

Carriers Forecast Employer Risk Before Renewal.

The party with the most information at the renewal table is almost always the party that wrote the policy. Carriers and reinsurers have spent decades building forecasting models that predict employer risk months before the conversation begins. Most employers arrive with no equivalent capability. The asymmetry is not incidental. It is structural, and it has a quantifiable cost.

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Inside every major health insurance carrier in the United States, there is an actuarial function whose entire job is to forecast the future cost of a given employer group. That function begins its work long before any renewal meeting takes place. By the time the carrier sends a renewal proposal, the projected loss ratio for the coming plan year has already been modeled, stress tested, and priced. The renewal number is not a negotiation opening. It is a forecast output. Most employers, and a meaningful percentage of brokers, treat the renewal as the start of the conversation. The carrier has been having the conversation by itself for months.

This is not an indictment of carriers. The carrier is doing exactly what its business model requires it to do. What is missing is the symmetric capability on the buyer side of the table. The employer arrives with a year of claims history, a binder of benefit summaries, and a request for a smaller increase. The carrier arrives with a predictive model trained on tens of millions of lives and a clear projection of where the employer's metabolic and chronic disease burden is heading. The result is a market in which the party with the better forecast wins the price, plan year after plan year.

What Carriers Actually Model

Modern carrier underwriting is not a single calculation. It is a layered modeling stack that draws on claims experience, demographic composition, geographic risk loadings, prescription utilization patterns, prior authorization data, and increasingly, signals derived from clinical

encounter notes processed through natural language tooling. On top of all of that sits a chronic disease progression model that predicts what proportion of a given group will move from prediabetic to clinical type two diabetes, from stage one to stage two hypertension, from elevated triglycerides into nonalcoholic fatty liver disease, from increasing body mass into clinical obesity, and from any of those into the coronary heart disease tail. The metabolic syndrome cluster, type two diabetes, hypertension, nonalcoholic fatty liver disease, obesity, and coronary heart disease, sits at the center of the model because it sits at the center of the spend.

The progression assumptions inside these models are well grounded. They draw on the same epidemiological literature that any serious analyst would use. Knowler and colleagues, writing in the New England Journal of Medicine in 2002, established baseline progression rates from prediabetes to type two diabetes in the absence of intervention. Tabák and colleagues, writing in The Lancet in 2012, refined the multi year trajectory of glucose and insulin in the run up to clinical diagnosis. The Centers for Disease Control, through National Center for Chronic Disease Prevention and Health Promotion publications first issued in 2017 and updated since, has quantified the share of national healthcare expenditure attributable to chronic disease. The Milken Institute, in 2019, placed the total economic burden of chronic disease in the United States at \$3.7 trillion when both direct medical cost and lost productivity are included.

The carrier reads this literature, builds it into the underwriting model, and prices the renewal accordingly. The employer, in most cases, has neither read the literature nor connected it to its own workforce.

"In any negotiation, the party with the forecast does not negotiate from the past. It negotiates from the projection. The employer who arrives without one has already conceded the meeting."

The Shape of the Information Asymmetry

The asymmetry between carrier and employer has three concrete components.

The first is data. The carrier holds the historical claims experience for the group and for a peer cohort against which to benchmark it. The employer typically sees only an aggregated summary. The carrier sees the line item detail.

The second is timing. The carrier begins its renewal modeling months before the employer is told what the renewal will look like. By the time the employer's broker is asked to negotiate, the carrier has already determined the boundary conditions of its position.

The third, and the most under appreciated, is forward looking science. The carrier knows that a workforce with a particular metabolic and chronic disease profile will produce a particular claims pattern in the coming year. The employer, having looked only at last year's claims, has no equivalent way to see what is coming. This is the asymmetry that the category of metabolic intelligence and forecasting is designed to close.

What an Employer Side Forecast Changes

An employer that arrives at the renewal table with its own forecast of workforce metabolic trajectory changes the structure of the conversation. It can argue that the projected risk is lower than the carrier's model implies, with evidence. It can argue that the intervention plan in place will shift the trajectory of a defined population segment, with a quantified projection. It can request alternative pricing scenarios that are tied to specific risk reduction commitments. And it can do all of this in the same financial language the carrier uses.

This is not a hypothetical reversal of the renewal dynamic. It is the same shift that has already taken place in every other negotiation an enterprise conducts. The procurement function does not buy raw materials without a market forecast. The treasury function does not refinance debt without a yield curve view. The workforce function does not plan headcount without a labor market projection. The benefits function is, at most large employers, the last major procurement category without a buyer side forecasting capability. The buyer pays for the gap every year, in the form of a renewal that the seller priced months earlier from a model the buyer has never seen.

A WORKING DEFINITION

Employer side metabolic forecasting is the ability to project workforce metabolic trajectory and its associated cost exposure thirty, sixty, and ninety days forward, using continuous metabolic signals at the individual level, modeled at the population level, and returned to the employer in aggregated, de identified form. It is the missing buyer side counterpart to the carrier's underwriting model.

Why the Capability Did Not Exist Before

For most of the history of employer health benefits, the data required to build a buyer side forecast was simply not available. Blood pressure was measured at an annual physical. Weight was self reported. Glucose was tested when ordered by a physician. Waist circumference was rarely recorded. Fasting and sleep patterns were not measured at all. The metabolic state of the workforce was, in any practical sense, invisible between annual physicals.

That has changed in the past decade with extraordinary speed. Continuous glucose monitoring has expanded into millions of healthy adults. Home blood pressure monitoring is routine. Sleep and fasting are tracked by consumer devices. Body composition is part of the everyday measurement layer of life. The raw material for a buyer side forecasting capability now exists in volume sufficient to support actuarial work. What has been missing is the intelligence and forecasting layer that turns that raw material into something a chief financial officer can put into a model and a benefits leader can put into a renewal conversation.

The Cost of Operating Without the Forecast

The financial cost of operating without an employer side forecast is the difference between accepting the carrier's renewal as the starting point and engaging the carrier's renewal with a counter projection of equal analytic weight. In aggregate, across the United States employer market, that difference is measured in tens of billions of dollars annually. At a single mid market or enterprise employer, it is the difference between a renewal increase that lands within a few percentage points of the carrier's first proposal and one that is meaningfully restructured against an alternative scenario.

The same principle that governs every other capital allocation decision inside the organization applies here. The party with the better forecast captures the surplus. The party without the forecast pays for the asymmetry. The market has tolerated this asymmetry for a long time because there was no alternative. The alternative now exists.

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