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Leading the way

Vol. II: Employer innovations in
healthcare affordability and value



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Employers remain the cornerstone of the American health system.

Today [more than 181 million Americans rely on employer-sponsored coverage](#), and employers absorb the vast majority of the cost of that coverage. Faced with ever-rising costs driven by provider consolidation, opaque pricing incentives that reward volume over value, and chronic conditions, employers are responding with creativity and determination. They are redesigning benefits, using data to target spending and partnering with providers to improve outcomes while seeking to hold down costs.

The American Benefits Council partnered with Mercer in 2018 to publish [Leading the Way: Employer Innovations in Health Coverage](#). This volume updates the examples first collected in 2018 and demonstrates a clear through line: employers are actively pursuing cost-effective, high-quality care because a healthy workforce is essential to competitiveness and productivity. The case studies that follow highlight practical strategies — from benefit design and care navigation to preventive programs and alternative contracting — that employers are using now to improve the health and well-being of workers and to control spending. These include examples of employer innovations to improve: Affordability, Quality, Access and Well-Being.

The stories in this volume are merely representative of the ingenuity taking place across the country. But committed employer action alone is not enough to solve systemic drivers of high cost. Federal policy must preserve and amplify employer efforts by protecting the tax framework that supports employer-sponsored health coverage, preserving ERISA's role in enabling nationwide benefits administration and removing barriers that impede value-based strategies.

For every dollar the federal government forgoes through the tax exclusion for employer health coverage, employers pay out more than five times as much in health benefits. But even that does not account for the investment of time, money and effort employers devote to the benefits and innovations described here (see sidebar).

2024 Group Health Insurance Benefits

\$247.3 billion

Tax expenditure¹

\$1.4 trillion

Benefits paid²

\$5.66

Ratio (per \$1)

Sources:

1. US Treasury Department, Office of Tax Analysis, *Tax Expenditures Fiscal Year 2026*, Table 3 (November 27, 2024)
2. US Bureau of Economic Analysis, *Employer Contributions for Employee Pensions and Insurance Funds by Industry and by Type*, Table 6.11 D, Lines 38 and 41 (accessed September 29, 2025)

Top five priorities for plan sponsors over the next 3-5 years

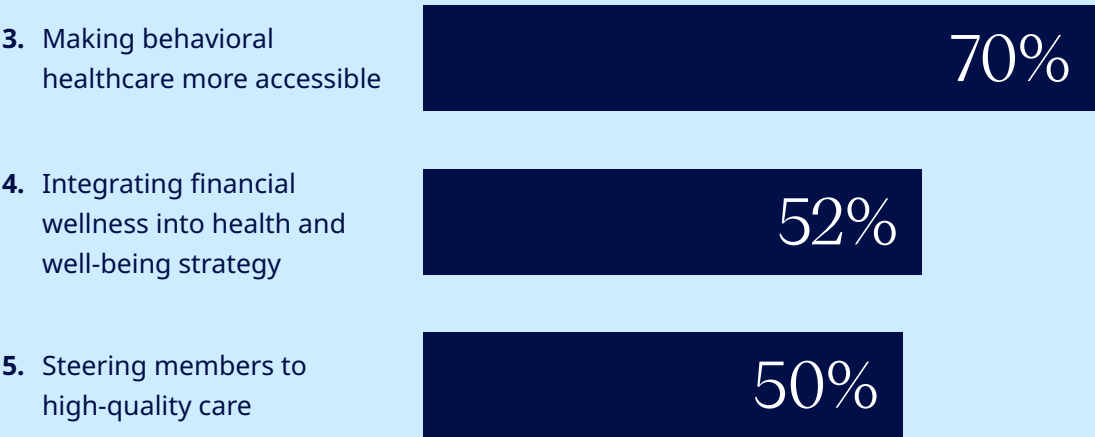
Each year Mercer asks employers about their strategic priorities for the coming years. This year, the two strategies that the most employers say will be important are focused on cost and value — managing high-cost claims and measuring the performance of their health programs to ensure they are providing value for the investment. But also in the top five are strategies to address important employee

needs, including making behavioral healthcare more accessible, which has been a top priority for a number of years. Just over half plan to integrate financial wellness into their health and well-being strategy. And half are prioritizing strategies to help ensure members can access high-quality care — a way to improve health outcomes and potentially save money as well.

Optimize value, reduce waste



Focus on employee needs



Mercer National Survey of Employer-Sponsored Health Plans 2025, employers with 500 or more employees



Policy Recommendations

To ensure continued progress, the Council urges Congress and the administration to preserve the policy foundations that enable employer-sponsored coverage and to remove barriers that obstruct employer-led innovations to improve affordability and value. Our core recommendations include protecting the federal tax exclusion for employer-provided health benefits and preserving ERISA preemption so employers can offer consistent, nationwide plans that scale solutions and control costs.

To improve healthcare affordability and quality, the Council urges payment reforms and stronger market competition: including policies to expand site neutral payments, modernize the 340B program, reform the No Surprises Act arbitration process, address anti-competitive hospital contracting, and improve price and quality transparency. Additional priorities focus on strengthening primary care and chronic disease management, expanding behavioral health and telehealth access particularly in shortage areas and improving employers' ability to support financial wellness, including readily accessible financial education.



Affordability

Rising health benefit costs continue to make affordability a top concern for employers.

According to Mercer's latest [National Survey of Employer-Sponsored Health Plans](#), total health benefit costs increased 6.0% in 2025 and are expected to increase 6.7% in 2026, pushing the average cost above \$18,500 per employee. And that's after accounting for planned cost-reduction measures. Employers estimated that plan cost would increase by more than 9%, on average, if they took no action to lower cost.

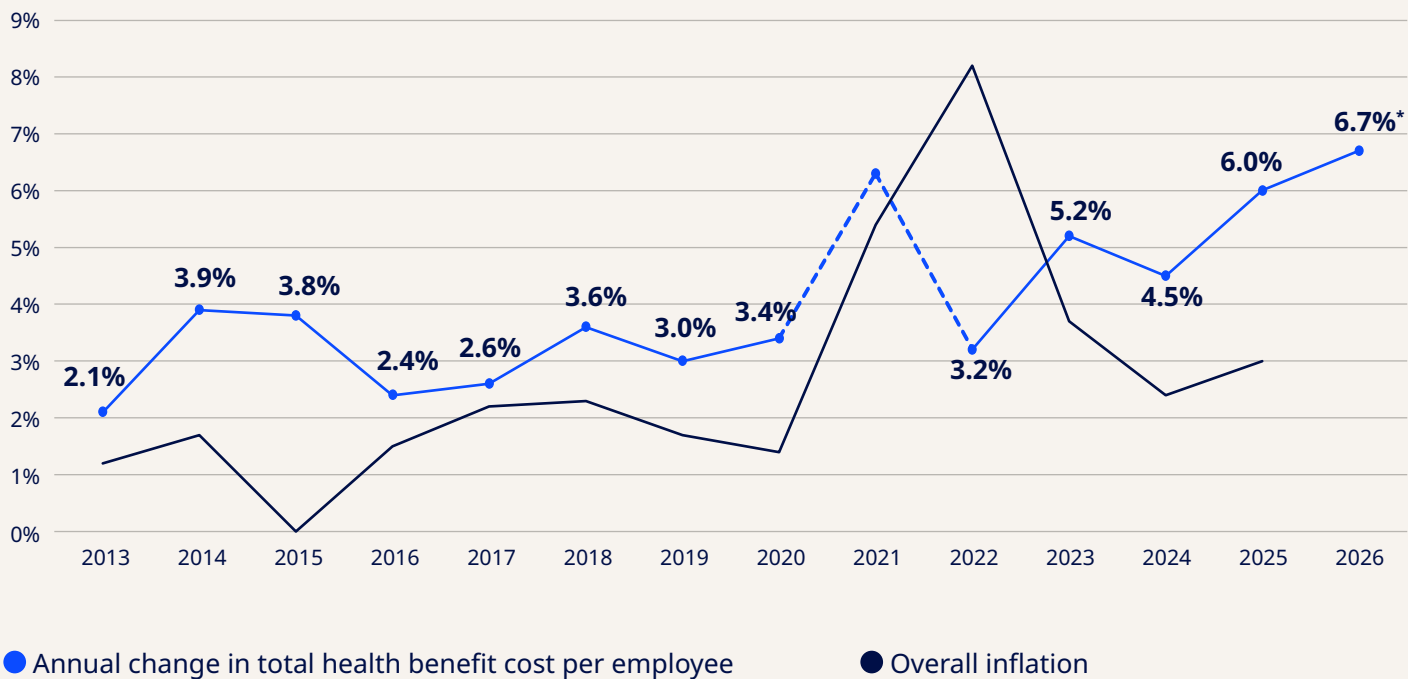
This level of cost growth can dampen wage growth, slow hiring, and crowd out capital investments. In a recent Mercer survey of 161 CFOs — [The CFO Perspective on Health](#) — only about one in four CFOs said that their organization was able to absorb the cost increases over the past two years without any of these business impacts. Taking action to reduce cost growth has become imperative for many employers.

To respond, employers are using a broader set of strategies to make coverage more affordable and reduce financial barriers to care. The [Mercer Survey on Health and Benefit Strategies for 2027](#) shows that nearly one-third of large employers currently offer, or plan to offer, at least one nontraditional medical plan in 2027, and another 38% are considering one. These plans can include high-performance networks and variable copay plans that lower cost sharing when members use high-

value providers. The survey also reports that 12% of employers offer free employee-only coverage in at least one medical plan, about one-fourth offer a traditional plan with no deductible or a low deductible, and 12% will offer a variable copay plan in 2027. Employers are also using lower deductibles, deductible smoothing, targeted communications, network design, care coordination, and pharmacy benefit strategies to improve affordability.

Total health benefit cost per employee rose 6.0% in 2025, with a 6.7% increase projected for 2026 — the highest in 15 years

Change in total health benefit cost per employee compared to CPI



*Projected.

- - - indicates disruptions to cost trend caused by pandemic-related fluctuations in utilization

Source: Mercer's National Survey of Employer-Sponsored Health Plans (beginning in 2020 results are based on employers with 50 or more employees); Bureau of Labor Statistics, Consumer Price Index, US City Average of Annual Inflation (September to September) 2013-2025.

An integrated approach to musculoskeletal care on track to reduce absenteeism and lower costs

Dow Inc.

A global materials science company serving customers in markets such as packaging, infrastructure, mobility, and consumer applications

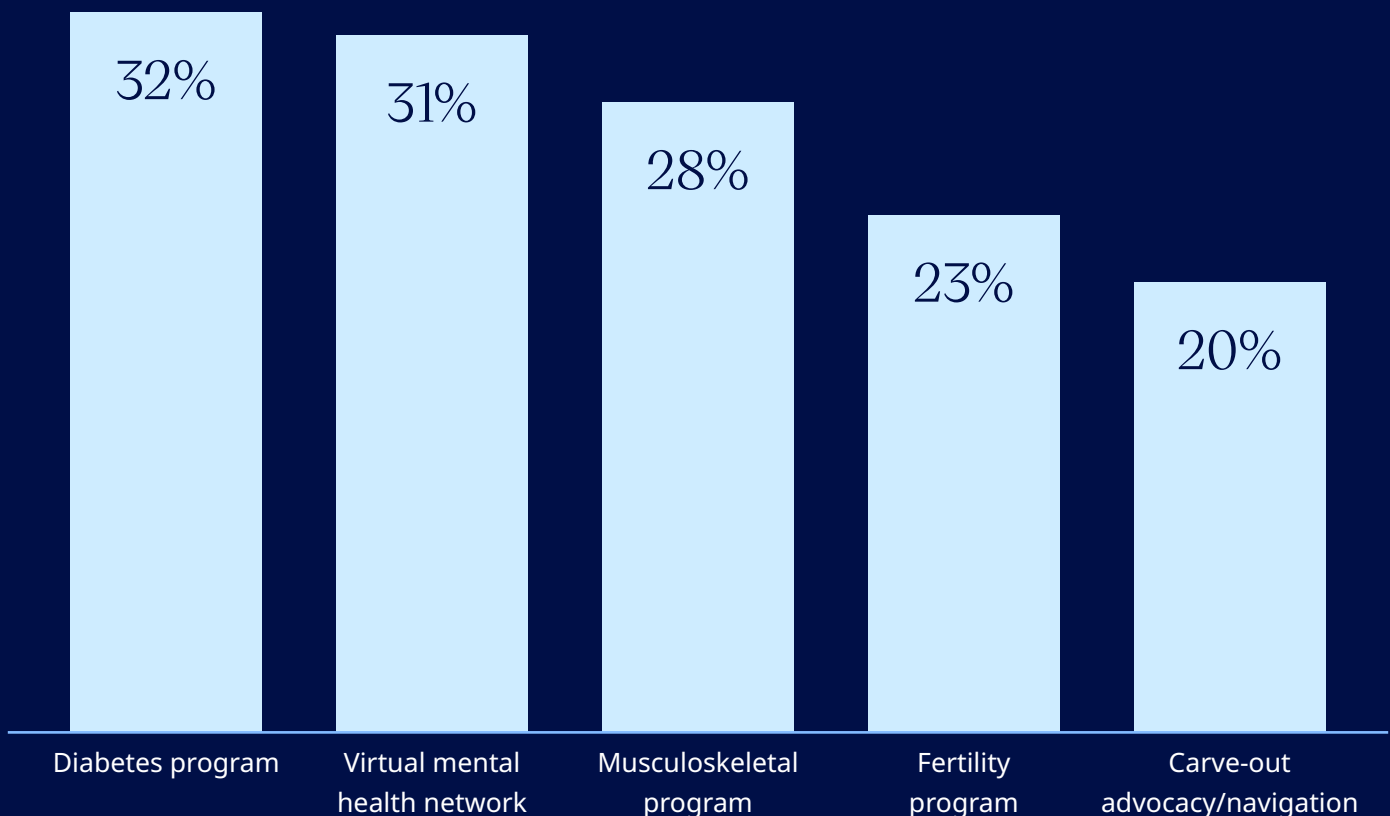
Issue: Through a claims analysis, Dow, Inc., discovered that musculoskeletal conditions were a leading driver of medical spend and absenteeism. This made musculoskeletal (MSK) care an obvious high-impact focus for early intervention to protect productivity and contain long-term costs.

Solution: Dow sought a targeted, data driven way to address a known cost and leave driver while minimizing implementation complexity. To do so, it embedded an MSK point solution into its existing well being portal, limiting operational lift and adding only incremental administrative burden. The program is positioned as an early intervention resource for employees experiencing, or at risk for, MSK pain, with access reinforced through targeted communications designed to encourage self referral before conditions escalate. The program delivers guided exercise therapy with wearable sensor feedback, one on one behavioral coaching, and structured educational content through a mobile app. Participation is voluntary and broadly available to eligible employees, enabling early engagement without the need for clinical referral or restrictive eligibility criteria.

Results: At just over one year, Dow observed relatively high engagement and positive participant feedback. Outcomes to date are primarily self reported, including employee statements that participation helped them avoid more intensive interventions, which Dow views as encouraging but not definitive. Dow plans to engage a third party to conduct a comparative cohort analysis of program users and nonusers to assess potential differences in MSK claims patterns, utilization, and paid leave over time. This approach highlights how early, accessible MSK interventions can be integrated into existing benefit ecosystems to promote prevention, reduce absenteeism, and reduce downstream health and disability costs.

Specialized stand-alone health programs offer targeted support

A strategy for supporting employees with special healthcare needs can make a meaningful difference for those coping with a chronic condition, helping to improve health outcomes and quality of life. It also has the potential to better manage health plan costs. While health plans typically provide some specialized support for members with chronic health conditions, some employers have taken the step of contracting one or more stand-alone programs that address specific conditions from specialty vendors outside the health plan. These are some of the most popular point solutions, but a wide range of programs are available in the market, addressing asthma, cardiovascular disease, cancer and other conditions.



Mercer National Survey of Employer-Sponsored Health Plans 2025, employers with 500 or more employees

A fully self-administered health plan produces durable financial and workforce results

Alliance Coal

A leading producer and marketer of coal in the eastern United States

Issue: Cost pressure is no longer driven only by hospitals or major procedures, but by specialty services, out of network billing practices, and administrative complexity that can quietly shift financial risk back to employer plans. For Alliance Coal, the issue became how to sustain visibility into claims, utilization, and outcomes over time so that emerging problems are identified before they translate into higher costs or diminished employee trust.

Solution: What differentiates Alliance Coal today is the depth of its ongoing involvement in care and payment decisions through a fully self-administered health plan. Alliance Coal maintains its own provider contracts, processes its own claims, manages utilization review, and handles provider and member services internally, allowing the plan to apply clinical review and claims analysis directly to care decisions. This includes situations where a different provider or facility may be better suited for a specific condition. In one example, Care Coordination supported a 45-year-old member in securing placement on transplant waitlists at three centers of excellence for a kidney transplant, with Alliance Coal covering associated travel costs to support access to this specialized care. Provider relationships are reinforced through consistent operational practices, including weekly payment cycles, timely reimbursement of the full allowable charge, and fast authorization decisions that are clinically reviewed by nurses and physicians.

Results: The approach has produced durable financial and workforce results. After moving to direct contracting, Alliance Coal reduced healthcare spending by roughly one-third and has held recent annual increases to the mid-single digits, below what many employers report nationally. Members pay no premiums and face no cost sharing for covered services at contracted providers, with a \$250 copay for emergency room use designed to discourage inappropriate utilization. Employee response reflects trust rather than resistance, as members express appreciation for direct communication and care coordination, even when the plan becomes involved in utilization management. This approach challenges the assumption that meaningful contracting requires large concentrations of employees in every market and demonstrates how employers can maintain oversight even in smaller locations by carefully examining data and staying directly engaged with providers.

An unintended consequence of the No Surprises Act is the higher-than-expected cost impact associated with the federal independent dispute resolution process. The experience of Alliance Coal provides a unique window into the cost of this law.

Alliance Coal's evolving experience with independent dispute resolution

Alliance Coal approaches the No Surprises Act and the federal independent dispute resolution process from a position of unusual operational visibility. The company is fully self-administered, processing every claim in-house while negotiating and maintaining its own provider contracts and managing utilization, appeals, and member and provider services without relying on a carrier or traditional third party administrator. After uncovering extreme price variation in its claims data in 2018, Alliance Coal exited PPO networks and moved to direct contracting. By 2020, it was processing all claims internally. Today, the plan manages roughly 11,500 covered lives and holds hundreds of individual contracts across hospitals, facilities, and clinicians. That structure has shaped how Alliance Coal engages with the No Surprises Act's arbitration process ("independent dispute resolution," or IDR) and, more importantly, how clearly it can see what the process is doing to plan costs.

Early on, that visibility worked in the plan's favor. When the No Surprises Act took effect, Alliance Coal used out-of-network claims data to proactively contract with frequently used providers. During the first two years, that strategy produced results. Open negotiations often led to new contracts, including with air ambulance and specialty providers. When disputes went to IDR, Alliance Coal prevailed in the majority of cases by demonstrating that its offers reflected fair, objective, data-driven market benchmarks.

That experience has changed markedly over the past year. Alliance Coal is now seeing a sharp increase in disputes with less engagement during open negotiation. Providers are initiating IDR more frequently. At the same time, IDR decisions are coming back faster, sometimes within hours, even when the plan submits detailed, multipage documentation. The result has been a reversal in outcomes. Where Alliance Coal once won roughly 75% of disputes, it now wins closer to 40%.

The most troubling shift involves niche out-of-network providers, particularly those using vendors to process their NSA disputes that have learned how to exploit the process. Remote neuromonitoring is one example. In a recent case, the qualifying payment amount (i.e., the median in-network rate) for the service was under \$1,000 and the Fair Health 90th percentile benchmark was approximately \$3,200. During the dispute, Alliance Coal offered \$6,000, an amount it viewed as well above a reasonable market rate, in an effort to resolve the case. Alliance Coal submitted six pages of documentation outlining its pricing rationale. The IDR entity issued a decision in less than four hours and awarded \$28,000. These outcomes are not theoretical. Alliance Coal sees them immediately because it processes every claim itself.

Alliance Coal's experience suggests that the impact of IDR is likely significant across the market, which is becoming a greater focus for many employers as the process continues to devolve. The company's shift from early success to mounting concern illustrates that the IDR process is not operating as Congress intended.

Incentive strategy helps close pricing gap in clinically similar care

The Alliance

A cooperative of self funded employers working to bring affordable, high-quality care to their employees

Issue: Employers in Wisconsin are confronting healthcare cost growth in a market where the cost of a single procedure can differ by three or four fold depending on where it is performed, even when the clinical service is effectively the same. Employers recognize this variation exists but have historically lacked practical tools to act on it in ways that are workable for employees and scalable across benefit plans. Early efforts by the Alliance focused on narrowly defined quality programs that delivered savings for individual procedures, yet required significant coordination and behavior change, making it difficult to expand beyond one major service at a time. At the same time, transparency requirements increased access to negotiated rates but failed to reflect how care is delivered. Employers could see prices on paper but not whether those rates were achievable or relevant in real world use. The result was visibility without usability and continued spending disparities for clinically similar care.

Solution: The Alliance shifted its approach toward steering and tiering services. Services it considers “steerable” include discrete services such as imaging and orthopedic procedures where care can be obtained outside a primary health system, rather than chronic or complex longitudinal care that requires more continuity and clinical nuance. The Alliance identified services where quality differences are limited and cost variation is

significant, then used its own claims data and contracted rates to establish benchmarks for preferred value providers, initially focusing on those with a savings of 20% or more. The cooperative blended transparency data with real world utilization to reflect achievable pricing and embedded those designations into benefit design through tiered structures, including zero cost sharing in copay plans and financial incentives in high deductible plans, supported by ongoing education to account for employer and employee turnover.

Results: Adoption of the steering-and-tiering strategy has grown as more employers incorporate it into their benefit plans. The Alliance has also observed early provider responses. Several independent hospital systems have approached the cooperative to understand what pricing is required to qualify for preferred status. The driver is straightforward: The risk of losing volume has created a feedback loop that brings providers to the table. Employee experiences reinforce how the model works in practice. One employee described navigating physical therapy and multiple MRIs at the end of the year with zero out of pocket cost, turning care decisions into a conscious exercise in choosing the right tier. These experiences show how clear incentives, repeated education, and practical guidance can translate cost transparency into everyday decisions without narrowing access.

Integrating clinical pharmacy expertise into benefit management gives greater control over costs

Auburn University

A top-ranked public research university founded in 1856 in Alabama and a member of the Southeastern Conference (SEC)

Issue: Prescription drugs account for a material portion of Auburn University's overall health plan spending making pharmacy a key area for ongoing attention. Benefits leaders in partnership with clinical pharmacists observed that certain medications were sometimes priced far higher without clear additional clinical benefit. The university wanted greater insight into whether pharmacy dollars were being spent wisely and in ways that supported both clinical outcomes and Auburn's employee-centered culture, rather than relying solely on pharmacy benefit manager recommendations.

Solution: Auburn leveraged its nationally recognized Harrison College of Pharmacy to incorporate clinical expertise directly into pharmacy benefit oversight. Pharmacists from the college review clinical evidence, interpret study findings, and provide an academic, clinically grounded perspective that informs formulary discussions and benefit decisions in coordination with the University's health insurer, Blue Cross Blue Shield of Alabama, PBM, Prime Therapeutics, and its broker, Lockton. This collaboration allows Auburn to question high-cost medications, consider when lower-cost generics are appropriate, and support the use of higher-cost brand therapies when clinical evidence indicates clear patient benefit. The College also operates four pharmacies, provides medication counseling and clinical pharmacy services, runs an incentivized wellness screening program, and participates in a multi-state government purchasing coalition to increase buying power.

Results: Integrating clinical pharmacy expertise into pharmacy and benefit management has enabled Auburn to take a more active, evidence-informed approach to managing prescription drug spending, while maintaining a focus on patient outcomes and employee choice. Clinical involvement was one contributing factor in Auburn reporting the second-lowest health insurance cost increase among SEC peers for the 2026 plan year. Employees have further benefited from access to medication counseling, individualized medication guidance, and wellness screenings that, in some cases, prompted earlier follow-ups with physicians, reinforcing Auburn's emphasis on value-based decision making and community-oriented care.

PBM overlay tool leads to lower employee spending on prescription drugs

Dow Inc.

A global materials science company serving customers in markets such as packaging, infrastructure, mobility, and consumer applications

Issue: Dow, Inc., faced rapidly rising healthcare costs driven primarily by pharmacy spending, with specialty drugs and GLP-1 medications contributing disproportionately to the overall trend. Existing pricing and rebate structures created incentives that did not always align with the lowest available costs, making it difficult to manage pharmacy spending effectively while maintaining access to needed medications. As a result, traditional formulary and utilization management approaches alone were insufficient to address these cost pressures.

Solution: Dow moved forward with implementing a pharmacy benefit manager overlay — a supplemental tool layered on top of the existing PBM to guide lower cost prescription decisions without replacing core pharmacy administration. Operating alongside the incumbent PBM, the overlay steers members toward lower cost pharmacies, formulations, and therapeutic alternatives, and supports outreach to prescribers when a more cost effective option is available. This approach focused on addressing underlying pricing and incentive dynamics rather than relying solely on changes to benefit design.

Results: Dow began seeing measurable savings from the PBM overlay within two to three months as members shifted to lower cost prescription options. The company also reported positive employee feedback, particularly because lower overall plan costs led to reduced out of pocket expenses for some members, an important consideration for individuals enrolled in high deductible health plans.

Employers are evaluating new approaches to managing the pharmacy benefit

Nearly two-thirds of large employers are looking at new ways to offer or manage pharmacy benefits, driven largely by fiduciary responsibility and concerns over transparency. When asked to rank their strategic priorities, employers favored surgical approaches that combine contract levers, utilization management and member support rather than blunt across-the-board benefit reductions or shifts in cost sharing.

Interested in pursuing

36%

Requiring PBM to disclose all enterprise revenue (e.g., rebate GPOs, biosimilar manufacturing, retail, mail order and specialty pharmacies)

41%

Evaluating different contracting models offered by major PBMs

37%

Evaluating new and emerging PBMs

11%

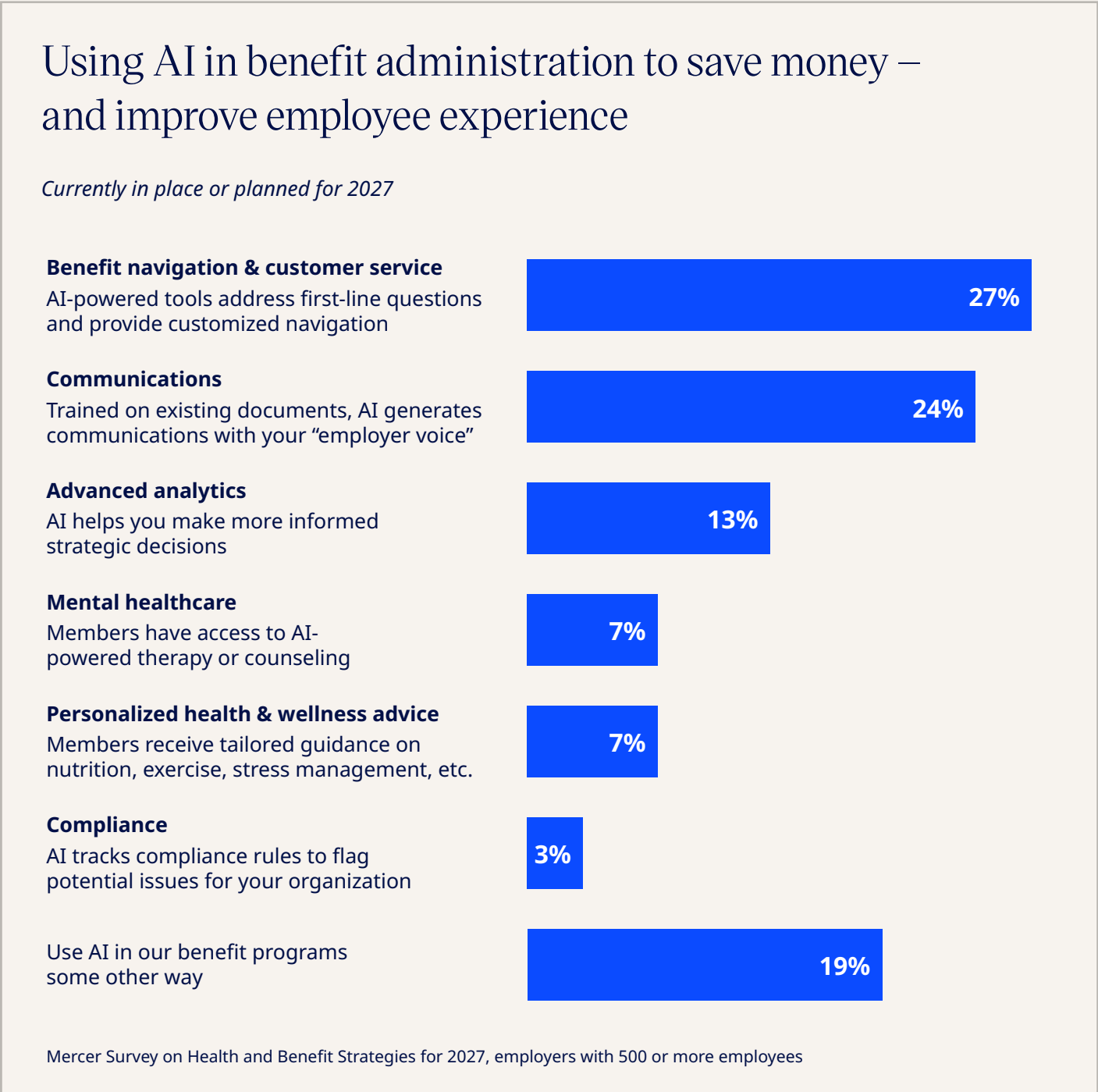
Evaluating a modular approach – rather than contract with a single PBM, different entities handle networks, rebates, utilization management, claims processing, etc

Mercer Survey on Health and Benefit Strategies for 2027, employers with 500 or more employees

AI in Healthcare Benefits

When employers are asked how they are now using AI in their benefit programs, they are most likely to point to customer service and communication. While many applications of AI in the benefits ecosystem are still developing, or are not yet under

plan sponsors’ direct control, we anticipate that in the next few years many benefit programs will have some AI components. To introduce the art of the possible, two different case studies demonstrate the use of AI in employee support and in care delivery.



Benefits-focused AI tool frees HR team to handle more complex issues

Manufacturing firm

Issue: At one manufacturing company, benefits questions consistently center on the same core topics — medical deductibles, paid leave, and retirement matching — but finding clear answers was often harder than it should have been. Human resources colleagues needed a faster way to locate accurate information without having to search across platforms or interrupt the benefits team. As artificial intelligence applications became more common internally, leadership also wanted to ensure that any use of AI for benefits information would be grounded in accurate, company approved materials and not produce responses that were outdated or difficult to verify.

Solution: The company already had an internally developed chatbot that was being used for core business needs. Building on that foundation, the benefits team partnered with IT to create a benefits focused version of the tool. Because the underlying technology was already in place, the effort moved quickly. The design was intentionally constrained, returning plan level benefits and policy information drawn only from documents the company has fed into the system. Each response includes references that link back to source materials, allowing users to see where the information originated. To avoid confusion across plan years, the chatbot is trained for a single year at a time, retrained annually, and tested to confirm accuracy before broader use. The tool is used primarily by HR but is available to employees through internal sites.

Results: The company measures success primarily in qualitative and operational terms. The chatbot has reduced the number of routine questions directed to the benefits team, helping to lighten workload and free up time for more complex issues. HR colleagues use the tool to quickly answer common questions, such as comparing medical plan deductibles, locating the paid parental leave policy, or confirming the company's 401(k) match. Trust in the tool has grown organically. Users can click directly into referenced documents, further supporting accuracy and consistency. Overall, the chatbot has made it easier and faster to access benefits information, improved consistency in responses, and strengthened confidence in the answers being shared.

How AI-supported digital experience helps to reduce healthcare complexity

Walmart Inc.

People-led, tech-powered omnichannel retailer, and largest US private employer with 1.6 million US associates

Issue: Healthcare complexities arise at moments of diagnosis or serious health concern. When someone receives a diagnosis, they may feel scared, overwhelmed, and unsure how to move forward in a complicated system. The problem Walmart set out to solve was not affordability alone but also ease of access by simplifying the navigation of benefits and care options.

Solution: Walmart recently launched an AI-supported Personalized Wellbeing Copay Plan in eight states: California, Kentucky, Louisiana, Mississippi, New Jersey, Tennessee, Washington, and West Virginia. The plan, which provides the option of connecting with an AI well-being agent and/or human care navigator, removes deductibles and replaces percentage-based cost sharing with simple, known copays so participants understand their costs in advance. When participants enroll, they acknowledge that they understand the plan uses AI. The AI well-being agent is trained in Walmart's benefits ecosystem, and the digital experience helps participants understand benefits, answer copay questions, and surface relevant programs such as the Centers of Excellence program for complex health conditions or family building support. When care is needed, the technology helps connect participants to either non-clinical support via the human care navigator or practitioners, or directly with pharmacists, physicians, or specialists. In practice, this creates a neutral environment for participants to ask questions and raise concerns they might not otherwise share, allowing the experience to surface additional needs and connect individuals to appropriate next steps within the health system.

Results: Although formal outcomes data have not yet been released, early indicators suggest meaningful impact. Participants can use the plan's AI well-being agent not only to check costs but to navigate care decisions in real time, including medication changes and specialist referrals. By combining predictable copays with guided navigation, Walmart is positioning the health plan as an active support system rather than a passive payer. The potential impact extends beyond lower out of pocket costs, with earlier access, fewer delays, and better alignment with quality providers supporting faster recovery, less time away from work, and more sustainable plan performance over time.



Quality

More employers are paying attention to healthcare quality and where members receive care.

[Mercer's Survey on Health and Benefit Strategies for 2027](#) shows growing interest in network strategies that promote the use of high-quality providers, including high-performance networks, centers of excellence, and quality-based provider selection tools. Some of these options are truly new models of coverage, grounded in the idea that higher-quality care — evidence-based treatment delivered in the right setting at the right time — is often less expensive than lower-quality care.

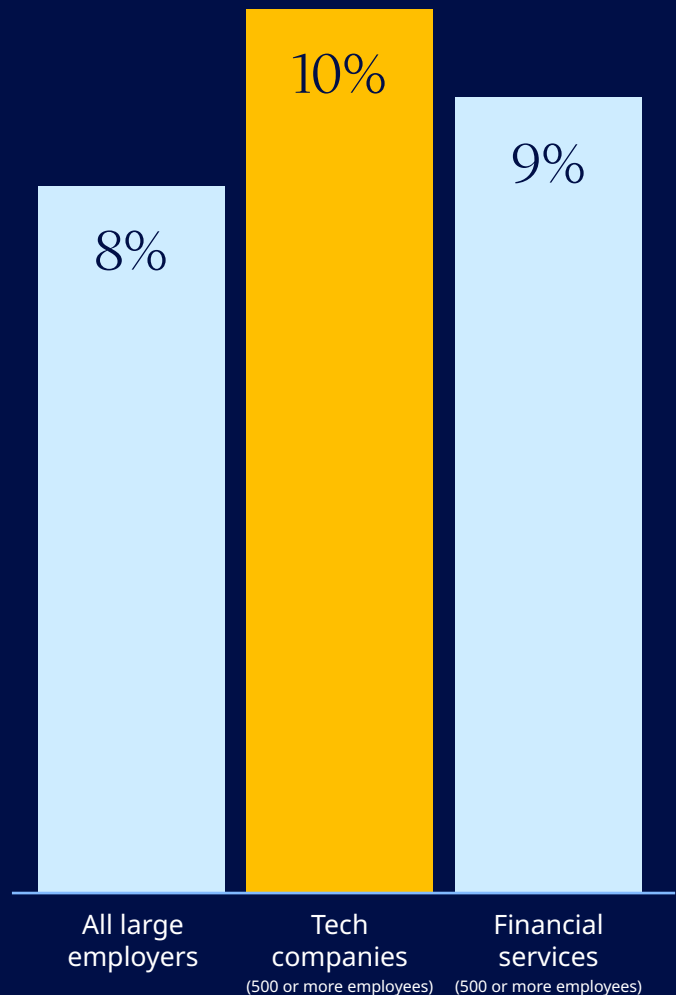
As employers seek to balance sustainable costs for the organization with affordable healthcare for employees, these models are designed to save money not by shifting more cost to employees, but by steering more care to higher-performing providers. Taken together, nearly a third of all large employers are utilizing some type of quality-focused health plan in 2026 — or will in 2027 — and many others are considering it for the near term.

Leading the way are employers (8%) that say they have already adopted a quality-based provider selection tool. Almost one-third are considering one for 2027 or 2028. These tools use a large database of medical records to identify doctors who deliver the best patient outcomes and help users make informed choices about their care. The ability to work with an existing provider network — minimizing disruption while steering members to higher-performing providers — likely explains the traction.

Employers are also looking more closely at whether health programs deliver value beyond participation alone. [Mercer's National Survey of Employer-Sponsored Health Plans 2025](#) suggests that benefit managers are committed to ensuring that health programs provide value. Over three-quarters of large employers (77%) say that measuring health program performance will be important or very important over the next three to five years. The survey shows that 60% of large respondents currently review metrics to establish cost savings or return on investment from the program. About half (51%) are reviewing medical or pharmacy claims trends, and 42% are reviewing clinical outcomes. In some cases, they are using longitudinal quality data, navigation, and care coordination to support better decisions, more consistent outcomes, and a better member experience.

Quality-based provider selection tool overlay can help members find high-value providers with lower copayments

Offer or will offer in 2027



Mercer Survey on Health and Benefit Strategies for 2027, employers with 500 or more employees

Structured benefit pathways improve quality and outcomes

Walmart Inc.

People-led, tech-powered omnichannel retailer, and largest US employer with 1.6 million US associates

Issue: Most patients facing complex health conditions pursue surgeries or treatment plans locally, which can leave consistency gaps in reviews of provider quality, clinical treatment appropriateness, or alternatives. Traditional care management support largely responds after care occurs, relying on utilization management and claims review rather than focusing on treatment decisions upstream. On top of that, in some parts of the country, there simply is no access to quality treatment options, especially in areas known as “healthcare deserts”. For moments that matter most, Walmart began exploring how to best help participants access the most appropriate treatment path recommended by specialists at some of the best facilities in the country.

Solution: Walmart designed its Centers of Excellence (COE) program to function as a clinical decision pathway in addition to an appropriate care delivery channel, rather than as a retrospective cost-control tool. The COE program includes complex health needs such as spine surgeries and hip and knee replacements. Walmart has expanded the program deliberately by condition, with rules shaped by clinical evidence and participant burden. Most COE services are covered at 100%, including travel for the participant and one adult caregiver when travel is recommended, reinforcing both clinical rigor and participant support.

Results: The program produced meaningful improvements in quality outcomes and in cost savings driven largely by access to more benefit choices. In cancer care, an upfront expert review helped participants confirm or refine treatment plans, with travel recommended only when it could change outcomes. The COE program demonstrated how benefit design, when aligned with clinical evidence and specialists, can help participants earlier in the journey while preserving choice and trust. For employers and policymakers, Walmart’s experience highlights the role of structured benefit pathways in improving outcomes, and at the same time enhancing the experience and value for participants.

Centers of excellence program builds on experience to address unnecessary procedures and inconsistent outcomes

Lowe's Companies Inc

Home improvement company that operates over 1,750 home improvement stores and 120 distribution centers

Issue: Lowe's has operated a centers of excellence program since 2010 as part of a longstanding commitment to providing associates with access to high quality specialty care. Over time, as the company continued to manage healthcare costs for a large, geographically dispersed, and primarily hourly workforce in physically demanding roles, leadership recognized the need to further evolve the program. Musculoskeletal conditions represent a significant area of impact on associates' quality of life and ability to work, while decisions about pursuing treatment can be difficult for associates without dedicated navigation and support.

Solution: Lowe's COE program supports MSK, bariatric, and selected cardiac procedures, as well as substance use disorder treatment, through a curated network of high performing providers. Associates receive concierge support that coordinates scheduling, travel, and care logistics. A key feature of the current approach is its focus on clinical appropriateness. Each case begins with assessment and navigation designed to determine whether surgery is the right next step or whether conservative treatment may be more appropriate. The company is also evaluating additional areas of support, including imaging and select specialty services, to determine where integration could further reduce friction and improve decision making.

Results: The current COE program is producing strong, measurable performance. Across the network, complication and readmission rates average 1.9%, well below national benchmarks that range from 3% to 10% depending on procedure type. In one regional partnership, readmissions have remained at zero since 2020. Higher quality, more efficient care is also being driven by the steerage to appropriate site of care for COE surgeries. The bariatric program specifically transitioned 35% of surgeries to outpatient/Ambulatory Surgery Center settings, resulting in a 32% lower average travel spend per bariatric procedure compared to traditional inpatient cases. This also results in shorter recovery times by eliminating the need for extended lodging and high acuity support. Independent repricing analyses showed lower costs of care compared with traditional carrier pricing.

Users report strong satisfaction with their experience, despite surgery being inherently undesirable. Additionally, utilization data shows that care is available locally for most associates. In 2025, approximately 90% of surgeries were completed within driving distance, minimizing disruption. In the substance use disorder program, the median time to treatment is two days, with most referrals occurring within one day. For Lowe's, these results support continued investment in a COE model that emphasizes clinical guidance, navigation, and experience as core components of cost and quality management.



Centers of excellence for specific care needs

Half of large employers say steering members to high-quality care through centers of excellence and high performance networks is an important strategy over the next three to five years, including 18% who say it is very important.

Cancer treatment centers of excellence are already in use.

20%

of large employers
offering one or more
in-network

2%

offering them
outside of network

Mercer Survey on Health and Benefit Strategies for 2027,
employers with 500 or more employees

Data-backed quality framework improves care without shifting costs

Microsoft

Creates platforms and tools powered by AI to deliver innovative solutions

Issue: Microsoft has placed a priority on improving healthcare quality and long term sustainability without having to shift costs to employees. The absence of a clear, physician level method for defining and assessing quality has made it difficult to distinguish truly high quality care from care that was simply more intensive or expensive.

Solution: Microsoft centered its health strategy on quality as the primary driver of outcomes and cost, working with specialized external partners to support physician level quality measurement and benefit design aligned to those measures. Using claims data and established practice patterns, the quality framework prioritized appropriateness of care first, followed by efficacy, allowing cost to follow rather than lead. Microsoft made this information visible and accessible to employees through its provider search experience, enabling informed choice while preserving full freedom to select any provider. The company reinforced these signals by introducing a second national medical plan option alongside its high deductible plan. For the second plan, it replaced deductibles with predictable copays that varied based on provider quality, and it required its onsite clinic in Redmond to use the same quality framework when making referrals. Physicians could also review their performance results and engage directly in discussions about practice patterns, supporting ongoing refinement rather than exclusion.

Results: The approach has been influencing behavior and supporting better value. Employees are using objective quality information to inform provider selection on a voluntary basis, even when it challenges common assumptions about availability and quality. Enrollment in the second plan option initially represented a smaller share of participants, while selection among new hires has been meaningfully higher when plan choices are evaluated side by side at enrollment. Early indicators suggest the approach is delivering care that is at least as effective and at a lower risk adjusted cost, without evidence of diminished health outcomes. Microsoft also views this experience as highlighting broader system considerations, including the importance of consistent quality definitions, access to claims based insights, and the ability for employers to act on quality information without contractual constraints.



Access

Helping members get care when and where they need it is becoming a more deliberate employer priority, especially as provider shortages and geographic gaps continue to limit access in some markets.

The US faces a [growing shortage of up to 86,000 physicians by 2036](#), according to the Association of American Medical Colleges, with the shortfall split between primary care and specialty care. Other [federal estimates](#) project an even larger shortage by 2038. [Mercer's National Survey of Employer-Sponsored Health Plans 2025](#) shows

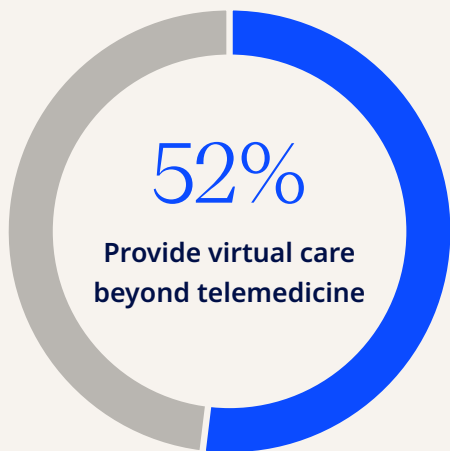
that employers are responding by expanding plan choice and using network design to improve access. In 2025, 67% of large employers offered three or more medical plan options at their largest worksite, up from 60% in 2023, and the largest employers offered an average of five choices.

Employers are also using a broader set of strategies to make care easier to reach. 20% have a stand-alone advocacy or navigation program, and 21% of employers with 5,000 or more employees offer an onsite or near-site primary care clinic. Among those clinic sponsors, nearly half allow dependents to use the clinic as well. More than half of large employers have also expanded their virtual care offerings beyond telemedicine. One of the main uses is condition-specific support, with 28% delivering solutions for diabetes and musculoskeletal care this way. In addition, 20% of large employers offer virtual primary care, which can include annual checkups, prescriptions, lab review and advice on topics such as weight management and nutrition.

Telehealth has become an important access point for behavioral health. The survey shows that 31% of large employers have invested in a stand-alone virtual mental health network. A [Mercer analysis](#) found that about 30% of behavioral health office visits have been virtual in recent years, compared with about 1% before the COVID-19 pandemic. That shift has been valuable in rural and partially rural areas, where provider shortages make access harder. Taken together, these approaches help close practical access gaps for geographically dispersed and hard-to-reach populations and support earlier intervention for behavioral health, autism treatment, and women's and family care needs.

Expanding virtual care beyond traditional telemedicine

Telemedicine for acute care is a nearly universal offering. But today nearly two-thirds of sponsors provide other virtual solutions to address a broader range of healthcare needs.



Virtual care solutions offered

Behavioral healthcare (network of exclusively virtual therapists)



Specific care categories, such as musculoskeletal or diabetes



Specialty care, such as dermatology or reproductive care



Primary care



Mercer National Survey of Employer-Sponsored Health Plans 2024, employers with 500 or more employees

Strengthening access to primary care boosts utilization and employee satisfaction

Organon

Global healthcare company with a portfolio of over 70 products across Women's Health and General Medicines, including biosimilars

Issue: When Organon spun off from a much larger pharmaceutical company, it inherited a health plan designed for scale but covering only about 4,000 lives. As contracts came up for renewal, the company faced rising healthcare costs and less favorable terms. Organon offered a single PPO plan with no requirement to designate a primary care provider, preserving flexibility but making it easy for employees to go without an ongoing primary care relationship. Data from the company's integrated medical and pharmacy analytics warehouse revealed gaps in preventive care, including missed wellness visits and overdue screenings, along with avoidable use of higher cost care settings, underscoring the need to improve access and value without reducing benefits.

Solution: Organon focused on strengthening and improving access to primary care. In October 2025, Organon launched a direct primary care program through a third party partner offering a curated national network of clinicians with same or next day access, longer appointments, and both in person and virtual options to support a geographically dispersed workforce. Organon covers the full membership fee, eliminating cost-share and creating a clear incentive for employees to engage with primary care. The vendor converts direct primary care bills into standard medical claims submitted to the carrier, enabling Organon to track utilization and engagement through adjudicated claims data.

Results: In the first eight months of the program, 12% of eligible members enrolled, 40% of whom had already seen a DPC clinician, exceeding early utilization benchmarks. Employee feedback has been overwhelmingly positive, with many expressing surprise at the quality and convenience of care provided at no cost. While it is still early to assess downstream health or cost outcomes, these early enrollment and utilization trends suggest strong employee interest and position Organon to evaluate the program's longer-term impact on primary care engagement, preventive care, and overall value as additional data becomes available.

Targeted design can address unmet needs without adding complexity

Walmart Inc.

People-led, tech-powered omnichannel retailer, and largest US employer with 1.6 million US associates

Issue: Across the nation, access to neurodiversity assessments can be difficult and include long wait times. Parents seeking evaluations for children often face wait times of a year or longer and in some cases close to two years. In certain parts of the country, there is simply not adequate access to providers for evaluation or ongoing treatment. These delays and access challenges limit how quickly individuals can move from concern to diagnosis and begin treatment, medication support, therapy, or other services. Because of this, Walmart sought to accelerate access to neuropsychological evaluations for associates and their families.

Solution: To address this access challenge, Walmart collaborated with an existing vendor to offer a neurodiversity assessment program focused on reducing wait times. The primary objective was speed of access to appropriate evaluations that yield accurate diagnoses. The program supports children, spouses/partners, and associates themselves, including adults who learn for the first time that they are on the neurodiverse spectrum. Once assessments are complete, participants can proceed more quickly with recommended care tailored to their needs, potentially including medication support, therapy, and applied behavior analysis.

Results: The accelerated assessment timeline has changed the experience for participants who previously waited a year or longer for evaluations. From the time a participant reaches out, assessments can typically be completed within four weeks. Virtual engagement allows clinicians to connect with individuals more quickly and helps shorten the overall timeline. Parents gain earlier direction, while adults who had not previously been assessed now have a defined pathway to care. Early participants have described the program as a game changer given their previous long wait times and unclear next steps toward diagnosis and treatment. It also reflects Walmart's belief that everyone belongs by extending support to associates and their families. By focusing on access and reducing delays, the program demonstrates how targeted design can address needs without adding complexity to the broader health plan.

Health Action Council

A member-driven, not-for-profit organization representing employers working to enhance human and economic health through group purchasing, education, and health improvement

Issue: Employers were investing heavily in managing healthcare cost, yet the most expensive outcomes kept repeating. Avoidable emergency room (ER) visits, preventable conditions that progressed before they were addressed, and employees moving into higher-risk categories were driving spend without improving health outcomes. Through a structured learning lab, Health Action Council's employer members compared claims data and experiences and reached a shared conclusion: Traditional cost controls such as network strategy and contracting were not addressing what actually drove utilization. Instead of focusing on claims after the fact, employers reframed the problem around prevention. Employer discussion and internal analysis pointed to factors outside the healthcare system, including food access, housing stability, and challenges with navigating care, with additional social issues emerging as the model developed. When those issues went unaddressed, employees were more likely to rely on emergency services and progress into chronic or complex conditions that were harder and more expensive to manage.

Solution: Health Action Council's members collectively shaped an innovative approach through shared design and iteration, beginning with a simple question: whether giving people a trusted point of contact could change how they navigated health and everyday challenges. That concept developed over time into a targeted social determinants of health outreach model integrated into existing benefit plan operations and call center workflows. Social and clinical risk factors were considered together to identify individuals who might benefit from additional support, using available medical information, community data, and operational insight. Risk indicators were embedded into both service and clinical interactions to guide customer service and clinical representatives on next steps when members

engaged. A targeted segment of the population was identified for proactive outreach. This captured individuals who typically fell through the cracks of traditional clinical management. Importantly, the program deliberately focused on people who were well or at risk, even though that approach resulted in lower engagement rates, with the goal of interrupting progression before individuals moved downstream into costly chronic or complex categories. Outreach was focused on human connections, designed to be conversational and practical, connecting people directly to custom resources and often uncovering multiple needs through engagement.

Results: Over a four-year period, the social determinants of health outreach model generated over a five -to-one return on investment for plan sponsors. The program was associated with \$82 in per member per month (PMPM) savings. Members engaged through social determinants outreach produced 8% greater savings per engaged member than those reached through traditional communications during the same period. Utilization patterns shifted as well. Member employers reported cases in which individuals with frequent emergency room use stopped cycling through avoidable care after social and clinical barriers were addressed together. In one example, a member with repeated ER visits received coordinated clinical support alongside food and caregiving assistance. As a result the member experienced no emergency room visits for more than six months. For employers, the experience showed that managing risk factors earlier—by embedding SDOH solutions directly into the benefits infrastructure—influences both the clinical path of the workforce and the financial health of the benefits plan. By shifting spend from reactive claims management to proactive social intervention with defined metrics, employers can predictably lower utilization and secure sustainable savings.

Healthcare staffing firm gets creative to meet needs of geographically diverse workforce

MedPro Healthcare Staffing

Joint Commission-certified provider of temporary and contract healthcare staffing services to acute and long-term post-acute hospitals, government facilities, and medical laboratories across the US

Issue: MedPro, a healthcare staffing company specializing in the placement of nurses, technicians, and other medical professionals in facilities across the United States, has some unique challenges when it comes to keeping healthcare-related costs down. Many of the firm's employees are recruited from overseas to help address persistent provider shortages. In recent years, rising healthcare costs have driven sharp increases in insurance premiums, making coverage increasingly difficult for employees to afford. As a result, some employees reduce or drop coverage, and in certain cases terminate their employment and leave the company. At the same time, chronic conditions and occasional outlier high-cost claims among covered employees have placed significant pressure on the plan's affordability and the company's ability to absorb ongoing cost increases.

Solution: To address affordability while supporting employee health and well-being, MedPro adopted a multipronged benefits strategy focused on access, education, and cost management. In 2024, the company joined a collective purchasing organization, enabling participation in contracts and administrative arrangements negotiated for larger populations and providing access to additional benefit options. MedPro also implemented targeted point solutions addressing key cost drivers, including musculoskeletal and chronic condition management, surgical navigation to help employees identify high-quality, cost-effective sites of care, and telehealth services. All programs were

extended to employees' dependents, recognizing that family health needs often drive both claims and employee stress. Given the diversity of its workforce, MedPro placed particular emphasis on education, investing in ongoing communication efforts — such as webinars, newsletters, and interactive tools — to help employees understand US health benefits, navigate coverage decisions, and engage with available resources.

Results: While it is still too early to quantify financial return or claims impact, the collective purchasing approach has provided MedPro with greater flexibility as the company works to manage continued premium increases. Engagement with the point solutions has been uneven but promising in certain areas, particularly programs focused on MSK support (12% engagement vs. 3% vendor average) and Diabetes Prevention Program (DPP) (21% enrollment vs. 12% vendor average) with 74% of MedPro members with maintained or improved blood pressure control. Other offerings have seen lower participation, underscoring the ongoing challenge of driving engagement in a geographically dispersed and highly stressed workforce. MedPro continues to work with its partners to monitor participation, gather data, and refine its approach over time, viewing these efforts as an evolving strategy aimed at supporting employee well-being, improving affordability, and sustaining a viable benefits program in an increasingly challenging cost environment.

Telehealth expansion drives rapid and sustained uptake of primary care services

Niagara Bottling

A leading beverage manufacturer in the US

Issue: Niagara Bottling's rapid expansion into smaller cities and rural locations created persistent healthcare access gaps for employees and covered household members. New sites often lacked nearby primary care clinicians, labs, or diagnostic services, and members faced long travel and time burdens to receive routine care. Those access barriers threatened preventive engagement and made it harder for the company to deliver consistent benefits across a geographically dispersed workforce.

Solution: In 2024, Niagara expanded a longstanding relationship with a virtual care provider into a telehealth-first architecture that paired its 24/7 virtual urgent care model with virtual primary care. Plan design changes removed financial obstacles, with telehealth visits carrying \$0 copays across all plans. The company integrated virtual primary care with its wellness program by making an annual wellness visit a required wellness activity starting in 2025. Under the virtual care model, Niagara offered four no-cost virtual visits annually, while virtual clinicians provided annual wellness exams and could order optional lab work when clinically appropriate. Niagara negotiated predictable set unit pricing for virtual visits and managed implementation with internal benefits staff and its vendor.

Results: The telehealth expansion drove rapid and sustained uptake. After the 2025 rollout, virtual primary care utilization rose 500% within one year, and in early 2026 most virtual visits were annual wellness encounters. Monthly volumes reached peaks of roughly 1,000 virtual visits, drawing from about 6,000 employee subscribers and 1,800 covered spouses. The model delivered clearer cost predictability. And beyond utilization and unit-cost control, telehealth closed geographic access gaps, raised preventive engagement across the covered population, and made it easier for household members with limited local access to obtain timely care.

Reimagined telehealth strategy meaningfully expands access to care for dispersed workforce

National Rural Electric Cooperative Association

The national service organization that represents America's electric cooperatives

Issue: For the National Rural Electric Cooperative Association (NRECA), access to healthcare has long been a practical challenge. The employers and employees served by the trade association reside across 48 states, many of whom live in rural communities with limited provider availability, long travel distances, and difficulty securing timely appointments. In these settings, access often comes down to whether someone can be seen after hours, avoid lengthy travel, and obtain care that feels private in a small community. These barriers affect not only treatment for common illnesses and preventive care, but also behavioral healthcare, where stigma and lack of local options can further delay treatment. Wellness visit patterns reflect these challenges, with about 40% of participants receiving a wellness visit in the prior year, most of them women, underscoring the need to make routine care easier and more accessible, particularly for men.

Solution: NRECA began exploring telehealth in 2016 and 2017, piloting virtual care to remove barriers and encourage appropriate use of services. Then in 2018, the association rolled out 24/7 nonemergency virtual care to address common conditions that might otherwise lead to urgent care or emergency room visits. As demand grew — particularly during the COVID 19 pandemic — NRECA expanded its offerings in 2022 to include virtual mental health services, later extending eligibility to adolescents age 13 and older to improve access in communities where privacy and provider shortages are ongoing concerns. In early 2026, NRECA added virtual primary care, designed to offer faster scheduling and longer visits, along with asynchronous virtual dermatology that allows

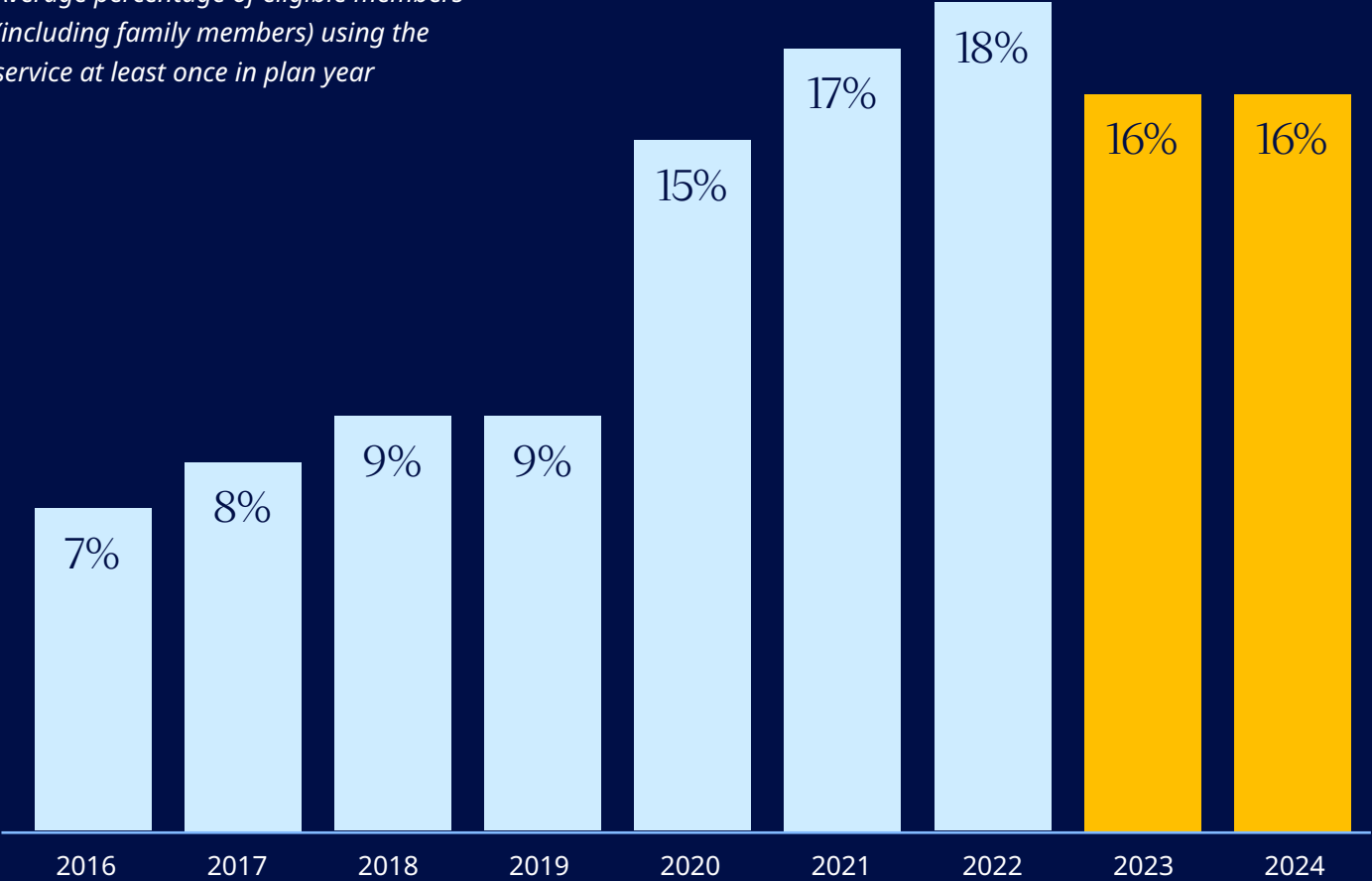
participants to submit photos and receive prompt evaluations through secure messaging. Across all services, NRECA focused on minimizing friction at the point of care, including waiving cost sharing for telehealth, recognizing that 70% of participants are enrolled in high deductible health plans.

Results: Utilization of NRECA's virtual care services increased steadily over time, with particularly strong growth during the pandemic. Utilization continued to grow in subsequent years until January 2025, when the pre-deductible cost share waiver for HSA-qualified high-deductible health plans expired. During 2025 NRECA saw a 15% decline in 24/7 care usage and a drop of about 40% in unique mental health users. Zero cost sharing was reinstated in late 2025 (retroactive to July 4), and the new virtual primary care and dermatology services were added effective January 1, 2026, prompting NRECA to refocus on promoting awareness of the programs and monitor renewed engagement. Utilization data for first quarter 2026 show a 95% uptick in use of mental health services and a 17% increase in 24/7 care when compared to first quarter 2025. Participant feedback underscores the access value of the programs: Post visit surveys show that about half of mental health users reported they would not have sought care without the virtual option, and most (58%) 24/7 care users indicated they would otherwise have gone to urgent care. Early experience with newly launched services has also been encouraging, reinforcing NRECA's view that thoughtfully implemented telehealth can meaningfully expand access to care, especially for rural and geographically dispersed workforces.

Employees have learned to rely on low-cost traditional telemedicine

Plan members now view virtual care as a standard part of their healthcare ecosystem, offering convenience, access and in many cases, more affordable care. Prior to the pandemic, utilization rates were stalled below 10%. When in-person healthcare was severely limited during the worst of the pandemic, utilization rates jumped to 15% in 2020 and rose to 18% in 2022. Growth slowed in the following years, however utilization remains higher than it was pre-pandemic.

Average percentage of eligible members (including family members) using the service at least once in plan year



Employers with 500 or more employees



Holistic well-being

Employee well-being is getting more attention as employers look for ways to support financial, physical, and behavioral needs.

[Mercer's Inside Employees' Minds 2026](#)

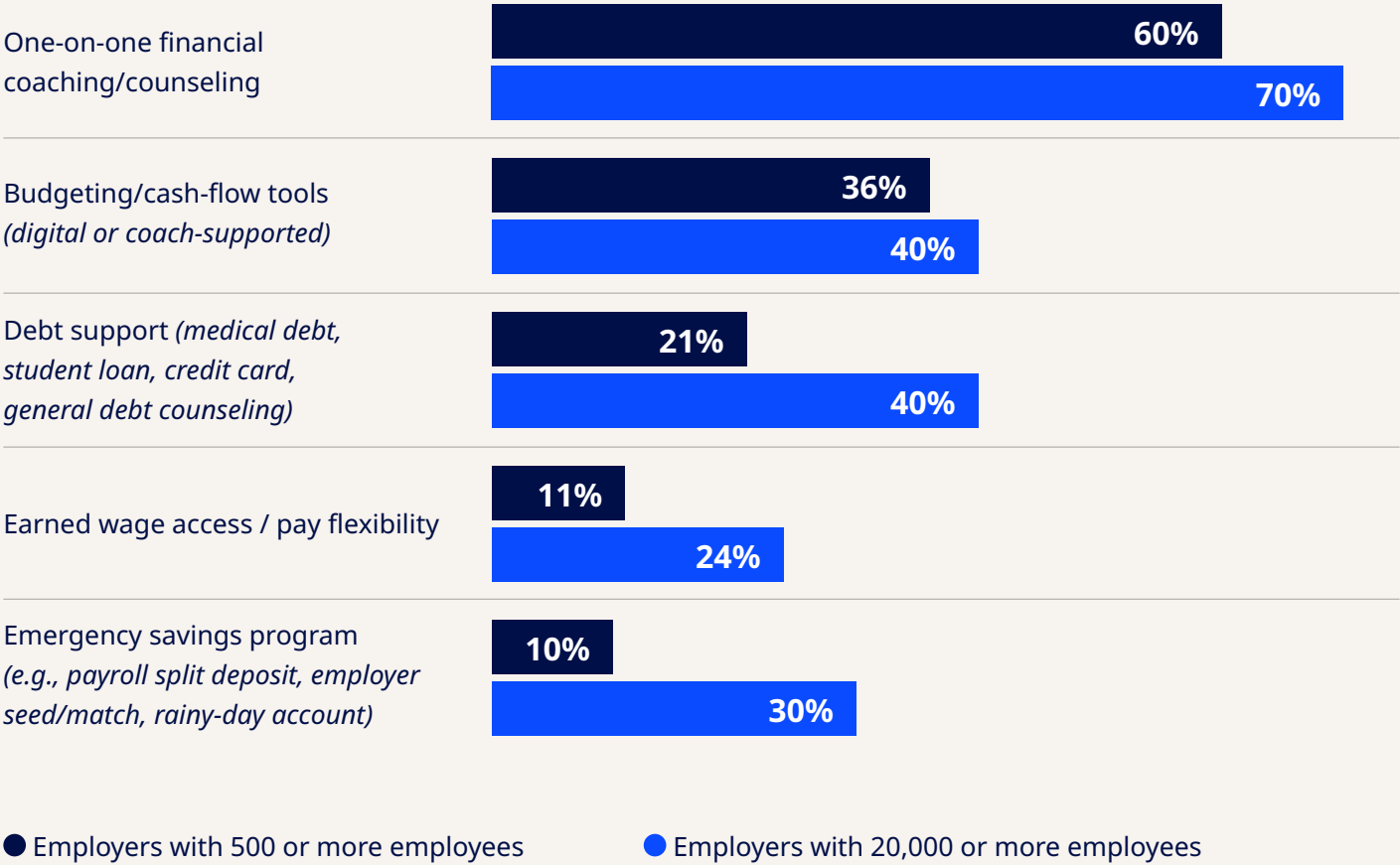
study found that economic conditions continue to weigh heavily on US employees. Asked about the various challenges they face, "covering monthly expenses" was the top concern cited, particularly among lower-paid workers.

In response, as we see in Mercer’s Survey on Health and Benefit Strategies for 2027, employers are broadening their financial well-being strategies: 60% of large employers offer one-on-one financial counseling, 36% offer budgeting and cash-flow tools, and 21% offer debt support such as credit, debt, and student-loan navigation. In addition, 31% provide enhanced communications to educate employees about available financial well-being and support tools,

while 17% offer healthcare bill support such as billing advocacy, consolidated billing, pay-over-time options, or deductible smoothing. Employers are also helping employees keep more of their paychecks through low- or no-deductible plan options and other affordability strategies. These offerings reflect the belief that financial strain shows up at work through distraction, absenteeism, and delayed healthcare utilization.

Supporting employees’ financial well-being with targeted programs for individual needs

Offer or will offer in 2027

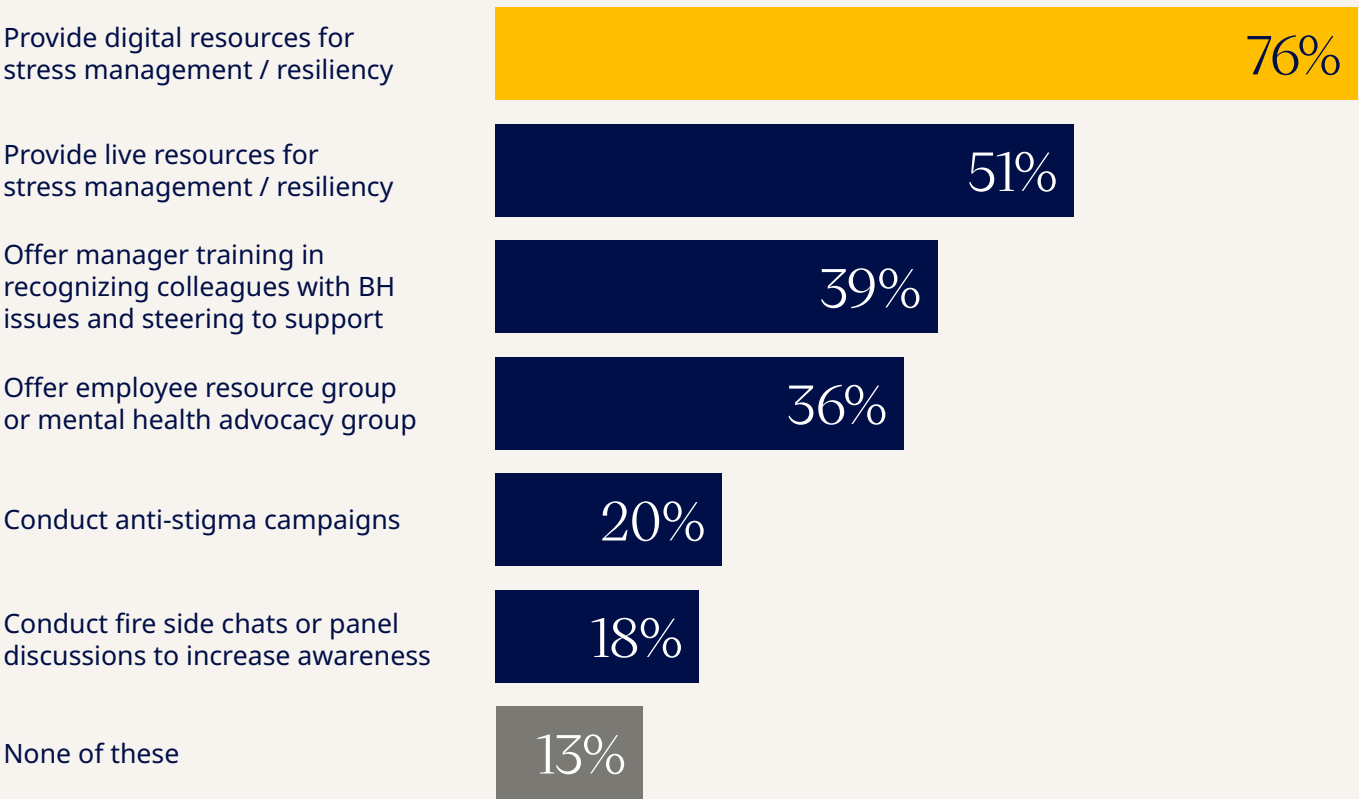


Mercer Survey on Health and Benefit Strategies for 2027

The same broad trends are apparent in behavioral health and family support programs. An important focus is offering more modalities for care to “meet employees where they are:” 39% of large employers have expanded their employee assistance programs to include therapy via text, 35% offer online self-paced cognitive behavioral therapy, 11% offer AI chatbot therapy and coaching, and 33% offer in-person counseling at one or more worksites or will in 2027. The median number of

counseling sessions available annually has risen to six. Employers are also using condition-specific and family-support programs to address needs that cut across the household, including autism treatment access, caregiver support, elder care, reproductive health, and financial support for adoption and surrogacy. Taken together, these options reflect a broader effort to help employees and their families access support earlier, reduce barriers to care, and improve overall well-being.

Employers are working to increase behavioral healthcare utilization and create a supportive work environment



Mercer Survey on Health & Benefit Strategies for 2026, employers with 500 or more employees

Behavior centered approach to financial wellness delivers actionable insights and measurable early returns

Delta Air Lines

Offers flights and vacation packages to over 300 destinations in 60 countries

Issue: Delta Air Lines identified short term financial stress among some employees, despite offering generous retirement benefits. Traditional indicators — self reported surveys and account balances — provided incomplete signals, leaving the benefits team uncertain about employees' true needs and which interventions would drive meaningful change.

Solution: Delta developed a behavior based financial health score using only data known by the employer. To address near term financial vulnerability, Delta introduced an employer funded emergency savings account tied to a structured financial education curriculum. Employees must complete a robust education program — covering budgeting, goal setting, and retirement planning — and participate in a one on one coaching session with a financial professional to become eligible. Delta funds the account directly to reinforce initial saving behavior, reflecting an organizational belief that employees should maintain a minimum emergency reserve while allowing balances to fluctuate over time.

Results: Retention in the emergency saving program is high. Approximately 80% of employees who begin saving continue to contribute. Participants complete pre and post program self assessments using identical questions, enabling measurement of perceived financial capability. Results show sizable gains, with overall financial confidence up approximately 69%, perceived ability to save for other goals up 102%, and basic budgeting confidence up 46%. Delta has also observed increased contribution rates for emergency savings accounts and reductions in hardship withdrawals, signaling improved financial resilience. With quarterly updates to the behavior based score, the company is building longitudinal data to assess seasonality, program impact across benefits and resources, and longer term outcomes. Together, sustained saving behavior and rising confidence indicate the approach is delivering actionable insights and measurable early returns all while preserving employee privacy.

Engagement followed when mental health benefits were designed for continuity and access

Niagara Bottling

A leading beverage manufacturer in the US

Issue: As Niagara Bottling expanded rapidly across the country, leadership recognized that its mental health benefits needed to evolve as well. The company had an employee assistance program in place, but it reflected an earlier model that emphasized limited, short-term support rather than ongoing care. Utilization was low, access to providers was constrained, and employees often struggled to move from initial outreach into continued treatment. Employees who needed ongoing support, particularly those requiring medication management or follow ups, encountered barriers. Rather than viewing this as a failure, Niagara identified an opportunity to modernize its approach and align mental health benefits with how employees and their families seek care.

Solution: In 2023, Niagara implemented a redesigned mental health program with a new vendor partner benefit built around continuity and clinical follow through. The program offers up to 12 free visits per year through a dedicated provider network that transitions directly into the health plan as in network care, allowing members to remain with the same provider as treatment continues. Medication management was deliberately included to address access challenges, particularly when providers were not readily available to support consultations and refills. Eligibility extends beyond employees to spouses, children, and other household members, reflecting the reality that mental health needs often affect the broader household. Together, these design choices shifted the benefit from short term assistance to a more seamless pathway into ongoing care.

Results: The redesigned benefit delivered higher and more sustained engagement. In 2025, 3.6% of covered members were actively receiving mental healthcare, compared with the 1% to 2% utilization often seen in free models. Use of the benefit reflected ongoing engagement rather than single visit use, with many members returning for follow up sessions as part of continued care. Access improved across age groups, including children and teenagers, supported by clinicians available to address cases that were previously harder to place. Employee feedback reinforced the data, with team members and senior leaders openly sharing positive experiences. Niagara's experience demonstrates that when mental health benefits are designed for continuity and access, engagement follows.

Manufacturing firm

Issue: The company wanted a clearer picture of how employees were navigating everyday financial pressures, particularly among lower wage and rural populations it did not always hear from directly, as they emerged from the COVID-19 pandemic. Through a small conjoint survey conducted in late 2021 and follow-up assessment during the 2022 annual enrollment period, leaders began to hear more consistently that employees were struggling with day to day financial challenges. The company recognized that when unexpected expenses arose, employees often turned to their 401(k) as a practical — but imperfect — source of emergency funds.

Solution: The company responded with a deliberate, phased approach. They first created a financial well being guide that consolidated resources already available across multiple vendors. To reach employees who were less likely to be at a computer, the guide was distributed widely in hard copy at worksites, translated into Spanish and other languages, and made available electronically. Leaders further approved a third party employee loan program. When the program launched in October 2025, the loans included payroll deduction for repayment, limits based on salary and credit, and a short term structure designed to help employees avoid becoming overextended. Employees also gained access to budgeting tools and one on one financial counseling. To support informed decision making, information about the loan option was added to the 401(k) webpage so employees would see an alternative while considering whether to borrow from their retirement account.

Results: The response was immediate and exceeded expectations. Despite modest communication — a brief mention during annual enrollment and limited outreach — several hundred employees signed up within the first few weeks. Adoption continued to grow quickly, doubling within the first four to five months. During the same period, about 10% of employees who visited the 401(k) website clicked through to learn more about the alternative loan option, indicating that employees were actively weighing their choices at a key decision point. With the program still in its early stages, the company continues to monitor participation through regular reviews with the provider and is refining its broader financial well being communications to better align with how employees prefer to engage.

How policymakers can help

Below are several recommendations from the American Benefits Council to make it easier for employers to continue providing affordable, quality coverage to over half the country and drive innovation that improves the healthcare system as a whole.

Preserve the tax treatment for employer-sponsored health coverage. Preserve, protect and defend the current tax incentives for employer-provided health coverage — both the full federal income tax exclusion for employees and the tax deduction for employers.

Preserve ERISA preemption. Preserve, protect and defend federal preemption for all benefit plans subject to ERISA.

Improve healthcare affordability. Address the root causes of rising healthcare costs — notably hospital and provider consolidation, a lack of transparency, and the prevalence of chronic conditions — by expanding site-neutral payment reforms, modernizing the 340B drug pricing program, reforming the No Surprises Act's arbitration-based independent dispute resolution process, ensuring greater price and quality transparency, and restricting anti-competitive contracting provisions.

Support quality improvement and paying for value. Support employers' access to nationally available price and quality transparency data and promote the use of evidence-based care. Crack down on the use of anti-competitive contract clauses.

Address chronic conditions and strengthen primary care. Support policies to increase the number of primary care providers, improve access to primary care, and support integration of other services with primary care.

Improve prescription drug access and affordability. Increase transparency, preserve employers' ability to design pharmacy benefits, remove barriers to employer coverage of high-value, often high-cost, innovative drug therapies and encourage innovation by supporting employers' ability to align drug prices with value.

Improve access to mental healthcare. Fund the expansion of the mental health workforce, improve access through more flexible state and federal licensing regimes, ensure clear and balanced mental health parity guidance, and develop evidence-based quality measures for mental and behavioral health providers and facilities.

Expand telehealth. Remove unnecessary state licensing barriers to telehealth services and support employers' ability to provide stand-alone telehealth services to employees who are not benefits-eligible.

Support the use of technology. Allow emerging and evolving technologies to transform and improve health and financial well-being, and ensure privacy and security policies are targeted, flexible and not duplicative or inconsistent with existing legal protections.

Promote financial wellness. Enable employers to provide more robust financial education through a simplified compliance process and permit employers to offer a qualified financial well-being plan to employees on a tax-free basis.



A full set of health policy recommendations is available [here](#).

For the Council's full long-term public policy strategic plan, **DESTINATION 2030**, which examines the present and future of employer-sponsored benefits and incorporates many of these recommendations, see www.americanbenefitscouncil.org/destination.

