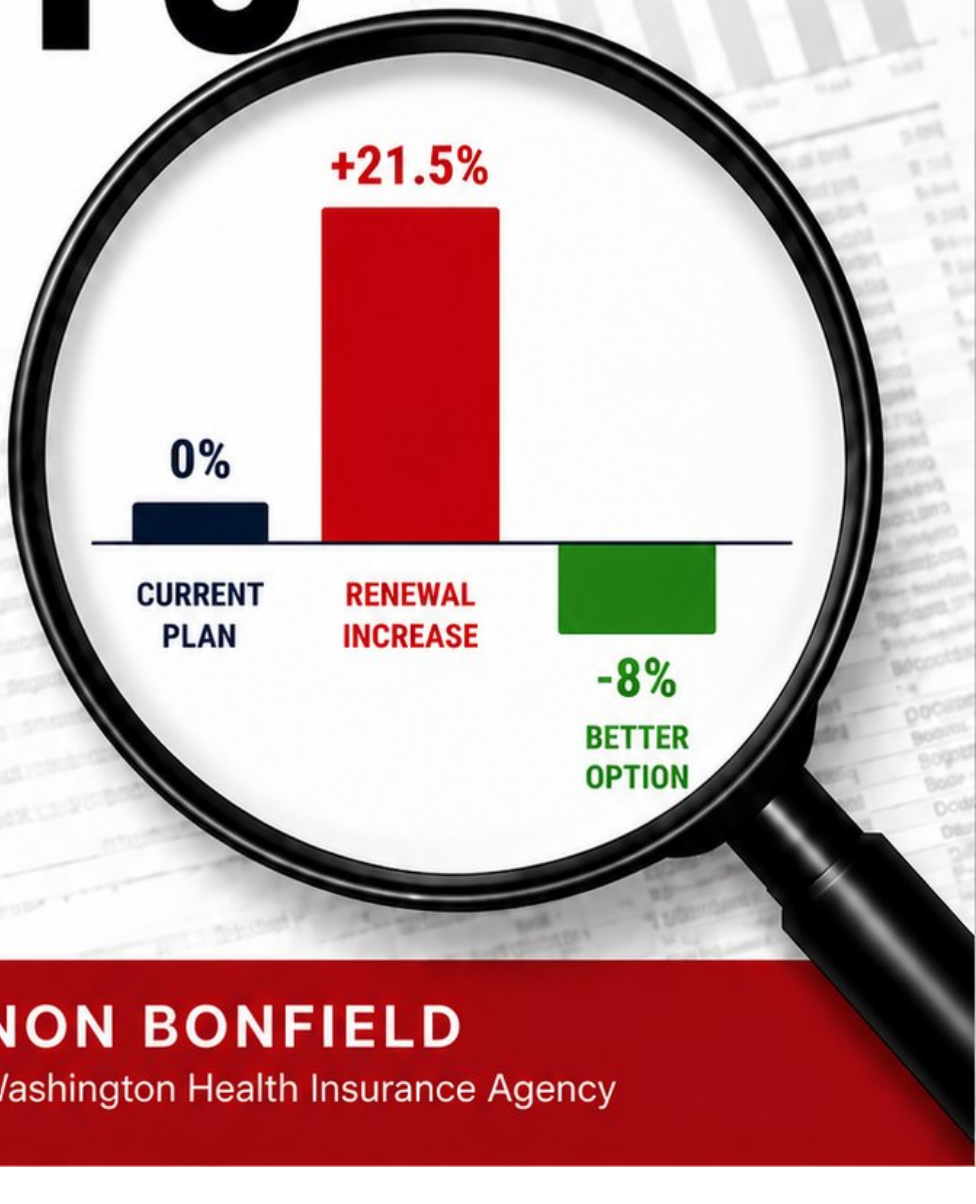
THE WASHINGTON EMPLOYER'S GUIDE TO

TAKING CONTROL OF HEALTH INSURANCE COSTS

Stop accepting bad renewals.

Find better options.

Build a smarter benefits strategy.



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The Annual Renewal Problem

Every year, around the same time, it arrives.

The renewal packet shows up in your inbox or on your desk, and before you even open it, you already know the headline: rates are going up. Again.

The explanation is usually vague. Something about claims experience. Market conditions. Carrier pricing adjustments. The age of your group. You nod along, because the language sounds plausible, but you have no real way to verify any of it. And then comes the menu of bad options.

Raise deductibles. Shift more of the cost to employees. Shop a few similar plans that are probably going to end up at roughly the same number. Accept the increase and move on.

This is the cycle most Washington employers have been living inside for years. Some have learned to budget for the annual bump. Others scramble to find cuts elsewhere in the business to absorb it. Almost everyone, at some point, has sat across from their broker and wondered: is this just the way it is? Or are we missing something?

Here is the thesis of this guide, stated plainly:

> ***Most employers do not have a health insurance problem. They have an advice problem.***

The plans are out there. The options exist. The tools to control costs, build better benefits, and stop the annual shock of a bad renewal are real and available to Washington businesses of virtually every size. What most employers are missing is an advisor who actually goes looking for them.

This guide is designed to show you what that looks like. By the end of it, you should know what questions to ask, what warning signs to watch for, and what a genuinely different kind of benefits conversation looks like.

Let's start with why this feels so broken in the first place.

CHAPTER 1

Why Health Insurance Feels Broken for Employers

Let's be honest about what this experience actually feels like.

You are running a business. You have margins to protect, people to retain, and a hundred decisions competing for your attention on any given Tuesday. Employee benefits are supposed to be one of the things you set up and trust to run. Instead, they have become an annual source of anxiety, a recurring line item that keeps growing, and a conversation you dread having with your team.

You do not know whether the increase is fair

When your carrier sends a renewal with a 12% rate increase, you have almost no way to independently evaluate that number. Is 12% normal for your group? Is it high? Is there a structural reason for it, or is it a carrier pricing decision dressed up in actuarial language? Most brokers cannot answer that question in a way that gives you real confidence.

Employees blame the company when benefits get worse

This is one of the parts nobody talks about in the abstract conversation about health insurance costs. When deductibles go up, when the network shrinks, when employees start paying more out of pocket for the same care, they do not blame the insurance company. They blame you. That perception hits morale. It hits trust. And it often hits retention, quietly, over time.

HR teams get stuck defending decisions they did not really make

If you have an HR manager or HR team, they spend a meaningful amount of time fielding benefits complaints they have no good answers for. Why did the plan change? Why is this claim not covered? Why did the deductible go up? The honest answer is often, because the broker said this was the best option and we did not have much else to compare it to. That is not a satisfying thing to explain to someone whose child just got a surprising medical bill.

Business owners feel caught between protecting margins and protecting people

This is the tension underneath all of it. You want to take care of your employees. You also have a business to run. When benefits costs keep rising, you are constantly choosing between absorbing the cost yourself, passing it to employees, or cutting coverage. None of those options feel good. None of them should feel good, because none of them are solutions.

The rest of this guide is going to help you find a better solution.

CHAPTER 2

The Easy Answer That Doesn't Solve the Problem

Here is the move you have probably seen more than once.

Rates go up. Your broker calls, acknowledges the increase, and then offers a solution: raise the deductible, have employees contribute a little more to the premium, or move to a plan with a slightly smaller network. On paper, these changes slow the growth of your health insurance line item. The employer cost looks a little less bad. But the pressure does not disappear. It shows up somewhere else inside the business.

> ***Cost shifting is not cost control. It is just moving the same problem to a different column on the spreadsheet.***

The Costs That Don't Show Up on the Invoice

What does it actually cost your business when employees absorb more of the health insurance burden?

- Employees delay care they need. High deductibles cause people to put off appointments and ignore symptoms, which can lead to more expensive problems later.
- High deductibles reduce real take-home value. A family deductible of $6,000 on a $55,000 salary is not abstract. Employees feel it, and it affects how they evaluate their total compensation.
- The plan feels like a worse deal. Even if premiums hold steady, a higher deductible and narrower network is a weaker benefit, and employees know it.
- Recruiting gets harder. A plan that looks weaker than competitors is a quiet disadvantage in every hiring conversation.
- HR complaints go up. More out-of-pocket exposure means more questions and frustration routed to HR, which creates a real cost in time and morale.

The goal is not to minimize what shows up on the invoice. The goal is to build a benefits strategy that controls real costs, for both the company and the people who work there. Those are different objectives, and the difference matters.

CHAPTER 3

Why the Traditional Broker Model Often Falls Short

Before going further, a clarification worth making: most brokers are not bad people. Many of them are hardworking, well-intentioned, and genuinely trying to help. The problem is not the individuals. The problem is the structure they operate inside.

Understanding that structure is one of the most useful things an employer can do.

How brokers are typically compensated

In the traditional model, many brokers are paid through commissions built into the premium. A common range is around 5% of annualized premium, though it varies. On a group paying $500,000 a year in health premiums, that is $25,000 in broker compensation. On a group paying $800,000, it is $40,000.

Here is the structural issue: when your premiums go up, your broker's compensation goes up with them. When premiums go down, their compensation goes down. This does not mean your broker wants your costs to go up. It does mean that when compensation increases alongside premiums, there is an inherent conflict between controlling costs and preserving revenue.

> ***How aggressively is your broker searching for ways to lower your premiums if a 35% reduction in your cost also means a 35% reduction in their compensation?***

The path of least resistance

Here is something else the structure creates: a strong incentive toward the easy renewal.

Doing a deep market analysis, evaluating alternative funding structures, exploring association plans, trusts and chamber programs, modeling out the tradeoffs of self-funding, negotiating aggressively with carriers: all of that takes significant time and expertise. Renewing with minor adjustments takes much less of both.

What you may not be seeing

A few specific consequences of this dynamic that Washington employers frequently do not realize:

- You may not know which plans were considered and which were not. If your broker presents three options and recommends one, you are seeing a sample of the market.
- Alternative funding structures may never come up. Level-funded and self-funded options exist and can be significantly better fits for certain groups. If your broker does not work with them

regularly, they may never surface.

- You may not know how your broker is compensated. Many employers have never asked this question directly. The answer can be illuminating.
- There may be little to no negotiation happening. Carriers do have flexibility. Renewal rates are not always take-it-or-leave-it. Whether any pushback is happening on your behalf is worth knowing.

None of this is about finding someone to blame. It is about understanding the system clearly enough to ask better questions and expect a higher standard of advocacy.

CHAPTER 4

Broker vs. Benefits Advisor: The Difference That Matters

Here is the simplest version of the distinction:

A traditional broker shops plans and manages placement. An independent benefits advisor diagnoses the business problem, searches the full market, challenges assumptions, negotiates renewals, and builds a sustainable strategy.

One is a transaction. The other is a relationship with a different objective.

The specialist analogy

Think about how you would approach a recurring, expensive, mission-critical problem in another part of your business. If your vendor bills kept going up every year and your supplier could not explain why, you would not just accept the increase. You would find someone with deeper expertise in the specific area causing the problem.

Healthcare benefits are no different. A traditional broker is like a general practitioner. They can handle a lot of situations competently. But when the problem is complex, recurring, expensive, and directly tied to your ability to attract and keep good people, you want a specialist. Someone who knows the Washington market deeply, understands the full range of funding options, can benchmark your plan against your industry and competitors, can negotiate with carriers from a position of knowledge, and is compensated in a way that aligns their incentives with yours.

That is what an independent benefits advisor does.

Traditional Broker	Independent Benefits Advisor
Often paid by commission tied to premium	Transparent flat-fee or advisory model
May present a handful of carrier options	Searches a broader market, 50+ options possible
Focuses on renewal placement	Focuses on long-term cost strategy
May recommend cost shifting to employees	Looks for true cost control without shifting burden
Often reactive, active only at renewal	Proactive advocacy and year-round support

What this looks like in practice

An independent benefits advisor does not just show up at renewal time. They are engaged with your business throughout the year. They understand your workforce, your growth plans, your claims history, your recruiting pressures, and your culture. They are proactively looking for opportunities to improve your plan design and control costs, not waiting for you to ask.

When renewal time comes, they are not presenting the options the carrier sent. They are presenting the best options they found after searching broadly, modeling the tradeoffs, and filtering through what they know about your specific situation.

And when the carrier sends a number that is not right, they push back. With data. With alternatives. With leverage built from actually knowing the market.

CHAPTER 5

The Options Most Employers Rarely See

One of the most consistent surprises for employers who go through a thorough benefits review for the first time is the number of options that were apparently available all along. Not theoretical options. Real plans, real structures, real purchasing channels that could have changed their cost picture years earlier.

Here is a tour of what the full market actually includes.

Fully insured plans

The traditional model. You pay a fixed premium to a carrier, they assume the risk. Predictable monthly cost, less administrative complexity, but typically the most expensive option over time and with the least flexibility.

Level-funded plans

A hybrid model that has become significantly more accessible for small and mid-sized groups. You pay a fixed monthly amount that covers expected claims, stop-loss insurance, and administration. If actual claims come in lower than projected, you may receive a refund. If claims run higher, the stop-loss coverage protects you. Level-funded plans offer more transparency and can be substantially less expensive for groups with favorable claims history.

Self-funded options

Larger groups can assume direct responsibility for paying employee claims, purchasing stop-loss insurance to cap exposure. Self-funding offers maximum transparency and flexibility but requires more administrative capacity and a higher risk tolerance. For the right group, the savings can be significant.

Association plans

Industry associations often offer group health plans to their members, leveraging the collective buying power of a larger pool. For businesses in specific industries, these can offer competitive rates and plan designs that would not be available on the individual employer market.

Chamber of Commerce programs

Regional chambers of commerce sometimes offer access to group health plans through membership. There have been cases where joining a specific chamber of commerce provided access to a significantly better risk pool. In one example, a Spokane manufacturer saved approximately $15,000 per year by joining the Seattle Chamber of Commerce and gaining access to a more favorable group plan. It is not always the answer, but it is always worth knowing whether it is an option.

Trusts and alternative purchasing channels

Various trusts and purchasing cooperatives exist that aggregate smaller employers to achieve better pricing. These are often underutilized simply because most brokers do not work with them regularly or are not familiar enough with the specific options in the Washington market.

HRA and contribution strategies

Health Reimbursement Arrangements allow employers to contribute tax-advantaged funds that employees can use for premiums or qualified medical expenses. Different HRA structures fit different employer situations and can be a meaningful part of a cost control strategy when used correctly.

Pharmacy and stop-loss considerations

Pharmacy costs are one of the fastest-growing components of health plan expense. A plan design that does not specifically address pharmacy may be leaving significant money on the table. Similarly, stop-loss insurance structures vary widely in how much protection they actually provide and at what cost.

The point is not that any one of these options is automatically better than what you have now. The point is that a thorough market analysis has to actually look at all of them before it can make a credible recommendation. Most employers have never had that analysis done.

CHAPTER 6

The 50-Option Mindset

Here is a number worth sitting with: 50.

That is roughly the number of options a genuinely thorough benefits review might evaluate for a mid-sized Washington employer. Not 50 nearly identical fully insured plans from the same handful of carriers. Fifty distinct options across different funding structures, purchasing channels, plan designs, network configurations, and carrier combinations.

Most employers have been shown between three and ten options at renewal. Some have been shown fewer. The gap between ten and fifty is the difference between a sample of the market and an actual market analysis.

Why more options change the outcome

When a broker is evaluating a narrow set of options, they are optimizing within constraints. They are finding the best answer available inside a small box. When an advisor evaluates a broad set, they are solving a different problem: finding the actual best answer, wherever it happens to live.

Take our case-study of a Washington-based trucking company that reached out to us after just receiving a 13% increase on their renewal. They had been accepting annual rate increases from their insurance carrier for a decade. Ten years of increases, year after year, with no meaningful alternative ever being presented to them. When our full market analysis was complete, 11 lower-cost options emerged. Not marginal improvements. Meaningful alternatives that had simply never been presented before. That analysis lowered their costs by 40% below renewal, 27% below current, and lowered the employee deductible by $1,000.

> ***Ten years of increases, and not one alternative was ever on the table. The plan options were there. The analysis was not.***

That is not an unusual story. It is a predictable outcome of a market that rewards passive renewal management over thorough advocacy.

What the 50-option approach actually involves

A broader market search means looking at:

- Multiple carrier relationships, not just preferred partners
- Level-funded and self-funded structures alongside fully insured options
- Association memberships and chamber programs specific to the employer's industry and region
- Different network configurations and their real-world impact on employee access

- Stop-loss structures across multiple providers
- HRA and contribution strategy options that change how the plan works for employees

Showing an employer 50 options is about proof. When the recommendation comes from the full market, you know it reflects what is actually available. The handful of plans convenient for a broker to quote is not the same picture. A limited search can only produce a limited answer, and you have no way of knowing what got left out. Full market research removes that doubt. The plan you land on is the best available option, and you have the evidence to prove it.

CHAPTER 7

10 Signs Your Benefits Strategy Is on Autopilot

Some of the most expensive mistakes in employee benefits management are not dramatic. They are quiet. A benefits strategy can coast along on autopilot for years, producing the same bad outcomes at the same predictable intervals, while everyone involved assumes it is just the way things work.

Here are the warning signs. Read through them honestly.

1. You only hear from your broker at renewal. If your broker is not in contact throughout the year with updates, ideas, compliance reminders, or market intelligence, they are managing placement, not strategy.

2. The renewal explanation is vague. If you cannot describe, in clear terms, why your rates went up and what factors drove the increase, you did not get an explanation.

3. You see the same carriers every year. The Washington market includes more options than what most brokers regularly present. If the same two or three carrier names appear every year, you are not seeing the full picture.

4. The recommendation tends to be higher deductible or higher employee contribution. If cost shifting is the only tool in the toolkit, the toolkit is too small.

5. Alternative funding options have never come up. If level-funded or self-funded structures have never been evaluated, no one has actually done a full market review for your group.

6. You do not know how your broker is compensated. This is a fair question to ask. The answer tells you something about incentive alignment.

7. Your employees call a generic 1-800 number for help. When employees have benefits questions or problems, where do they go? If the answer is a carrier call center rather than a person who knows your plan and your people, that is a gap.

8. Your broker cannot explain why a plan is best beyond the lowest premium. The cheapest premium is not always the best plan. If that is the primary justification you are hearing, it is a sign the analysis did not go very deep.

9. There is little to no negotiation with carriers. Renewal rates are not always fixed. An advisor who knows the market and has leverage can push back. Whether that is happening on your behalf is worth asking.

10. Your broker does not bring proactive ideas during the year. New structures, emerging options, legislative changes that affect your plan design: an advisor is tracking all of this and bringing it to you before renewal season.

CHAPTER 8

What a Better Advisory Process Looks Like

It helps to have a clear picture of what a genuinely different benefits experience actually involves.

Here is how a thorough independent advisory engagement works, from start to finish.

Step 1: Diagnose the business problem

Before looking at a single plan, a good advisor wants to understand your business. How many employees do you have, and where are they located? What is your current claims history? What are the recruiting pressures you are facing? What is the budget reality? What do your employees actually care about when it comes to benefits? When is your renewal?

Step 2: Audit the current plan

What are you actually paying, and what are you actually getting? Current premiums, deductibles, networks, employer and employee contribution splits, plan utilization data, and the list of employee pain points. A current plan audit often surfaces things that were not visible: coverage gaps, plan design quirks, and contribution structures that are not serving anyone well.

Step 3: Search the full market

This is where the 50-option mindset comes in. Fully insured options across multiple carriers. Level-funded and self-funded structures. Association plans relevant to your industry. Chamber programs in and out of your region. HRA strategies. Pharmacy arrangements. Stop-loss options. The analysis covers the actual market.

Step 4: Model the tradeoffs

Every option has tradeoffs. Cost versus risk. Network breadth versus premium savings. Plan simplicity versus customization. A good advisor does not just present a list of options. They model the actual impact on the business and on employees, across multiple scenarios, so you can make an informed decision rather than guessing.

Step 5: Negotiate and advocate

When the analysis is done and the best options are identified, the work is not over. A good advisor goes back to carriers with data and pushes on the renewal number. Sometimes that negotiation produces meaningful movement. Sometimes it does not. But the difference between an advisor who negotiates and one who does not can be tens of thousands of dollars on an annual basis.

Step 6: Support the team year-round

After the plan is in place, an advisor becomes an HR partner and advocate. A relationship that doesn't go quiet until next year, but rather supports both the company and the employees throughout the year. Employees need support navigating claims, understanding their coverage, and getting answers when something does not work. HR needs compliance guidance and administrative support. And you need someone who is watching the market and will come to you with ideas before you are forced into another reactive renewal conversation.

CHAPTER 9

Better Benefits as a Retention Strategy

There is a version of the employee benefits conversation that is entirely about cost control. Lower the premium line. Reduce the employer contribution. Manage the renewal number.

That version is incomplete.

Benefits are compensation. Not a metaphor for compensation. Actual compensation. When you tell a candidate your total package, the health plan is part of it. When an employee is deciding whether to stay or look elsewhere, the health plan is part of that calculation. When your employees compare notes with their colleagues, as employees do, the benefits are part of what they are comparing.

What employees actually evaluate

The research on this is consistent: employees, especially those with families, weigh health benefits heavily. A plan with a $3,000 deductible and strong network coverage affects an employee's real take-home pay very differently than a plan with a $6,000 deductible and a narrower network, even if the employee contribution looks similar on the surface.

When employers cut benefits to save money without finding a smarter alternative, they are not just changing a line item. They are changing how employees experience their total compensation package. That change has downstream consequences.

The retention math

Turnover is expensive. Conservative estimates put the cost of replacing a single employee at somewhere between one-half and two times their annual salary, accounting for recruiting, onboarding, lost productivity, and institutional knowledge. A company with 50 employees and a 20% annual turnover rate is absorbing that cost repeatedly, every year.

If better benefits meaningfully reduce that turnover rate, even partially, the savings can dwarf the additional cost of a stronger plan. The employer who is focused exclusively on minimizing the premium line may be optimizing the wrong number entirely.

The recruiting advantage

In competitive labor markets, benefits differentiation is real. Candidates compare packages. If your health plan is noticeably better than what competitors are offering, that is a recruiting asset. If it is noticeably worse, you are starting every hiring conversation at a disadvantage.

A smarter benefits strategy is not just an HR topic. It is a business strategy.

CHAPTER 10

The Washington Employer Benefits Checklist

Use this checklist to evaluate where your benefits strategy stands right now. If you cannot check most of these boxes confidently, that is important information.

■ You have experienced at least one renewal decrease without increasing deductibles, copays, employee contributions, or reducing benefits.

■ You have avoided double-digit premium increases in the past two years.

■ You received a clear, specific explanation for your most recent renewal increase.

■ You reviewed multiple plan options before selecting your current benefits package.

■ You evaluated alternative purchasing channels, including association plans, chamber programs, trusts, or other group purchasing arrangements.

■ You evaluated level-funded or self-funded options to determine whether they were appropriate for your group.

■ You know exactly how your broker is compensated.

■ Your employees are generally satisfied with the current plan design, provider network, and prescription coverage.

■ Your deductibles, copays, and employee contributions are not creating morale, retention, or recruiting challenges.

■ Your employees have a dedicated benefits contact who can help them directly instead of relying only on a generic 1-800 number or calling the insurance company call center.

■ Your broker has negotiated with carriers on your behalf and provided documentation of the outcome.

■ Your compliance, ERISA, Section 125, COBRA, ACA, and required plan document responsibilities are being proactively addressed.

■ Your benefits strategy actively supports recruiting and retention.

■ Your plan is reviewed throughout the year, not only when the renewal arrives.

If you cannot confidently answer most of these questions:

It may be time to speak with an independent benefits advisor before your next renewal.

CHAPTER 11

When to Bring in an Independent Benefits Advisor

There is a right time to have this conversation, and it is not always obvious. Here is a practical list of the situations where bringing in an independent advisor typically makes the most sense.

Your renewal increased again

If you have absorbed two or more consecutive years of increases without any structural change to how your benefits are managed, you are almost certainly in a pattern that will continue. A fresh outside analysis is the fastest way to understand whether alternatives exist.

You have between 10 and 200 employees

This size range is where the traditional broker model most frequently falls short. Groups this size are large enough to have real options, but small enough that most brokers do not invest deeply in their analysis. An independent advisor who specializes in this market can change the outcome significantly.

Your team is frustrated with deductibles or premiums

Employee dissatisfaction with benefits is a leading indicator. It tends to surface in exit interviews before it shows up in turnover numbers. If people are already vocal about benefits frustration, the cost of inaction is accumulating.

You are growing and need a more strategic benefits plan

A plan that worked for 15 employees may not be the right structure for 40. Growth is one of the best forcing functions for a real benefits review, because the stakes of getting it right are higher.

You are losing candidates because benefits are not competitive

If this is showing up in recruiting conversations, it is time to address it directly. A stronger plan design does not always cost more. It sometimes costs less when the right purchasing channel is identified.

You want a second opinion before accepting the increase

This is one of the most common entry points. The renewal arrives, the increase is significant, and you want to know whether there is a better option before signing off. An independent review can answer that question with data rather than guesswork.

You want transparent compensation and aligned incentives

If you have never had a direct conversation with your broker about how they are paid, now is a good time to have it. Under the CAA, employers have a fiduciary responsibility to understand whether broker compensation is reasonable. That means the disclosure should include actual numbers, not vague language like "standard commission" or "carrier paid."

You should be able to see how much your broker is paid, how that amount is calculated, whether it changes by carrier or plan, and whether any bonuses, overrides, or incentive compensation may apply. If you cannot get a clear answer, a complete disclosure, and compensation figures you can easily understand, it may be worth taking a closer look at whether your current broker relationship is providing the level of transparency required.

CHAPTER 12

The WHIA Difference

Washington Health Insurance Agency was built on a simple premise: Washington employers deserve a benefits advisor who actually works for them.

For the business. For the people inside it. For the outcome the employer is actually trying to achieve.

Who we are

WHIA is a licensed independent benefits agency with more than 20 years of experience serving Washington residents, business owners, and nonprofits. Vernon Bonfield, the founder, has spent two decades building relationships with carriers, tracking the Washington market, and helping employers find options they were never shown anywhere else.

We travel across Washington to meet business leaders face to face. We sit in conference rooms in Spokane, Seattle, Bellingham, and everywhere between them. We want to understand your workforce, your culture, your growth plans, and your constraints before we ever put a plan recommendation in front of you.

What makes us different

- **Washington-focused.** We know the carriers, the programs, the association options, and the purchasing channels that are available specifically in this market.
- **Independent.** We are not captive to any carrier. Our recommendations come from a full market analysis, not from preferred partnerships.
- **Transparent.** We will tell you exactly how we are compensated, what options we evaluated, and why we are recommending what we are recommending.
- **Advisor-led engagement.** This is not a transactional referral model.
- **Market-wide.** We evaluate 50+ options before making a recommendation. We have found meaningful savings for clients by simply providing access to the full range of viable options for their employees.
- **Hands-on.** We provide year-round support for employers and employees.
- **Built for small and mid-sized employers.** We specialize in the 10 to 200 employee range, where thorough independent advocacy makes the most difference.

Before you accept your next renewal, get an independent review.

If your company is tired of accepting annual increases, shifting costs to employees, or wondering whether your broker really searched the full market, Washington Health Insurance Agency can help.

Schedule a no-pressure benefits review with the WHIA team. You will get a clearer picture of your options, your current plan, and whether there may be a better way to control costs while protecting the value of your employee benefits.

There is no obligation and no pitch. Just a real conversation about whether what you have is actually the best available, or whether something better is out there.

Schedule Your Independent Benefits Review

Washington Health Insurance Agency
Vernon Bonfield, Founder & CEO
Licensed Independent Benefits Advisor
Serving Washington Employers for over 20 Years

Contact WHIA to schedule your no-pressure review before your next renewal.

Call 360-464-1622 or email vernon@whia.com directly to schedule your review.

About Washington Health Insurance Agency

Washington Health Insurance Agency (WHIA) is an independent, licensed employee benefits advisory firm serving Washington State businesses and nonprofits. Founded by Vernon Bonfield, WHIA specializes in helping employers with 10 to 200 employees find better health plan options, control costs, and build benefits strategies that support both the business and its people.

WHIA is not affiliated with any single carrier and earns no additional compensation for recommending one option over another. Our only measure of success is whether our clients end up with better benefits at a better value than what they had before.

Disclosure: This guide is intended for general informational purposes and does not constitute legal, tax, or financial advice. Plan options, market availability, and regulatory requirements vary. Consult a licensed benefits advisor regarding your specific situation before making plan decisions.