable and sustainable profitability.

The PEO industry continues to face important strategic questions. Are we penetrating our addressable market effectively? Are we acquiring the right clients? And are we creating long-term economic value, or simply adding revenue?

Historically, success has been measured by new worksite employees, proposal activity, close rates, pipeline growth, and administrative revenue. While these remain valuable metrics, they tell only part of the story simply because not all growth creates value.

Many profitability challenges originate from clients that were successfully sold, onboarded, and retained—but are not sustainable profit contributors. Revenue alone does not guarantee profitability. The real measure of success is the lifetime economic contribution each client generates.

Nearly every PEO has clients that consume excessive service resources, require pricing concessions, introduce operational complexity, or create underwriting challenges that outweigh their financial contribution. Individually these decisions often appear reasonable. Collectively, they can materially erode portfolio profitability.

Leading organizations therefore evaluate growth through the lens of lifetime client value, not simply acquisition volume.

The most valuable client is rarely the largest. Instead, it is the client that aligns with the organization's operating model, generates healthy margins, presents acceptable risk, requires manageable service resources, and remains with the company for years.

This changes the acquisition strategy from one focused on volume to one centered on specific criteria as defined by you and your economic thresholds.

Sophisticated PEOs go beyond industry, geography, and employee count when defining ideal prospects. They analyze profitability by client segment, retention patterns, workers' compensation performance, payroll complexity, onboarding effort, service utilization, et. al. These insights create a disciplined framework for identifying clients that consistently produce attractive long-term economics.

The same discipline applies to business development underwriting.

Sales organizations naturally pursue growth, while underwriting protects pricing and risk. Rather than viewing these objectives as conflicting, leading firms recognize underwriting as one of the primary drivers of profitable growth. Pricing exceptions and underwriting concessions may occasionally be justified, but they should always be intentional, measurable, and fully understood.

Client acquisition channels deserve similar scrutiny.

Rather than evaluating marketing channels solely by lead volume or new accounts, successful organizations assess the quality of clients each channel produces. Some consistently generate

stronger retention, lower service demands, better risk characteristics, and higher lifetime profitability. Capital is then allocated toward channels that create the greatest long-term value—not simply the most opportunities.

Retention is equally important!

Every client requires substantial investment before becoming profitable. Sales, underwriting, implementation, training, and service all occur before meaningful returns are realized. Each additional year a client remains increases the return on that initial investment, making even modest improvements in retention highly valuable.

Retention, however, is rarely determined by a single interaction. It reflects the cumulative client experience—from sales expectations and onboarding through payroll accuracy, benefits administration, service responsiveness, and ongoing strategic support.

Highly profitable organizations establish clear client boundaries, communicate service expectations early, and maintain alignment between pricing and service delivery. They also monitor client health throughout the relationship, identifying risks early while creating opportunities to expand services.

Ultimately, the industry's future leaders will not be defined by how many clients they acquire, but by the quality of those clients. Organizations that consistently attract, serve, and retain profitable clients develop stronger margins, more predictable earnings, greater resilience, and higher enterprise value.

As the PEO industry continues to mature, the distinction between growth and value creation will become increasingly important. The firms that achieve lasting success will be those that consistently acquire—and retain—the right clients. ■

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A CONNECTED GO-TO-MARKET FRAMEWORK FOR PEO GROWTH

BY AMANDA ORTEGA

The PEO industry is in a strong position. The results are real, and there is still room to grow. NAPEO reports more than $400 billion in estimated industry revenue and more than 230,000 businesses using PEO services, yet only 14% of employers with 20 to 499 employees use a PEO. A real growth opportunity exists in that gap.

For PEO leaders, the question is whether your growth plan is built to capture that opportunity or trapped in spreadsheets. Your approach cannot look like everyone else's. You need to win buyers in a market where AI algorithms, independent research, and shortlisting happen before the sales call.

This connected go-to-market model gives PEO leaders a simple litmus test for growth readiness. It shows whether your company is clear, credible, findable, visible, aligned, and consistent enough to earn trust before buyers ever reach out. The model looks at six structural pillars beneath a strong GTM: identity, culture, authority, discoverability, visibility, and momentum.

IDENTITY: WHO ARE YOU BEST BUILT TO SERVE, AND HOW DO YOU SERVE THEM?

Many PEOs describe what they offer: payroll, HR, benefits, compliance support, technology, and service. Pull the first few lines from your website and two competitors' websites. Remove the logos. If a buyer could not tell which one is yours, your identity is not specific enough.

Your brand identity is not a functional description of what you offer. It is a simple statement that tells the market where your unique point of differentiation meets your ideal customer's needs. To position your PEO for growth, your message needs to clarify the buyer and business context where you are proven to be the right choice.

Getting specific does not narrow your window of opportunity. It aligns your proof to your story so you can build trust and scale from a stronger foundation.

Here are two simple ways to test whether your ideal customer profile (ICP) and customer value proposition (CVP) are clear.

Ask a few people across leadership, sales, marketing, and service to answer this in one sentence: "When a _____ company is facing _____, we are the best PEO for them because _____."

Then look through your case studies for evidence. What patterns show up in the clients you serve best, the problems you solve repeatedly, and the strengths clients value most? What needs are you meeting in a way competitors cannot easily copy?

That honest reflection is where your clearest growth opportunity begins.

CULTURE: DOES THE EXPERIENCE MATCH THE PROMISE?

Proof does not only live in case studies but also in client feedback. Culture is not only an internal issue. It directly impacts the client experience, which either supports or weakens your CVP.

PEO buyers are looking for a partner they can trust with sensitive, essential parts of the business. If your brand promises high-touch guidance, clients should feel guided. If your message is built around simplicity, the experience should feel easier. If you talk about partnership, your service model should feel personal and accountable.

> *Authority is about proof that supports your value. Discoverability is about matching your content strategy to the questions your best-fit buyers ask in their research.*

A simple way to test this is to compare your CVP with feedback from the clients who best fit your ICP.

Look at your last several client compliments and your last several client complaints. Where do clients praise you? Where do they feel friction? What do they say they value most?

Then compare that feedback to the promise you are making in the market. If the promise and the lived experience do not match, culture is weakening your differentiation.

The work here can get complex, but the simple path is to document your mission, vision, values, and culture in a way employees can actually use. Communicate them internally through employee training and leadership consistency. Then connect them to performance expectations, reviews, and compensation so the client experience is reinforced by the way the company operates.

AUTHORITY: ARE YOUR PROOF POINTS CLEAR AND ACCESSIBLE?

PEO buyers are making a high-trust decision and need to believe you understand their business. Do not wait until the sales conversation to overcome their objections. Buyers are searching, asking AI tools, reading reviews, and scanning PEO websites looking for credibility signals. If your strongest proof lives only

in sales conversations, proposals, or the minds of your team, growth will suffer.

Authority is built through relevant proof that supports the value you are promising: case studies, client stories, practical education, compliance guidance, executive perspective, referral partner confidence, FAQ content, and clear sales materials.

A simple way to test this is to type your ICP description and CVP statement into an LLM, such as ChatGPT, or a search engine, such as Google. Then look at what PEOs show up. Can buyers find your company, your content, or proof that supports your CVP? If the answer is no, your authority is not visible enough to support growth.

DISCOVERABILITY: CAN BUYERS FIND YOU WHEN THEY RESEARCH SOLUTIONS?

Authority is about proof that supports your value. Discoverability is about matching your content strategy to the questions your best-fit buyers ask in their research, so your PEO shows up as a relevant solution before they have made a shortlist.

Start with buyer personas that reflect the decision-makers aligned to your ideal customer profile. Make sure those personas include the questions they are likely to ask as they research HR support, growth challenges, and outsourced PEO options. These may include questions about co-employment, HR risk, benefits costs, payroll complexity, compliance, employee experience, or how to compare PEO providers.

Then search those questions the way a buyer would. Use various tools like Google, ChatGPT, Claude, LinkedIn, and Reddit. If your company's point of view is missing, your discoverability strategy needs work. If buyers do not find you during their research, you may not make their shortlist.

VISIBILITY: DO YOU SHOW UP CONSISTENTLY WHERE BUYERS ARE LOOKING?

Once your ICP and CVP are clear, visibility becomes more focused. You are no longer trying to show up everywhere. You are building a consistent presence in the places that matter most.

For PEOs, that often includes referral partners, industry associations, local business networks, LinkedIn, webinars, events, email, trade publications, and executive relationships.

A quick way to test visibility is to list the five places your best-fit buyers and referral partners already pay attention. Then look back over the last 90 days.

Did your PEO show up in those places with a clear point of view? Did you give

people language they could remember and repeat? Did your presence make your value easier to understand or refer to someone?

If visibility only happens in occasional bursts, the market you are targeting will not have enough repetition and consistency to remember you when the need becomes urgent.

MOMENTUM: IS YOUR GTM CONNECTED ENOUGH TO MOVE THE MARKET?

Momentum is the whole point of growth, and connected go-to-market is critical for executing and measuring progress along the way. Measurement matters because "busy" is not a marketing metric. A full calendar does not equal business growth. Activity is not the same as momentum.

Momentum happens when the work is orchestrated around a single, clear growth story. Your message, campaigns, content, sales tools, website, referral strategy, events, and follow-up should all reinforce the same best-fit audience and differentiated customer value, backed by proof. That connected execution is what turns a growth plan into a truly scalable business.

To test this, look at your last campaign, last sales deck, last event, last email, and last piece of content. Do they sound like they are coming from the same strategy? Do they point buyers back to the same CVP? Would the market, and the AI systems shaping buyer research, understand what you want to be known for and who you are best built to serve?

If the work is busy but disconnected, the marketing noise will not support business growth. If the work is connected and intentional, every touchpoint makes the next one stronger.

WHAT GIVES A GROWTH PLAN LIFT

When growth loses traction, the problem often gets labeled as lead volume. But for many PEOs, the deeper issue is a disconnected growth architecture.

Like an airplane, a growth plan needs a preflight systems check. The individual parts matter, but lift only happens when they work together as a whole. Sales may carry the deal forward, but it cannot get off the ground alone.

Use this connected GTM framework to make sure every part of your growth plan is market-ready and prepared for takeoff. ■

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EXPANDING HORIZONS: HOW GLOBAL EOR PARTNERSHIPS DRIVE GROWTH FOR PEOS

BY EZRA SCHNEIER

Geography used to define where small and mid-sized businesses hire. Today, borders are no longer boundaries. And PEOs are uniquely positioned to help clients capture international opportunities.

By integrating a global employer of record (EOR) solution into their service portfolio, PEOs unlock new revenue streams, protect their existing books of business, and help clients turn those opportunities into real hires.

PEO VS. EOR: WHAT'S THE DIFFERENCE?

While a traditional PEO operates on a co-employment model within the U.S., a global EOR acts as the sole legal employer for international professionals. Global EORs have established legal entities in countries outside the U.S. to compliantly onboard, pay, and manage global talent.

From employment contracts and localized benefits administration to payroll, tax withholding, and ongoing HR support, global EORs handle the operational complexities of international employment. This allows the PEO's client to hire anyone, anywhere, without the burden of regulatory compliance.

THE STRATEGIC VALUE FOR PEOS AND THEIR CLIENTS

Global EORs offer a fast and compliant way to scale internationally without the high costs and time drain of entity setup. For the PEO, integrating an EOR solution is a competitive differentiator.

Client retention. When a valued client needs to hire internationally, PEOs without a global solution risk losing that client to a competitor who does.

Expanded revenue. Partnering with a global EOR allows PEOs to attract and serve clients with global needs and monetize the segment of a growing market that's expanding internationally.

Trusted advisor status. It positions the PEO as a comprehensive partner capable of supporting a company's scaling lifecycle—from local startup to global enterprise.

4 USE CASES FOR A GLOBAL EOR/PEO PARTNERSHIP

There are four main scenarios where introducing a global EOR solution can solve a PEO client's cross-border talent challenges:

1.) Sourcing global remote talent.

The shift to remote work means the best fit for a role might be in Toronto, Stockholm, or Mumbai. When a PEO client identifies top-tier international talent, a global EOR allows them to extend an offer quickly, bypassing local employment and operational hurdles.

2.) Retaining relocating U.S. employees.

Employee mobility is at an all-time high. Whether due to a partner's relocation or a desire to return to their home country, the number of high-performing U.S. employees relocating abroad continues to grow. Rather than losing institutional knowledge or risking permanent establishment tax penalties, the client can keep valuable talent by seamlessly transitioning the relocating professional to a global EOR.

3.) Staying agile during international market expansion.

When companies test a new international market, they typically start small—hiring one or two business development managers in the target region. Between legal fees, local counsel, and ongoing maintenance costs, setting up a local subsidiary for a pilot program isn't worth the investment. A global EOR provides a low-risk path to pilot new markets before committing significant capital.

4.) Mitigating misclassification (contractor-to-employee transitions).

Many U.S. companies inadvertently expose themselves to legal and financial penalties by using independent contractors for full-time roles. When a short-term project evolves into a permanent need, or when local regulations tighten around gig work, a global EOR provides a seamless pathway to transition international contractors into compliant, full-time employees.

FUTURE-PROOF YOUR PEO

In a competitive market, differentiation is everything. Partnering with a global EOR ensures that when your clients look across borders to scale, they don't have to look for a new HR provider. A PEO and global EOR partnership delivers a fast, compliant, and seamless international employment experience—strengthening the client relationship and driving mutual growth. ■

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ADVOCACY IN ACTION

BY CASEY M. CLARK

For PEOs, healthcare has always been a benefit in more ways than one. It is often one of the clearest, most tangible ways our industry helps small and mid-sized businesses compete for talent, take care of employees and manage complexity they could not reasonably shoulder alone.

Many of you will remember how the policy debates and media coverage around the Affordable Care Act created an inflection point for the PEO industry. As employers grappled with new rules and obligations, PEOs were there with expertise and solutions.

Today, healthcare and employee benefits still play a major role in PEO operations and sales, so much so that during our CEO retreat this April, rising healthcare costs was cited as the top concern of PEO executives.

The industry's ability to offer cheaper healthcare is at risk, driven in part by rising provider reimbursement rates, higher prescription drug spending (think GLP-1s), increased utilization of services, growth in high-cost claims from specialty drugs and labor shortages within the healthcare system. The challenge facing PEOs is to ensure clients recognize the full PEO value proposition and not distill it down to cheap healthcare.

Apart from healthcare and benefits, PEOs also help businesses manage an increasingly complicated employment landscape across compliance, payroll, retirement plans, workforce expectations and technology. That is why NAPEO's engagement with policymakers is so important. The better policymakers understand the PEO model, the better they can appreciate how their decisions affect not only our members, but the hundreds of thousands of businesses and millions of worksite employees our industry supports.

NAPEO has made meaningful progress in deepening that engagement this year. One important example is our ongoing dialogue with the IRS. In March, NAPEO began monthly meetings with IRS officials who oversee Employee Retention Tax Credit (ERTC) processing. These conversations give us a regular forum to raise your concerns, share practical feedback and reinforce the need for efficient and accurate administration of ERTC claims. Perhaps more importantly, the IRS officials have welcomed our engagement, asked insightful questions and asked us to communicate important updates on their behalf. This includes the bifurcation of claims whereby portions of a Form 941-X that include ERTC claims may be disbursed while other portions remain under examination. I appreciate Kara Childress of Vensure for first learning of this development and sharing the information with NAPEO members.

We have also met with officials at the Department of Labor (DOL) regarding Form 5500 issues, including Assistant Secretary Daniel Aronowitz who also offered a keynote address at PEO Capitol Summit. Our conversations with DOL have allowed us to explain those concerns directly and constructively, while continuing to advocate for practical solutions. Assistant Secretary Aronowitz appreciated our input and perspective.

These meetings are not simply one-off events or the product of luck. They are a prime example of our strategic plan in action to deliver a favorable policy environment for PEOs. Advocacy is often most visible when there is a major legislative fight or regulatory proposal, but some of the most important progress happens through consistent relationship-building and education.

Healthcare is a fitting theme for this issue because it illustrates both where the PEO industry has been and where it is going. The Affordable Care Act era helped introduce many employers to the PEO model. Today, our industry's role is broader and more sophisticated. We help businesses offer competitive benefits, manage risk and focus on growth.

NAPEO's job is to make sure decision-makers everywhere—from Wall Street to Main Street to Pennsylvania Avenue—understand that story. This year, we have taken important steps forward and we will continue building on that momentum on behalf of our members and the businesses they serve. ■

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