



insights from
the experts



US Benefits
Trend Report
2024





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A Letter from Kim

Healthcare costs continue to rise, compelling employers to seek novel ways to contain them. In fact, recent data projects a 7% hike in trend, suggesting that inflation will continue to impact efforts to provide affordable access to quality care. As part and parcel of increasing medical trend, there are well-founded concerns about rising provider costs, gene therapy treatments, and unyielding demand for GLP-1 weight loss drugs.

This is especially salient given employee demand for more than simple access to care. Employees want a comprehensive benefit package that can be tailored to their individual needs. Perhaps unsurprisingly, the majority of employees are paying closer attention to what is being offered to them and placing more emphasis on financial protection and overarching well-being support.

Complicating this effort are conflicting viewpoints on the value of various benefit components. There are noted differences between what employers and employees value, on top of generational differences across the workforce. Resolving discrepancies in employee benefit perception and overall satisfaction will be one of the defining factors in plan design in the coming years.

Employers and HR leaders today face mounting challenges. However, despite the seemingly unending medical and pharmacy threats that employers face, opportunities exist for those armed with the right tools and information.

- Managing spend through innovative plan design, data analytics and employee health management will continue to be crucial to overall strategy.
- Advanced data analytics will help to identify areas within the plan where employers can contain costs and aid in meeting new fiduciary responsibilities under the Consolidated Appropriations Act.
- Approaching employee well-being with a mental health and fitness lens will pave the way for the employee engagement and loyalty that underpin business success.

The US Benefits Trend Report represents NFP's ongoing effort to deliver modern, actionable insights aimed at empowering employers to create personalized benefit offerings that elevate employee satisfaction, well-being, engagement, and organizational success while tackling head-on the reality of uncertainty and increasing costs.

Much gratitude to all who contributed their expertise to the NFP Benefits Trend Report — your passion for serving clients propels our progress. We deeply appreciate your continued partnership as we work together to shape the future of benefits.

With gratitude,

Kim Bell

*Executive Vice President
Head of Health & Benefits*



Key Takeaways



.....
76% of employers report that it is either **very or extremely important** to establish a best practice **fiduciary policy and practice** in **2024**.



21%

of employers plan on *increasing* their benefits budget by at least **10%**.



76% of employers are concerned about increasing pharmacy costs.

However **31%** **do not use a** pharmacy consultant.



Half of all employees have **\$1,000 or less** in savings to cover the cost of unexpected expenses.





33% of employees report feeling **distracted** at work by non-work issues.

For **60%** of those reporting increased distraction, the **affordability of basics** (like rent, food, utilities and healthcare) tops of their list of concerns.



58% of workers are interested in mental fitness programs.



56% of employees note that economic concerns will **impact** their benefits **decisions**.

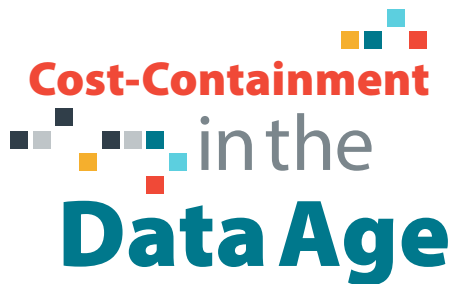


38% of employees feel that **economic concerns** will cause them to choose a **lower-cost plan**.



29% of employees report that their benefit offering somewhat meets their needs while

13% report that it **does not meet** their needs well at all.



Cost-Containment in the Data Age

Rising costs continue to be a significant concern for employers, especially for their group medical and Rx benefit plans. According to new data from the International Foundation of Employee Benefit Plans (IFEBP), for the second time in as many years, employers are projecting a 7% rise in healthcare costs.¹ The primary reasons, according to employer responses on the IFEBP 2024 Cost Trend pulse survey, are utilization due to chronic health conditions, catastrophic claims, specialty/costly prescription drugs, cell and gene therapy and medical provider costs.

“Employers are realizing that decades of delegation of oversight in their healthcare spend is not working,” states Heidi Cottle, SVP of Cost Containment Strategies. “The continued escalation of medical/Rx costs is not sustainable. With the advent of price transparency, employers are beginning to expect greater cost and quality accountability in the market for both the provider of healthcare services and the payers (such as carriers and third-party administrators).”



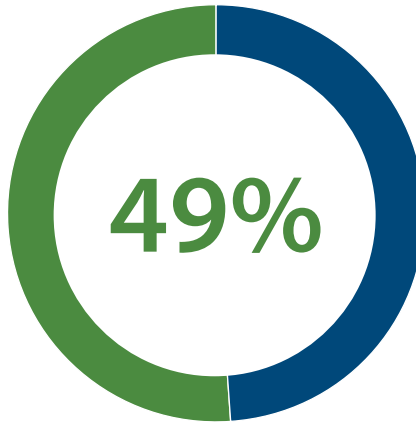
Further fueling this increase are ongoing inflation, supply chain challenges and labor shortages, which have a profound effect on healthcare providers and manufacturers of prescription drugs. This becomes readily apparent when examining the financial stability of hospitals and health systems.

According to a 2023 study by the American Hospital Association, sustained and significant increases in the costs required to care for patients and communities are putting the financial stability of the entire system at risk. After two years of battling COVID-19, health systems experienced a 17.5% increase in overall hospital expenses between 2019 and 2022, primarily due to the macro effects of inflation.²

Coupled with a decrease in the demand for profitable elective procedures and signs that cost barriers are driving delayed preventive and necessary medical care, it is likely that healthcare conglomerates will have little choice but to pass even more costs on to employers in the coming year.

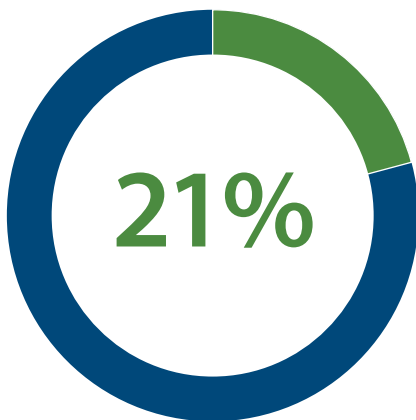
Inflation similarly affects the operational costs of manufacturing medications. With increases in the costs of energy and transportation, along with disruptions in the supply chain, pharmaceutical companies are facing their own struggles. Despite the notion that drug manufacturers are typically immune from market pressures, rising expenses due to inflation affect their bottom line the same as any other organization. As a result of increased expenses, pharmaceutical companies will also likely continue to raise drug prices to protect their margins — even the already costly blockbusters such as Ozempic, Wegovy and Humira.

Figure 1:



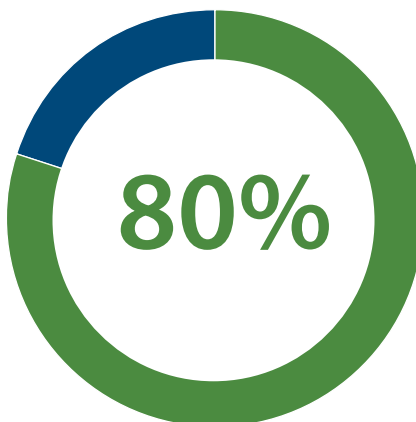
of employers plan to **increase medical/Rx budget** at renewal

Figure 2:



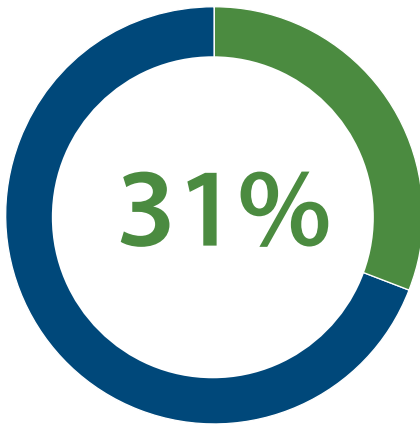
plan to **increase benefit budget** by 10%+

Figure 3:



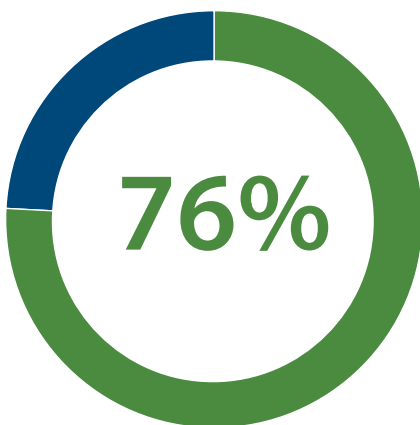
of employers **find it very or extremely important** to control Rx spend in designing Rx benefits

Figure 4:



of employers
do not use
a pharmacy consultant

Figure 5:

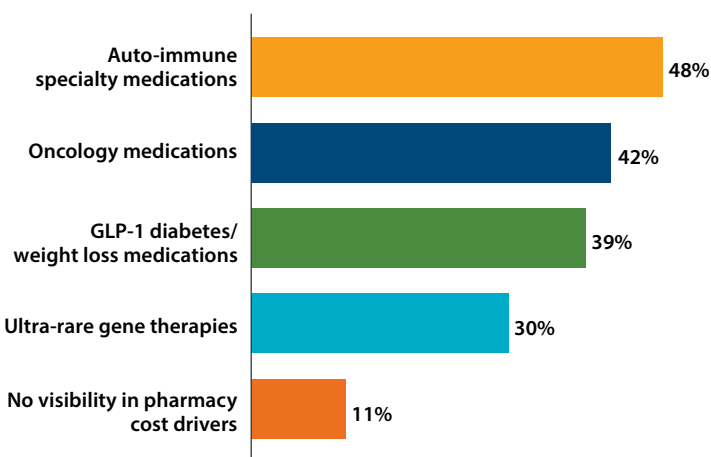


of employers
are concerned
about **increasing**
pharmacy costs

As every major stakeholder in the US healthcare system seems to struggle with inflation, employers are clamoring for strategies to manage these mounting costs while limiting disruption so their benefit offerings can remain attractive to workers. With great interest in identifying insurance plan strategies that can optimize the value of pharmacy benefits while accounting for high-priced drug therapies, employers would be wise to partner with experienced employee benefits advisors who can provide customized solutions to tame rising prescription drug costs. Fortunately, employers can also take proactive steps to curb healthcare cost increases while protecting their workforce and bottom line. Employers can optimize their spend with a medical strategy that utilizes advanced data analytics (paired with AI and machine learning capabilities) while advancing a value-based cost-containment strategy.

Figure 6:

Biggest Cost Drivers in Prescription Drug Spend





Medical/Rx Planning

Strategic Foundations

When developing a comprehensive medical/Rx strategy, the following key elements will provide a firm foundation for plan design:

Develop a fiduciary evaluation and selection process for the medical/Rx plan.

ERISA, bolstered by the Consolidated Appropriations Act (CAA), requires a plan sponsor to adopt a formalized process of evaluation and selection for their employer-sponsored group health plans.

Ensure data analytics drives strategy and design.

To maximize value, employers must identify specific ways to apply advanced analytics to improve cost management, health outcomes and overall population management.

Utilize transparency – introducing cost, quality accountability and trend drivers.

Legislative advancements, including the CAA, have triggered market opportunities for cost transparency and opened the door for the creation and development of new market solutions.

Minimize disruption through a multiyear cost containment strategy and design.

To achieve optimal long-term outcomes, pair incremental, sustainable plan participant engagement measures with plan performance measurement through advanced data analytics.

Evaluate funding options.

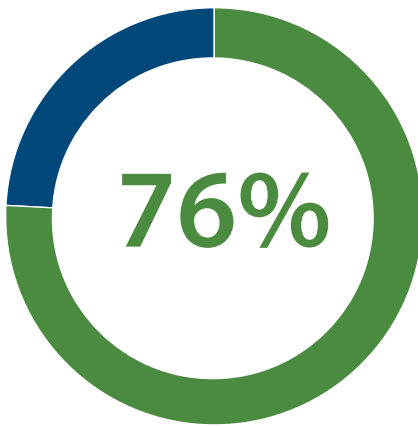
There are two primary funding methods for medical/Rx plans: fully-insured and self-insured. However, there are a multitude of options within those funding methods which should be evaluated.

Adopt value-based benefit design.

Support clinical best practices by providing non-discriminatory incentives for members to adopt practices which lead to better health while addressing the overuse and underuse of healthcare services.

In each of these areas, there are many opportunities to optimize your medical/Rx strategy in ways that support employees and the bottom line.

Figure 7 :



of employers report that it is **either very or extremely important** to establish a **best practice fiduciary policy and practice in 2024**

Building from Strategy

After laying the groundwork on some of the key drivers of rising healthcare costs and potential high-level strategies to alleviate them, employers can take critical considerations into account around plan design. By leveraging data analytics, introducing greater transparency and accountability measures, and adopting value-based designs, plan sponsors can put conceptual strategies into actual practice. Delving into innovative plan models, targeted pharmacy management programs, and ensuring fiduciary responsibilities are met, the design process cements the creation of actionable steps to optimize benefits strategies.

Develop a Fiduciary Evaluation and Selection Process for the Medical/Rx Plan

BACKGROUND

ERISA and the CAA require a plan sponsor to adopt a formalized evaluation and selection process for their employer-sponsored group health plans. Working with an outside team for support keeping up with these requirements can be helpful. For example, NFP's Compliance department provides a client toolkit for a comprehensive overview of requirements.

IMPLEMENTATION

The following steps are a good faith guideline. However, the guideline does not constitute legal advice. An employer should seek internal legal counsel for further guidance.

Step 1: Develop an internal Medical/Rx Plan Committee

Step 2: Evaluate the medical/Rx plan data claims analytics to determine a multiyear cost containment strategy and design. The data will define key utilization trends, better-performing networks throughout the US, and claims-specific areas where cost savings opportunities can be balanced against potential disruption to plan participants and access to quality care.

Note: The Dept of Health and Human Services (HHS) CAA FAQ release on February 23, 2023, makes clear requirements of the payers and their required release of data. Combining the transparency data with the claims data from this step establishes a plan sponsor's current "unit cost of care" baseline. Medical procedural costs of care fluctuate considerably depending on geographic location.

Step 3: Develop a price transparency policy to include cost and quality accountability measures. Possible policy measures could include:

1. Network cost evaluation: Claims repricing analysis to determine the most cost-effective network.
2. Network quality evaluation: Perform network evaluation of in-network provider quality scoring. Depending on employer size, DEIB/social determinants of health can also be included in the evaluation process.
3. Evaluation of self-service tools required by CAA.

Step 4: Develop a methodology for evaluating your medical/Rx administrative service providers and funding methods.

Step 5: Define what "value" means to your organization. Develop value-based designs to support and incentivize the defined organizational value.

Ensure Data Analytics Drives Strategy and Design

BACKGROUND

Providing employee benefits is an expensive proposition, and the one-size-fits-all approach to designing a medical/Rx plan has proven to be ineffective. Following compensation, healthcare expenses are the second largest line item on an organization's P&L statement.

To assess the appropriate use of cost containment and value-based designs requires the use of data analytics. Under current conditions, employers continue to broaden and refine their metrics management and advanced data analytics requirements to identify emerging trends, earlier. Early adopting employers rely upon their advanced data analytics systems as an integral part of their benefit strategy. "If you can't measure it, you can't manage it," states Cottle.

By identifying emerging claims trends, gaps in care and necessary reme-

diation to mitigate unexpected costs in their healthcare spend, these leaders can take proactive measures to optimize expenditures and health outcomes.

Advanced data analytics systems are further able to monitor and validate the key performance indicators of adopted benefit strategies.

IMPLEMENTATION

Establishing an effective business case for the use of advanced data analytics requires:

1. Defining organizational priorities.
2. Establishing a baseline for measurement.
3. Determining reasonable goals based on clinical insights and ability to influence change.
4. Monitoring outcomes that validate performance of the established goals.

Done correctly, companies can leverage historical and current information to predict future trends and patterns with

a high degree of accuracy, enabling organizational key performance indicators (KPIs) for both short and long-term forecasting.

As Cottle explains, "Data is a window into the art of the possible. Accurately interpreting the data turns the art of the possible into actionable insights."

Generally speaking, advanced data analytics combines and extends prescriptive and predictive analytics as a broader business intelligence capability. Most data analytics platforms offer easy-to-understand visualization with supportive insights, and some platforms provide proposed actions for remediation used by a skilled advisor.³ It is important to note that all advanced data analytic platforms are not created equal. Those which support both data and clinical methodologies offer the broadest lens for employers to improve a plan participant's access to quality healthcare services at the most optimal price.

In Focus

Data Analytics

Essentially, data analytics is the science of analyzing raw data to make conclusions about information.⁴ According to Amazon Web Services, one of the biggest players in the big data analytics game, through the use of tools, technologies and processes, data analytics can convert raw data into actionable insights that can identify trends, solve problems, improve decision-making and foster business growth.⁵ In the world of employee benefits, where containing medical costs is paramount, data analytics can unlock transformative opportunities to optimize benefit spend through granular insights.

Advanced Data Analytics

Advanced data analytics is a data analysis methodology that uses predictive modeling, machine learning algorithms, deep learning, business process automation and other statistical methods to analyze information from a variety of data sources.⁶ It applies data science beyond the scope of traditional strategic

business intelligence to predict patterns and estimate the likelihood of future events. Utilizing empirical data empowers the organize to introduce cost and quality accountability supported by value-based benefit incentives, performance standards and guarantees for healthcare providers and administrators of healthcare services.

Predictive Analytics

The process of using historical and current medical and pharmaceutical cost data (including financial projections), with standard actuarial science methodologies to predict what will likely happen in the future and make educated forecasts.

Prescriptive Analytics

The process of using data from a variety of sources, including statistics, machine learning, data mining and clinical outcomes to envision predictive outcomes and understand why they will happen.

Utilize Transparency – Introducing Cost, Quality Accountability and Trend Drivers

BACKGROUND

Over the past few years, various transparency laws have gone into effect that require hospitals and payers across the healthcare system to post their negotiated commercial prices, all as part of a larger effort to make medical costs less opaque. These legislative advancements have triggered market opportunities for cost transparency and opened the door for the creation and development of new market solutions.

One such opportunity gives employers the capacity to compare negotiated pricing across health systems, networks and regions all over the country. The potential for data-driven pricing transparency to help employers make more informed and strategic decisions around plan design and network strategy is promising. So is the ability to make these decisions while forecasting current and future healthcare costs. However, achieving these outcomes relies on sophisticated analytical tools.

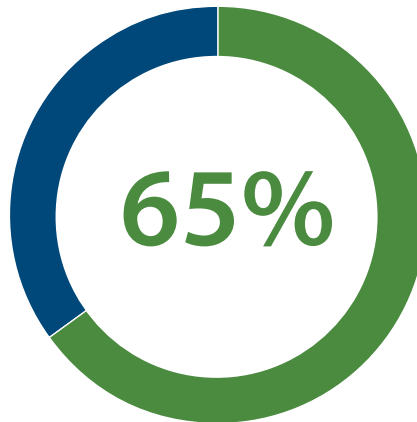
IMPLEMENTATION

Introducing cost and quality accountability through transparency legislation adds opportunities for employers to adopt broader clinical risk management and enhanced pharmacy management strategies, including:

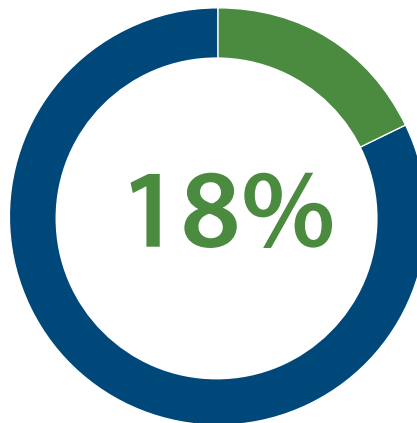
- **Network analysis:** Validate the best network based on plan participant access, cost and quality accountability factors.
- **Enhanced pharmacy management:** Engaged pharmacists and consultants focus on pharmacy benefit management and medical/Rx

Figure 8:

Transparency in Healthcare Costs Creates More of an Opportunity to Educate Members



of employers see **transparency as an opportunity***



of employers see **transparency as a challenge***

* Among those aware of changes

strategies to optimize employer cost savings. Additionally, this can include site of care management, guidance based on the social determinants of health and other pharmacy arrangement opportunities.

- **Clinical care navigation:** Consumer improvement in medical literacy is needed. To help participants access the appropriate care and providers according to their plan, a clinical guidance program should be established to bridge the literacy gap and ensure plan adherence.

With the right tools at their disposal, employers can now effectively analyze the negotiated pricing across various health systems and utilize that information to explore the variables related to healthcare, just as they would do with other significant expenditures. This allows employers to ascertain if they are currently getting the best unit cost and actively seek out providers whose cost and quality metrics fit their cost containment goals.



Employers can now effectively analyze the negotiated pricing across various health systems with cost and quality metrics that fit their **cost containment goals**.

Cost and quality accountability utilizes the following cost containment and clinical risk management “checklist” that covers the leading disease conditions, and can be used by employers to evaluate the performance of their medical/Rx plan:

Cost and Quality Accountability Checklist	
Evaluate effective cost of care: access to quality providers, management of emerging disease states and management of chronic diseases.	
✓	Provider Network Analysis
✓	Pharmacy Transparency
✓	Clinical Care Navigation
✓	Advanced Primary Care
✓	Second Opinion Services
✓	Disease Prevention
✓	Behavioral Health
✓	Cancer Support
✓	Chronic Disease Management
✓	Diabetes Reversal
✓	Musculoskeletal Health
✓	Digestive Health
✓	End Stage Real Dsease (ESRD)/Dialysis
✓	Other Emerging Trends Specific to Your Population

Minimize Disruption Through a Multiyear Cost-Containment Strategy and Design

BACKGROUND

We already know that medical/Rx benefits are a top priority in recruiting and retaining employees. However, influencing change is difficult. Fortunately, implementing positive change while minimizing plan participant disruption is possible through a multiyear cost containment strategy. This strategy requires two main elements, focusing both on the short- and long- term. First, establish short-term milestones with incremental and sustainable plan participant engagement measures. Second, to achieve optimal long-term outcomes, it's essential to measure and monitor plan performance through advanced data analytics.

IMPLEMENTATION

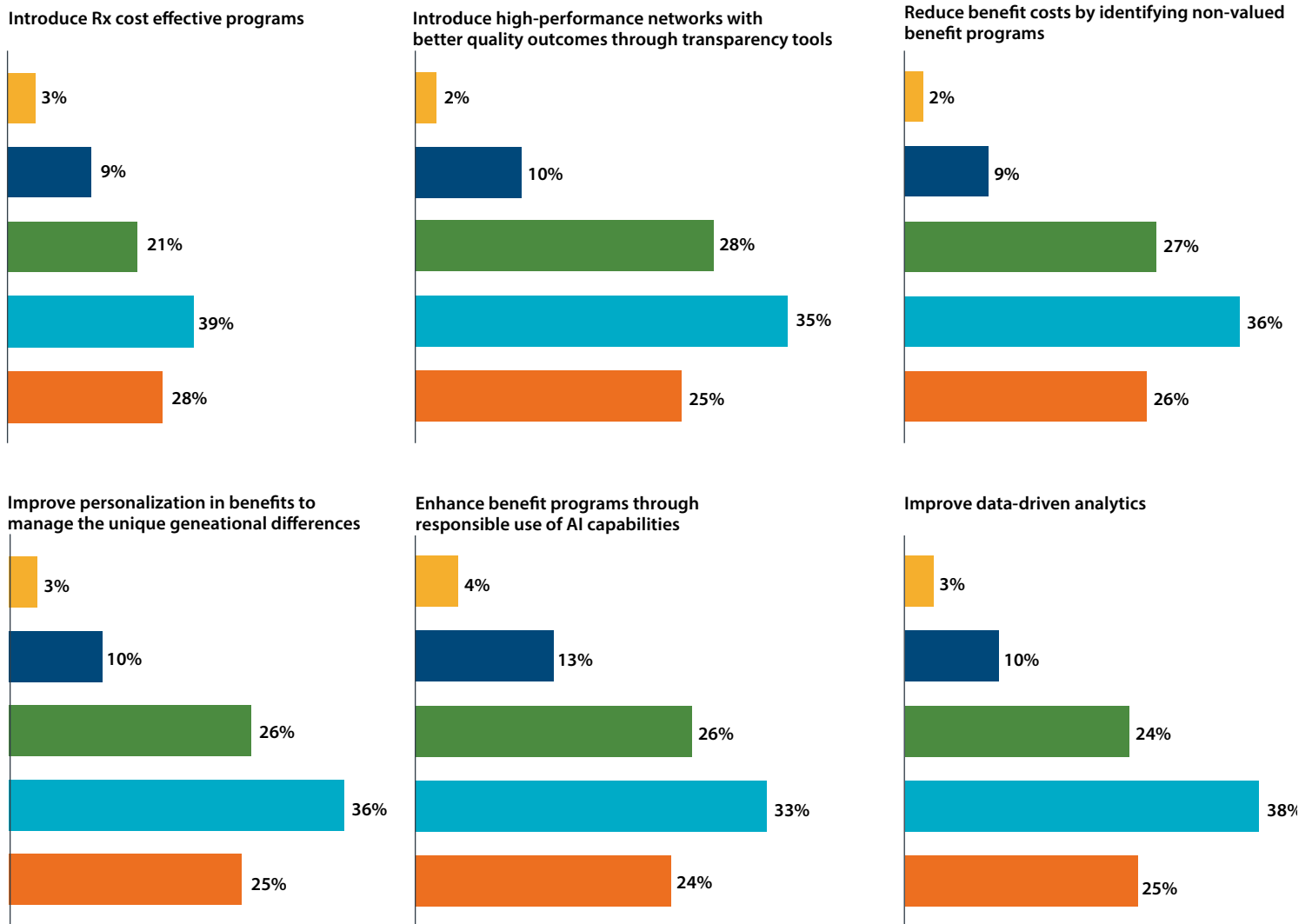
To contain medical and pharmacy costs, employers need access to their claims data so they can identify areas where appropriate clinical influence can be supported. Employers can drive health improvement while containing costs through increased early detection, stronger utilization management programs, reduction in gaps in care, population health, addressing social determinants of health and adoption of value-based incentives in plan designs to encourage plan participant engagement.

Figure 9:

The survey identifies key strategic levers being considered by employers. However, the design for implementation requires the use of data analytics to support the business case for adoption.

<p>62%</p> <p>Of employers are very/extremely willing to consider non-valued benefit programs.</p>	<p>61%</p> <p>Of employers are very/extremely willing to consider personalization of benefits.</p>	<p>60%</p> <p>Of employers are very/extremely willing to consider "high performance" providers.</p>
<p>This can be achieved through well written employee surveys, with supportive data analytics.</p>	<p>With four generations in the workplace this is important for effective recruiting and retention of key employees.</p>	<p>Utilizing advanced data analytics with the new transparency data sets (i.e., hospitals' and payers' posted costs for procedures) offers employers insight into negotiated costs with the various carriers/payers/third-party administrators. The initial data demonstrates that cost and quality are not synonymous. High-quality providers, based on industry acceptable clinical standards, are consistently the most optimal choice for cost.</p>

Figure 10:
Areas of Cost Containment



- Not all willing to consider
- Slightly willing
- Moderately willing
- Very willing
- Extremely willing to consider

According to McKinsey, a wide range of organizations are contributing to systematic changes that improve the quality of care and outcomes while better controlling costs. McKinsey further reports that following private capital over the pandemic, investment in value-based care companies increased more than fourfold from 2019 to 2021 and, given the current momentum, could result in \$1 trillion in enterprise value as the landscape matures.⁷

- **Evaluate administrative needs:** Understand the requirements to establish fiduciary evaluation and selection process.
- **Analyze financial targets:** This includes evaluating the medical/Rx funding options.
- **Mitigate risk:** Ensure proper compliance practices, protocols and oversight are in place.
- **Establish qualitative and quantitative metrics for evaluation:** Establish reasonable and achievable goals. Utilize the cost and

quality accountability “checklist” to establish performance standards and guarantees for your selected medical/Rx vendors.

- **Monitor and manage qualitative and quantitative metrics:** Establish data analytics (advanced data analytics) to evaluate performance of the metrics. Integrate data analytics in the ongoing emerging claims utilization trends, disease management adherence, gaps in care, DEIB/social determinants of health, and wellness incentive programs tied to risk modifications.
- **Consider HR matters:** Do you adopt a “crawl,” “walk” or “run” approach to minimize disruption and align with business goals?

Evaluate Funding Options

BACKGROUND

For employers to consider emerging trends and other innovative options, an annual evaluation of funding methods is required. A trusted advisor can assist through risk management, advanced data analytics, price transparency, actuarial and other plan design tools to support an organization’s business objectives. Through this process you can identify and exploit advantages in a carved-out pharmacy plan with access to claims and audit rights ensuring service performance guarantees.

NFP’s survey found that the vast majority of covered workers in mid-size and larger organizations are enrolled in a self-insured plan, while smaller firms are less likely to be self-insured. The Kaiser Permanente annual national report supports the NFP survey results, showing that smaller firms are more likely to be fully-insured. Their results showed that

Figure 11:
Prevalence of Self-Funded Plan Model

Firm Size	% of Covered Workers in a Self-Funded Plan
200-999	61%
1,000 - 4,999	81%
5,000 or more	93%

58% of firms with 3 to 49 employees are fully-insured, 52% of those with 50 to 199 employees are, and 55% of small firms overall are.⁸

Being self-insured or fully-insured are the two primary funding methods for medical/Rx plans. However, there are a multitude of options within those funding methods which should be evaluated. The funding method an organization decides on for its employer-sponsored medical/Rx plan determines the level of risk/reward and value-based plan design levers which can and cannot be used. Your advisor can assist you with evaluating all appropriate options.

IMPLEMENTATION

The different funding models each have their own mechanisms to allocate risk and financially cover medical/Rx expenses and, as such, create different relationships and responsibilities between employers and insurers depending on which entity takes on the most risk. In general, due to the nature of state filing requirements for insurers, fully insured options are limited to the plans filed with the state department of insurance. In some states there may be a limited risk-sharing fully insured option,

but most states preclude this type of funding. Self-insured plans are federally qualified ERISA plans, and as such are not subject to most state mandates. There are advantages and disadvantages to the funding options available. Your advisor can provide broader evaluative insight into the options which are best aligned with your organization’s objectives. The following provides a broad level explanation of key funding options available in the industry.

The Affordable Care Act, enacted in 2010, aimed to usher in new measures, including certain mandates and affordability rules, meant to address rising costs (particularly for employees). Even carriers utilized narrow networks of providers to bring cost containment to the market. The latest alternative health plans are a modern cost-containment initiative aimed at providing high-quality care through a patient-centered approach, evidence-based practices, and appropriate, coordinated care. These plans strive to create a transparent cost environment before healthcare procedures are performed, thus helping individuals avoid unexpected costs.

There are several emerging plans which appear on a broad continuum of services in the US. For example, Coupe

In Focus

Fully Insured

A group health plan in which the employer or association purchases health insurance from a commercial insurer. The employer pays premiums to the insurer in trade for the insurer taking on the financial risk associated with providing coverage and administering the plan.⁹

The primary benefits of a fully insured plan are financial predictability, cost stability, less administrative burden and lower risk. However, they can be far more expensive, given that the employer needs to cover the insurer's profit margin, overhead, taxes and fees, and they are far less flexible in terms of plan design, network and rates. Atop this there are compliance issues and costs in play given that fully-insured plans are subject to state and federal regulations.¹⁰

Self-Insured

A group health plan in which the employer takes on the risk involved with providing coverage instead of purchasing coverage from an insurance company. The employer pays for enrollees' medical/Rx care directly to the providers. This is most commonly supported by an external administrator. The plan can be administered by the employer, but an administrative services only agreement with a carrier or an independent third-party administrator is often used.¹¹

Level Funded

Visibility into the actual cost of care through transparency laws has prompted the development of alternative funded plan designs, which allows small and mid-sized employers the opportunity to participate in a smaller percentage of the funding risk, while also having the opportunity to share in the savings.

Most level-funded plans are self-insured plans and, therefore, are not subject to state regulations. For many small or mid-sized employers, level-funded plans are a good entry point into the benefits of self-insured funding. With lower-level stop-loss coverage mitigating risk exposure by limiting financial liability coupled with set monthly payments, these plans incentivize employers to control costs. Given that the plan's maximum annual liability is prepaid over the course of the calendar year, plan administrators use these premiums to pay claims as they occur. If at the end of the year claims exceed the prepayments, the administrator files a stop-loss claim; if claims are lower than the prepayments, the employer receives the excess funds.¹²

Captive

A hybrid model combining elements of self-funding and lower-level pooled stop-loss insurance with other employers. The employer takes on some of the risk while placing a cap on volatility. The insurer calculates an expected monthly cost covering estimated claims, stop-loss premiums and fees which the employer covers as a set monthly payment.

Alternative Health Plans

Consumers expect better health outcomes, lower costs and a seamless continuum of care to assist them to make better informed decisions and participate in managing their health. Creating that experience is the objective of the new emerging alternative health plans.

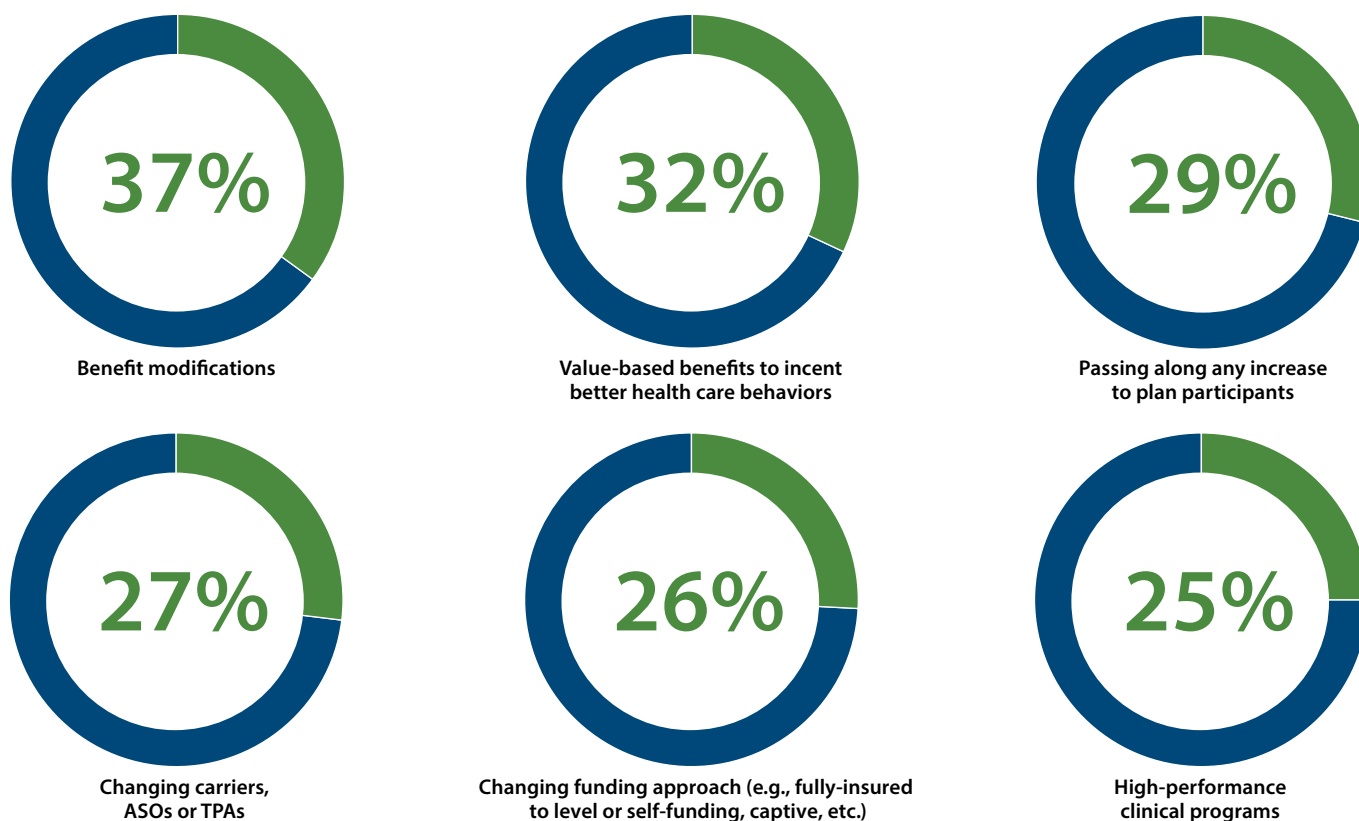
Health, Fair Market Health, Surest Health Plans (UHC), SimplePay Health (Aetna/Meritain), Transcarent Health — just to name a few (examples listed alphabetically). Additionally, there is a multitude of transparent self-service tools with complimentary overlay programs as differentiators in the market.

Adopt Value-Based Benefit Designs

With targeted, non-discriminatory incentives and disincentives, value-based benefit designs can address one of the most pressing issues driving costs — the overuse and underuse of healthcare services.

Strategic benefits programs that employ the use of targeted incentives can address both underutilization and overutilization. Through plan design, healthcare cost-sharing arrangements can be established to avoid overuse of unnecessary or low-value care. Throughout this process, plan participants begin to understand, through appropriate incentives, other options which lead to

Figure 12:
Strategies to Offset Increasing Medical/Rx Costs



the advancement of better-informed non-emergency healthcare decisions. To enhance participant engagement of value-based designs, employers are leveraging the new digital self-service tool required under the transparency law. The digital self-service tool gives participants visibility to the cost and quality of providers of their healthcare services in advance of non-emergency procedures.

In the US, we see rampant overuse of low-value or no-value care, which has been consistently identified as contributing to the high costs occurring in the US healthcare system.¹³ Conversely, the low intake of effective and affordable evidence-based care is just as problematic, given the expensive downstream effects on morbidity and mortality. Through thoughtful plan design, employers can address both problems.

The goal is to steer employees to seek out only useful and appropriate healthcare services from reputable, low-cost, high-quality providers. This encourages things like better engagement with chronic condition management while discouraging unnecessary tests and procedures. By aligning the right mix of plan components, employers can help educate employees on the proper use of health services to not only maximize their health outcomes but also optimize spending on care.

FULLY INSURED – VALUE-BASED DESIGN

Despite the industry’s investment in innovative value-based care companies, some fully insured health plan options haven’t really changed in decades. It is recommended that value-based fully insured solutions become a priority in

the organization’s selection process. At an organization like Garner Health, which believes that fully insured employers have been denied access to innovative data-driven solutions for far too long, they’ve created a new plan design that allows employers to keep their existing medical carrier while incentivizing employees to see the highest quality doctors throughout their course of care. Based on claims records from over 180 million patients, their self-service pricing and quality tool gives employers and their employees greater visibility into cost and quality of service, all backed by a dedicated concierge team.

Generally speaking, fully insured employers have had little incentive to control their costs and lower their claims because the majority of the savings would go to the payer. However, with Garner’s innovative funding mechanism involving a self-funded health reimbursement arrangement designed to replace an existing HRA or HSA program, fully insured employers are given the opportunity to not only steer employees toward top-performing practitioners but finally share in the savings from more efficient and effective healthcare.

LEVEL-FUNDED - VALUE-BASED DESIGN

In the last few years, the popularity of level-funded plans as a subset of self-insured has grown. Many level-funded programs offer cost-effective maximum funding of liability. This allows the participating employer to limit their exposure but participate in savings based on lower claims usage. Depending on the payer or independent TPA offering the Level-Funded Option will determine the flexibility of value-based benefit designs that are offered.

SELF-INSURED – VALUE-BASED DESIGN OPTIONS

Although there are a number of self-insured organizations involved in value-based care, challenges remain in executing and scaling initiatives for many more. With recent evidence from Health Affairs demonstrating that unadjusted prices for common services in self-insured plans were typically (albeit slightly) higher than fully insured plans, it suggests that employers have not yet explored all the opportunities available to them to contain costs.¹⁴

When considering self-insured options, there is an array of administrative options, networks and value-based point solutions to evaluate prior to making a well-informed decision. Your advisor can support evaluation and consideration of the following options.

Self-Insured - Value Based Design Options

Administrators

- Payer, Administrative Services Only (ASO) (e.g., Aetna, BCBS plans, Cigna, UHC, regional payers)
- Payer, Third-party Administrators (TPAs) (e.g., Aetna/Meritain, Anthem BCBS/Ameriben, UHC/UMR etc.)
- Independent, Third-party Administrators (TPAs)

Provider Networks

- Payer owned Networks – ASO Only
- Leased Payer Networks to Independent TPAs (e.g., Aetna, BCBS plans -Associations, varies by States, Cigna, UHC etc.)
- High Performance Networks – specifically designed by using a cost/quality scoring methodology. Alternative health plans use a form of high-performance provider cost/quality scoring.

Stop-Loss

- Payer – ASO with Integrated Stop-Loss
- Payer – ASO with Carve-out Stop-Loss
- Payer – TPA with Integrated Stop-Loss

- Payer – TPA with Carve-out Stop-Loss
- Independent TPA – with Integrated Stop-Loss
- Independent TPA – with Carve-out Stop-Loss

Rx

- Payer – ASO with Integrate Rx
- Payer – ASO with Carve-out Rx.
- Payer – TPA with Integrated Rx
- Payer – TPA with Carve-out Rx
- Independent TPA – with Integrated Rx
- Independent TPA – with Carve-out Rx

Disease Management Point Solutions

- Payer – ASO, no integrated point solutions
- Payer – ASO, yes preferred point solutions
- Payer – TPA, no integrated point solutions
- Payer – TPA, yes preferred point solutions
- Independent TPA – employer selected point solutions
- Independent TPA – preferred point solutions



*Employers can help educate employees to not only maximize their health outcomes but also **optimize spending** on care.*

DIRECT EMPLOYER CONTRACTING OF HEALTHCARE PROVIDER SERVICES (E.G., COALITION, CONSORTIUM OR COMMUNITY-BASED HOSPITAL PLAN)

Employers are beginning to consider all market solutions including aggregators who standardize contracts and pool lives for purchasing directly with providers. These aggregators are typically referred to as a coalition or consortium; some are community-based hospital plans. Employers' objectives include a focus on a long-term strategy and design to overcome cost containment obstacles.

With access to new transparency data, the aggregators use the visibility into pricing structures to negotiate payer equity, monitor quality scores, and better facilitate value-based care. Furthermore, simply coordinating with groups of clinicians, hospitals and other healthcare providers to provide high-quality care is an excellent first step in any program design to incentivize employees and optimize health expenditures. For that matter, stronger partnerships between employers and providers can help lay the foundation for even more transformative change.

DIRECT EMPLOYER CONTRACTING FOR ADVANCED PRIMARY CARE, DIRECT PRIMARY CARE, ACCOUNTABILITY CARE ORGANIZATION AND OTHER HIGH-PERFORMANCE PROVIDER SERVICES

Along the value-based care continuum, which is an option outside of the health plan, is the opportunity for employers to directly contract with advanced primary care, direct primary care (DPC) or accountable care organization (ACO) for better access to primary care services and other high-performance provider services. Some early adopting employer examples:

Example 1: Accountable Care Organization (ACO)

Although ACOs are primarily used in Medicare arrangements, some private plans have contracted with ACOs to create an affordable, outcome-oriented benefit. Employers like Intel, Micron Technology and Boeing have been pioneers in this space.¹⁵

Example 2: Center of Excellence (COE) Programs

As many benefits teams may recall, early center of excellence programs by Lowe's and Walmart, among others, targeted high-cost interventions and partnered directly with healthcare entities utilizing bundled pricing to optimize costs and outcomes.¹⁶

Example 3: Integrated Independent Third-Party Administrators

Unlike traditional models where employers contract with carrier/payers, independent TPAs are expanding their services to include direct to provider contracting model(s), allowing employers to partner directly with disease management point solutions, ACOs and other advanced primary care, as well as other high-performance providers to design value-based care solutions. This alignment between providers, patients and the employer incentivizes better health outcomes and lower costs. It also aligns clinical processes and financial incentives between stakeholders (e.g., employees receive premium reductions for participating in condition management programs) as well as eliminating administrative barriers.

Navigating direct provider negotiations is a time and resource-intensive process and for benefits departments with limited bandwidth, overhauling contracting models would be a formidable endeavor. With so many employers relying on their broker or the plan itself for strategic guidance, leveraging experienced consultants or advisors to facilitate these discussions can keep the focus on value-driven outcomes, and the methods in place to minimize disruption. As most employers continue to remain dependent on their plan for healthcare delivery, the exploration of alternative solutions, such as direct contracting, has yet to reach its full potential.

POINT SOLUTIONS

For many years now, employers have been inundated with a seemingly never-ending array of novel point solutions designed to address chronic health conditions, gaps, inefficiencies or a specific component contributing to rising benefit costs. Although the vendors of these products have been successful in raising awareness of solutions that deliver positive outcomes outside of the health plan, emerging trends show that many fragmented, one-off offerings are actually hindering employers' capacity to align benefits, well-being programs and health-care partners under a single strategy focused on overall population

health. In addition, point solution programs pose unique compliance challenges, including implementing and coordinating point solution program compliance requirements in conjunction with the major medical plan.

Rather than implementing additional disjointed point solutions, employers are increasingly seeking integration strategies that consolidate disparate vendors and create a seamless experience for their workforce, allowing for a holistic view of data and a more strategic approach to workforce health and cost management.

Integrated platforms can mitigate these risks by streamlining administration, coordination, data aggregation and providing a unified experience. Furthermore, rethinking point solution offerings can help identify and prioritize those solutions that are beneficial, relevant and in line with your value-based care offering and those that are causing your efforts to become brackish.



In Focus

Point Solution Fatigue¹⁷

A condition that occurs when HR professionals become overwhelmed managing the multiple vendors behind an organization's total benefits program.

The concept of "point solution fatigue" has developed over the last few years, the effects of which are felt by not only members but HR teams as well. Fragmented point solutions pose administrative, tracking, cost and branding risks. Juggling multiple vendors strains resources and hinders holistic measurement. Vetting and integrating disparate tools increase expenses. Without cohesion, it undermines program branding and engagement.¹⁸



Pharmacy Benefits

Carving Out Opportunity

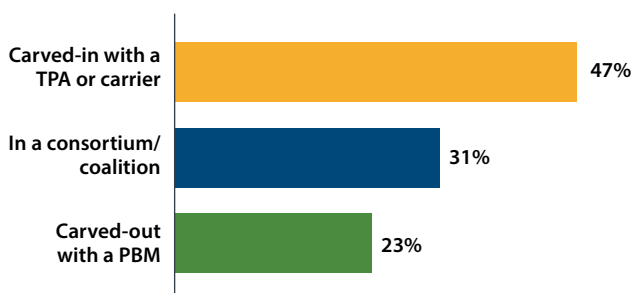
Along with optimized funding structures for the medical plan, employers are looking for strategies that can maximize the impact of pharmacy benefits to further control overall costs. There are two main ways self-insured employers can go about this: carving in or carving out their pharmacy benefits.

According to the Centers for Disease Control and Prevention, 6 in 10 adults in the US have a chronic disease with 4 in 10 suffering from two or more.¹⁹ As heart disease, cancer and diabetes are the leading causes of death and disability in the United States and leading drivers of the country's \$4.1 trillion in annual healthcare costs,²⁰ employers have a vested interest in managing costs resulting from employee chronic

conditions. With growing year-over-year pharmacy spend, especially due to specialty medications like Humira and the rising popularity of GLP-1 medications, the need for pharmacy strategies aimed at optimizing overall prescription drug costs is becoming increasingly urgent.

Deciding to carve-in or carve-out the pharmacy benefit is contingent on the funding structure for the medical plan. Pharmacy carve-in is typically applied to the fully-insured funding model, whereas carve-out strategies are more common with the self-insured funding model. When weighing the potential to maximize the impact of pharmacy benefits through either strategy, employers should carefully weigh the pros and cons of each. Serious attention should be given to evaluating current pharmacy plan costs, integrating with medical management, accessing data and rebates, reducing administrative complexity, offering plan design flexibility, and leveraging pricing. Timing and potential disruption should also be taken into account as plan changes of this magnitude require significant resources to strategically administer.

Figure 13:
Types of Pharmacy Arrangements Deployed



Comparison: Carve-In vs. Carve-Out

When a pharmacy carve-in strategy is used, the pharmacy benefits are folded in with the medical benefits to provide integrated, comprehensive coverage through a single insurer. The health plan will then either administer the program itself or subcontract a PBM to administer and manage the program. The primary advantages of carving-in pharmacy with medical are evident in the coordinated and streamlined services as well as integrated claims data which helps to better identify cost-saving opportunities.

With a carve-out strategy, the pharmacy benefits are separated from the medical benefits and managed outside of the health plan. This typically occurs within a self-insured funding structure and results in the employer contracting directly with a PBM. Carve-outs occur on two levels of the medical insurance business: payer level and plan level. In plan-level carve-out situations, the insurance provider, employer or sponsor assigns some benefit to a third-party contractor.

By carving out pharmacy plans, employers have the flexibility to shop around and design a benefit plan that best meets the needs of participants at a lower price. Additionally, the ability to have a flexible plan design allows employer groups to react swiftly to industry changes and adjust their plans for maximum value.


Figure 14:
Comparison: Carve-In vs. Carve-Out

Carve-In	Carve-Out
Contract for medical and pharmacy is with one vendor, which can simplify administration and management	Flexible plan design and clinical programs that can help reduce costs
Potential for better coordination of care between medical and pharmacy benefits	Standard language in the PBM contract allows for increased transparency
Easier coordination with stop-loss insurance	Access to pharmacy claims data
Less flexibility with plan design	Audit rights include: claims audit and operational assessment
Combined medical and pharmacy contract allows for limited transparency and audit rights	
Limited access to claims data experience to see if you are “winning” or “losing” under the fully insured mode	
Limited audit rights, if any	
The contract typically includes penalty fees if the employer wants to change to a carve-out in the future	

Carve-out pharmacy plans often involve direct contact with clinical experts who provide perspective and insight on patient health and plan design. Proactive clinical experts are largely responsible for patient well-being and plan success.

Lastly, carved-out pharmacy plans provide oversight to employer groups.

They offer employer groups a greater understanding of their pharmacy spend and the ability to negotiate better deals based on informed decisions. Audit rights, claims data, clear definitions, discount and rebate guarantees, and market checks are strong elements of a pharmacy benefit carve-out.



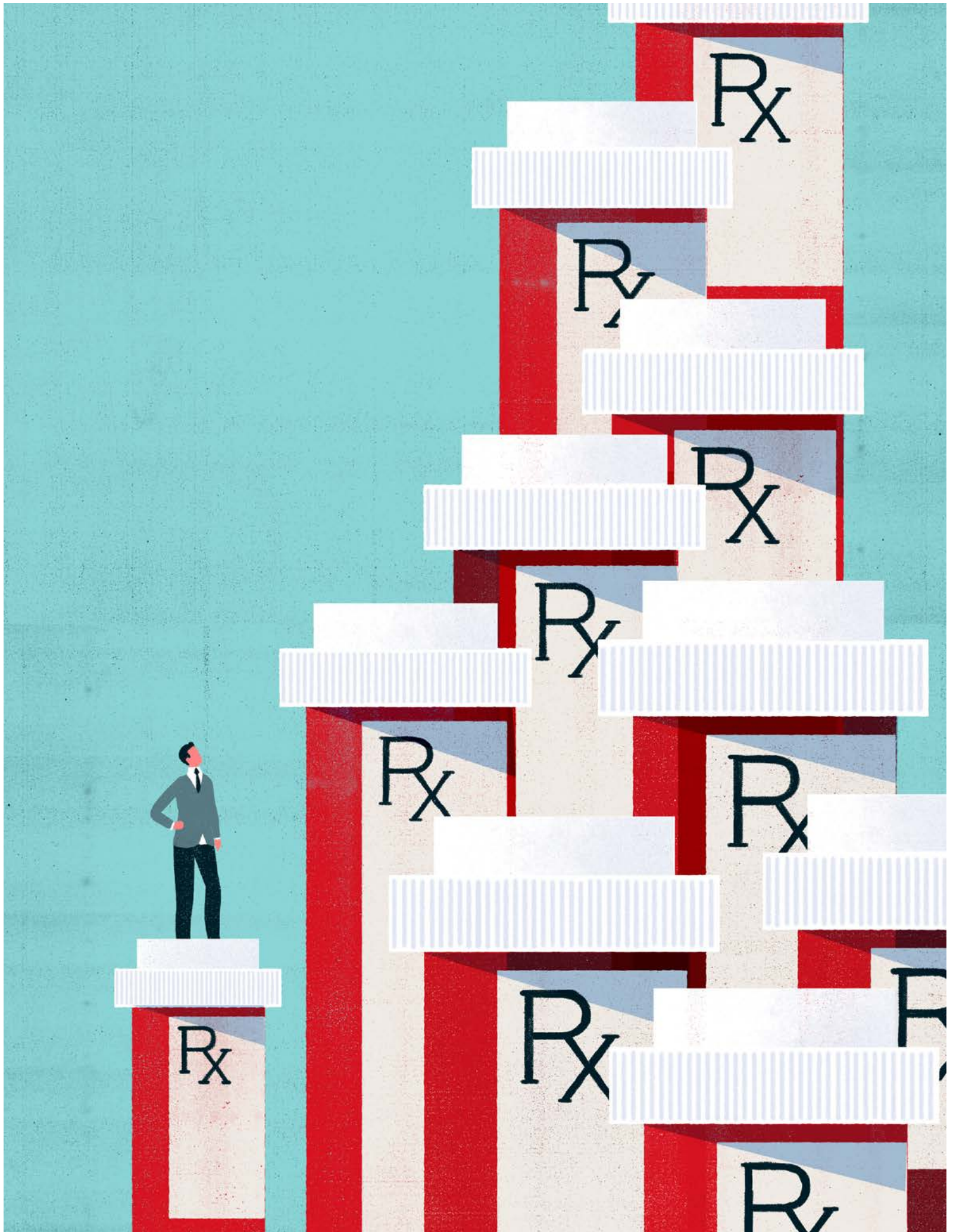
In Focus

Carve-In

A management strategy in which the employer contracts directly with the medical plan vendor for medical and pharmacy benefits.²¹

Carve-Out

A management strategy in which the employer contracts with a specialist firm or pharmacy benefits management (PBM) vendor to administer some or parts of its pharmacy benefits program.



Rx Cost Control through Claims Data

Carving out pharmacy grants plan sponsors access to Rx claims data, which is key to any Rx strategy. Data provides insight into what is currently taking place within the Rx plan as well as emerging trends that can inform cost-containment tactics. By analyzing quantitative information on drug spend, employers can get a snapshot of the root causes of their highest expenditures and uncover opportunities to better manage those costs through solutions such as therapeutic alternatives, identification of inappropriate utilization of high-cost specialty medications, auditing for waste and non-adherence, or identifying members who could benefit from care management programs.

Once a plan sponsor carves out pharmacy, they also gain access to a team of experts who can help analyze their claim data and identify real-time solutions to inform planning and strategy. Improving the accuracy of forecasting can help prevent overspending on prescription drugs. By involving pharmacy consultants in monitoring the current status of GLP-1 drugs, upcoming major changes in biopharmaceuticals and the future wave of gene therapies, that team can be better positioned to offer proactive advice to plan sponsors on how to mitigate the costs of pipeline drugs before they impact the market.

Balancing GLP-1 Drug Demand

The high costs of GLP-1 drugs, which average \$1,200 to \$1,400 per month, are giving employers pause. Indicated for Type II diabetes, obesity, and overweight, drugs like Ozempic and Wegovy are skyrocketing in popularity due to their effectiveness in weight loss. Because they also lower blood sugar levels and have been shown to lower blood pressure, improve fatty liver disease, and reduce the risk of heart disease and kidney disease, it could be argued that this class of drugs is the most popular in America today.²²

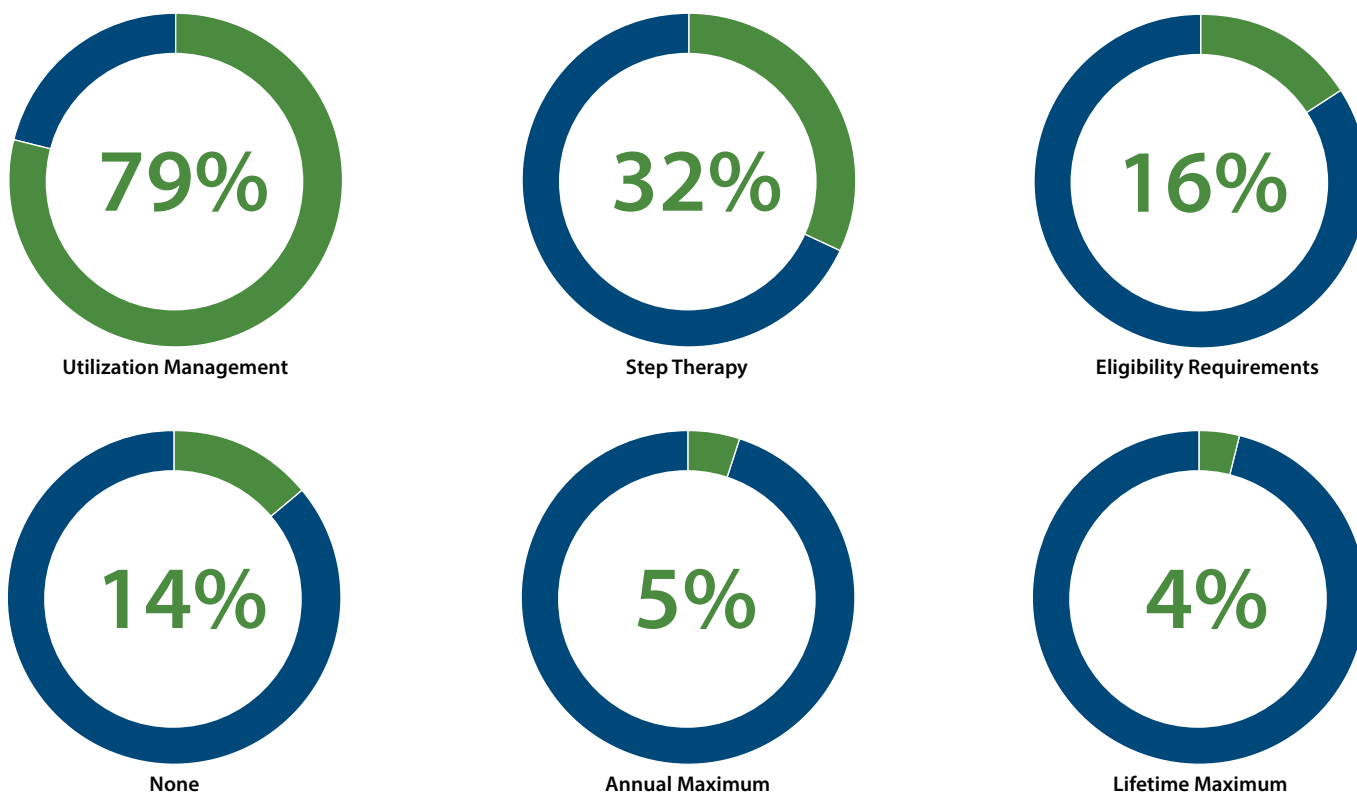
Despite the long list of increased health risks that accompany diabetes, obesity, and overweight, such as heart disease and cancer, many companies are wrestling with whether to cover these weight loss medications in their sponsored benefits health plans. With obesity

affecting 42% of US adults (projected to reach 50% by 2030),²³ the demand for these weight loss drugs has complicated efforts to manage rising healthcare costs.

The path toward health is often associated with weight loss, and it's hard to ignore the potential impact these drugs can have. Coupled with a reported 44% of obese individuals who would change jobs to gain coverage for GLP-1 treatments,²⁴ employers will have to devote serious time and effort to balancing costs for these new therapies and providing access for those who will benefit most from them, but there appears to be growing interest in expanding coverage for these new drugs. As more and more workers are asking employers for covered access to them, balancing employee demand with financially responsible benefits spending is challenging.

Given employee demand as well as the effectiveness of these drugs, plan sponsors are re-examining their coverage options. As off-label prescriptions proliferate, it makes fiscal sense for employers to proactively manage this booming class of drugs.

Figure 15:
 Cost-Control Mechanisms in Place for
 GLP-1 Drugs for Weight Loss (IFEBP)*²⁵



*Respondents were asked to select all that apply.
 SOURCE: IFEBP 2023 Pulse Survey

As the GLP-1 drug class is relatively new and there are no long-term studies, many employers are examining the impact of diabetes, obesity, and overweight on their health spend and their employee's health and well-being. Treating these conditions with GLP-1 agonists is an expensive proposition, and the mishandling of these new drugs could add to those costs. In the meantime, employers should look for enhanced prescribing requirements and utilization management to ensure the appropriate use of these drugs. Furthermore, they should examine the

intersection of their most costly diagnoses and identify whether their true underlying cause is, indeed, obesity.

By pinpointing those areas that are driving costs upward, employers can begin to define what success looks like. For some organizations, success may lie in keeping year-over-year increases below medical trend. For others, success may be defined by achieving greater flexibility and control by going self-funded. For pharmacy plans, in a self-funded environment, it could mean carving in or carving out PBM services

from the plan to achieve optimal savings. Given that consulting pharmacists provide valuable insights into reasonable plan design modifications based on current utilization patterns and identifiable opportunities, they offer employer groups a greater understanding of their pharmacy spends and the ability to negotiate better deals based on informed decisions. Regardless of the exact definition, setting clear markers of success around cost and plan optimization is essential to the design of multiyear strategies.

In Focus

Biosimilar Drug

To be called a biosimilar, a biologic drug must be shown to be as safe as, work as well as, and work in the same way as its reference drug. It must also be used in the same way, at the same dose, and for the same condition as the reference drug.²⁶

Managing Biosimilar Momentum

Most specialty medications are large-molecule biologics that come at a high cost. Controlling spending on these medications is fundamental to any Rx plan design.

In January of 2023, California biotech Amgen released its drug Amjevita, the first biosimilar to Humira — the best-selling drug in the history of pharmaceuticals. Humira is an injectable tumor necrosis factor blocker indicated for the treatment of rheumatoid arthritis and several other autoimmune conditions such as Crohn's Disease and psoriasis.²⁷ The release of this first biosimilar was significant as it put an end to Humira's \$200 billion rein of unopposed revenue.²⁸

Biosimilars are just what they sound like — in comparison to biologics they are similar. In fact, there is no significant clinical difference between a biosimilar and a name-brand biologic. So, when a branded biologic drug loses its exclusivity, a biosimilar, if approved, is immediately launched, offering patients

a lower-cost alternative. According to drugs.com, there were 44 approved biosimilars as of November 2023, with more than 100 more under development.

All this comes as great news for employers given that by one estimate, plan sponsors see an average annual cost of \$38,000 at the member level to cover specialty drugs and typically speaking, specialty prescription costs account for 50% or more of an employer's total drug spend.²⁹

As of the time of writing, there are now nine FDA-approved biosimilars for Humira, with three more pending approval. As use of these biosimilars increases, it is projected that there will be a significant financial impact in 2024 or 2025. As more patents expire and the exclusivity period ends for other specialty drugs, there will be more cost savings opportunities for pharmacy.

In 2021, McKinsey declared that an inflection point for biosimilars had arrived.³⁰ This insight was based on the substantial growth of the biosimilars market, opportunistic regulatory

environments, and the pharma companies themselves continuing to innovate with new products. Much like generic medications, the current and future success of the biosimilar market is partly contingent on the fact that they can offer their medications at a lower price in comparison to their costlier name-brand biologics. While these lower-priced products proliferate and patient access increases, the clock continues to tick on patent exclusivity for incredibly expensive, big-selling drugs.

Most famous among these expirations was AbbVie's exclusive patent over Humira in 2023, which now faces competition from several new biosimilars. Other therapies from Johnson & Johnson, Takeda, AstraZeneca, Roche and other organizations are also on the precipice of facing biosimilar competition.³¹ As more of these therapies reach market, plan sponsors will need to review coverage and reimbursement strategies. As a projected \$76 billion in projected savings is on the immediate horizon, employers will further need to ensure minimal disruption for employees as they evaluate different scenarios to maximize cost-savings with these new biosimilars.³²



*Specialty prescription costs account for **50% or more** of an employer's total drug spend.*

Preparing for the Rise of Gene Therapy

Gene therapy is a cutting-edge tool that modifies or manipulates gene expression to treat genetic diseases.

Unfortunately, with unbelievably high costs attributed to handling and controlling the cells or viral vectors to produce them, they are, by far, the most expensive therapy on the market. As a result, the rise of gene therapy treatments could eventually threaten the funding system for the US healthcare system as average costs *per dose* range from \$1 to \$2 million dollars.³³ For an employer-sponsored insurance plan, especially a smaller plan that bears its own risk, the impact of one of these treatments could be catastrophic if not properly prepared for and managed.

As of mid-2023, the FDA has approved 12 gene therapies for conditions such as hemophilia B, beta-thalassemia, and retinol dystrophy, among other predominantly rare conditions. This may seem like a small number, but considering that the first gene therapy was only approved in 2017, it's clear that pharmaceutical companies are working diligently to bring more of these therapies to market. Although they treat extremely low prevalence conditions, the probability that every employer will eventually be impacted grows with each new approval. For example, with research ongoing, it is thought that these therapies may one day evolve to treat other inherited disorders, such as cystic fibrosis or sickle-cell anemia, in the future.

Given how rare the qualifying conditions are for gene therapies, as well as the limited types of treatments available, the current probability of this happening is extremely low. As more gene therapies come to market, though, the likelihood of such an event will correspondingly

increase, which may require consideration of new payment models.

Indeed, the financial exposure for employers grows with the expansion of gene therapy. Preparing for it will require a multiyear, data-driven strategy to mitigate future risk. Current wisdom suggests that stop-loss insurance should protect employers in a fashion similar to biologics, and for the vast majority of employers, it will. However, for patients already identified by the carrier as high-risk because of diagnoses or medication usage, there are typically terms written in the contract that exclude coverage for these individuals. This could leave the employer exposed to the risk despite having purchased protection.

NFP has been working to develop opportunities with payment arrangements and stop-loss carriers to share and spread out the financial risks of gene therapy, but many employers have not mapped out their potential exposure scenarios as of yet.

In Focus

Gene Therapy

A technique that uses gene(s) to treat, prevent, or cure a disease or medical disorder. It often works by adding new copies of a gene that is broken, or by replacing a defective or missing gene in a patient's cells with a healthy version of that gene.

In the coming years, employers should pay attention to the number of new gene therapies coming to market and *strict* attention to those whose use is indicated for more common conditions e.g., different types of cancer. They should also watch for increases in premiums and deductibles from stop-loss carriers for gene therapy, as well as changes to coverage levels and cost-sharing. Consulting with a trusted advisor may lead to a conversation about carving out financial responsibility for specific gene therapies from employer health plans, although the current availability of such plans is limited, and coverage typically only lasts one year.

With hundreds of potential new gene therapies in development, it is almost certain that alternative funding models involving the plan sponsor, stop-loss carrier, and pharmaceutical company will arise to better manage these new treatments. Right now, consultants are strategizing with larger insurers and PBMs to identify ways to mitigate the risk to self-insured plans. However, the effectiveness of these emerging partnerships and corresponding solutions remains uncertain due to the newness of strategy. Regardless, risk management strategies that leverage integration, data, and cross-sector partnerships will be the most prepared for future developments in gene therapies.

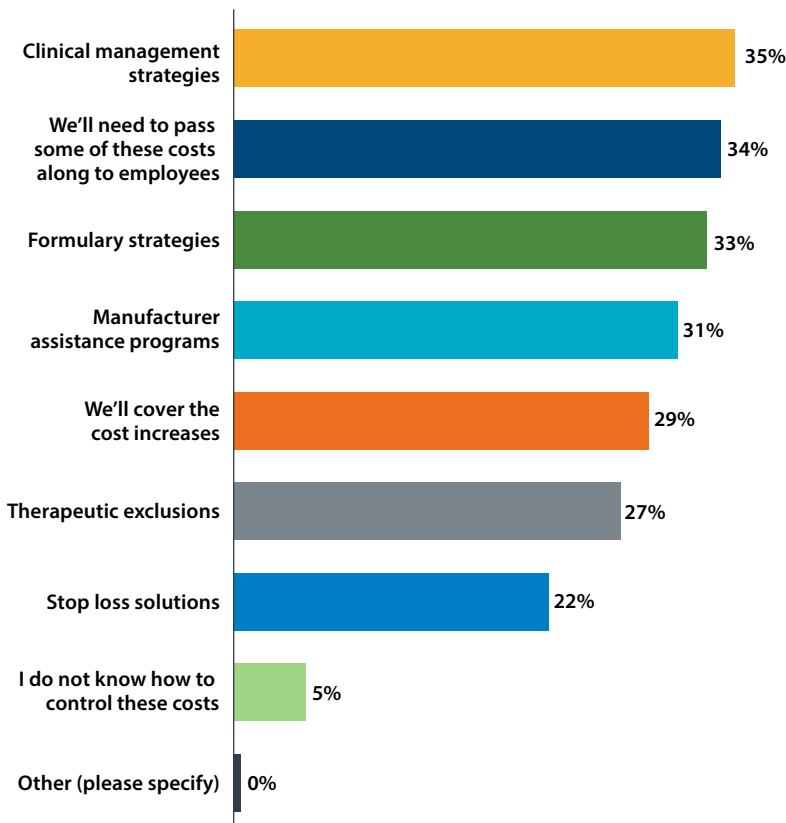
Savings, Flexibility and Control

Carve-out plans have a lot to offer employer groups, including customization, adaptability, insight and oversight. By carving out pharmacy plans, employers have the flexibility to shop around and design a benefit plan that best meets the needs of participants at a lower price. Additionally, the ability to have a flexible plan design allows employer groups to react swiftly to industry changes such as the impact GLP-1 drugs have recently had on plan design, and adjust their plans for maximum value.

Removing the pharmacy benefit from the medical benefit and allowing it to be managed outside of the health plan is one of the many positives of carve-out pharmacy. Typically resulting in significant employer savings, carving out pharmacy offers employers greater transparency, flexibility and control with plan design as well as access to rebates and utilization data. Ultimately, the increased leverage and insights of a pharmacy carve-out model enable more impactful management of out-of-control prescription costs.

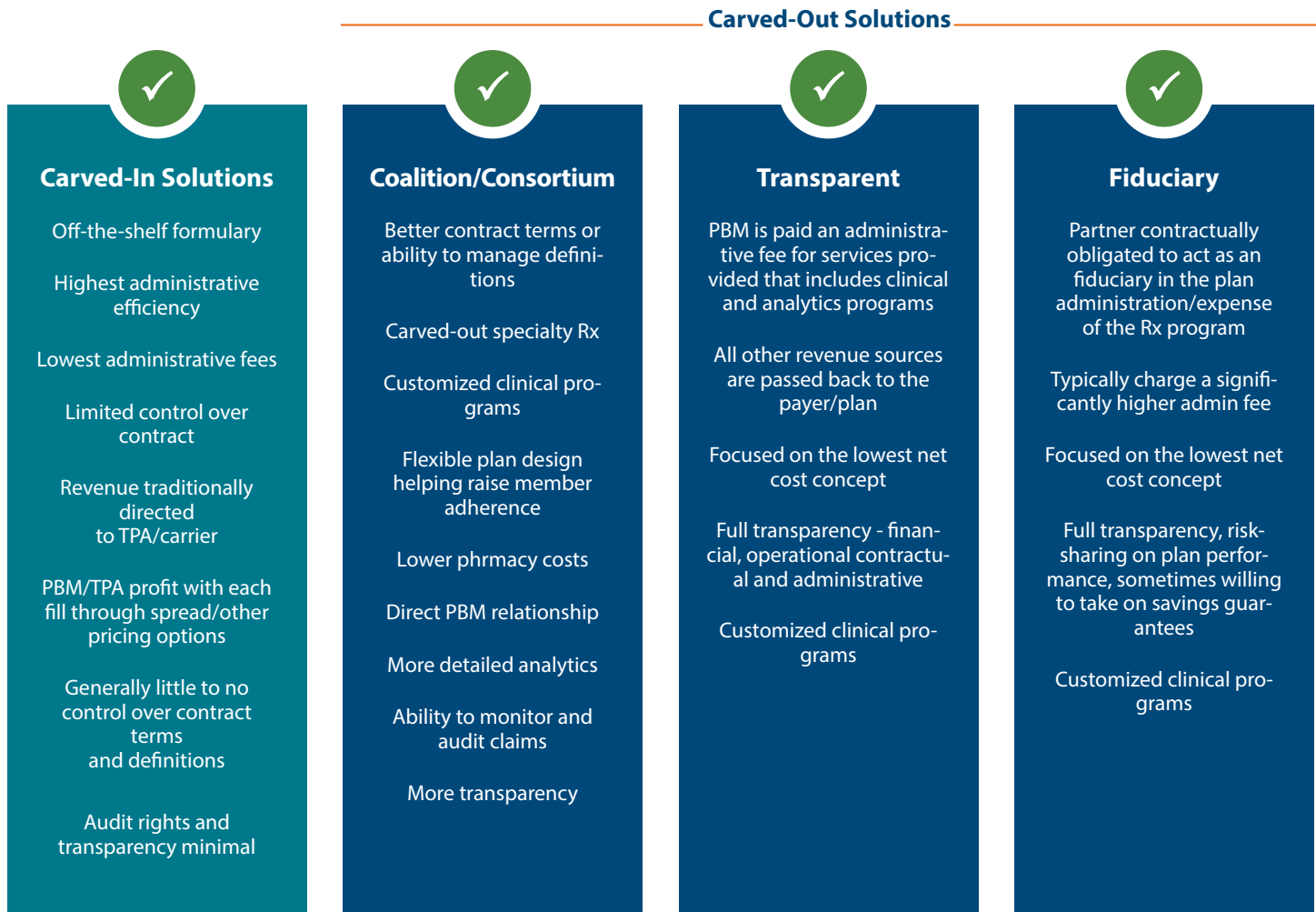
Furthermore, carved-out pharmacy plans provide oversight to employer groups. They offer a greater understanding of pharmacy spend as well as the ability to negotiate better deals based on informed decisions. Lastly, audit rights, claims data, clear definitions, discount and rebate guarantees, and market checks are strong elements of a pharmacy benefit carve-out.

Figure 16:
Strategies for Controlling Prescription Drug Costs*



*Respondents were asked to select all that apply.

Figure 17:
Carved-In vs Carved-Out Solutions



Self-insured plan sponsors who are interested in carving out pharmacy should be focused on finding the right fit for their organization. There are many things to consider in the evaluation, including per-member-per-month (PMPM) cost measures, step therapy, and prior authorization structures, along with denial rates and average costs for the top therapeutic classes of drugs. Formulary options, including standard and customized, are another important concern that must

align with the financial and clinical goals of the organization. Although customizing formulary options can be a complex process, they do allow the plan sponsor some control over volatility by having the capacity to move drugs on and off the formulary. Additionally, plan sponsors should choose the right pricing model that suits their organization's needs.

Lastly, the type of relationship the plan sponsor wants to have with the PBM should be taken into con-

sideration. Based on the size of the group, intent of management, and understanding of utilization and clinical opportunities, employers may want to join a coalition, contract with a fiduciary, or take advantage of a transparent PBM. Regardless of choice, the PBM must align with the employer and their employees' best interests.



Aligning PBM Relationships with Plan Goals

Coalition / Consortium Benefit Management

Pharmacy coalitions and consortiums can be categorized as group purchasing organizations that bring any number of employer groups and plan sponsors together to leverage their combined purchasing power and negotiate from a position of greater strength. Given that these coalitions can number anywhere from the thousands to millions of covered lives, they are able to secure more favorable pricing, rebates, and contract terms that any individual employer or health plan could achieve independently.

In addition, coalitions often offer preferred medication lists, patient assistance programs, and customized clinical programs. Plan sponsors should also expect access to custom reporting and detailed analytics to identify additional opportunities and financial and performance tracking.

Transparent PBMs

Transparent pharmacy benefits empower purchasers with data-driven decision-making based on full visibility into factual drug information. This model places control in the hands of the purchaser, who, by leveraging their own financial, operational, contractual, and administrative data, can make optimal choices around pharmacy offerings. Transparency ensures members have relevant information for informed decisions, while clinical choices follow efficacy and real cost.

Ultimately, transparent pharmacy benefits should work entirely in the purchaser's best interest. It encourages members of the plan to be better engaged in their therapy and can help patients make better choices and, in some instances, increase the likelihood of healthier outcomes.

Fiduciary PBMs

Under a fiduciary pharmacy benefit, the partner is contractually obligated to act not only in the employer's best interest but without any conflict of interest whatsoever. This means that the fiduciary PBM has no ownership stake in any pharmacy nor does it engage in so-called spread pricing, where they would charge the plan sponsor more for a therapy than they would pay the pharmacy. Furthermore, all rebates go to the plan sponsor, and the fiduciary receives no payment whatsoever from pharmaceutical manufacturers.

Eliminating conflict of interests comes at a cost, though — typically speaking, they will charge a significantly higher administrative fee as it is the sole source of their compensation. However, this allows the fiduciary to stay laser-focused on clinical management while securing the best price for medications.

Data Analytics and Trend Drivers

Given that data plays a significant role in identifying trend drivers in a pharmacy plan, there is huge potential for self-funded employers to implement design changes that lower costs and risks with little to no member disruption.



AI and machine learning have the potential to provide unprecedented visibility into cost drivers... as well as savings opportunities.

Bringing a level of transparency into the equation that is, quite frankly, overdue, data analytics puts employers in position to optimize their pharmacy benefit by examining plan performance and utilization, identifying financial and clinical risks, and forecasting costs and potential program impact.

Utilizing real-time data analytics in biosimilar management, gene therapy, and GLP-1 cost-containment can help initiate targeted interventions in key high-cost categories with precision and efficiency. Although biosimilars and gene and cell therapies are nothing short of miraculous, having even a single member of the plan file a claim for one of these therapies could be catastrophic. Therefore, self-insured employers need to consider a multi-faceted approach to pharmacy benefit design, one that involves plan design, clinical oversight, and stop-loss at the minimum.

Involving Pharmacists in Disease Management and Population Health

Employer success in disease management should be measured by the effectiveness of interventions rather than the volume of services. An

often-overlooked player in the design of effective disease management programs is the pharmacist. With expertise spanning medication management, preventive care, chronic disease support, and overall wellness, pharmacists contribute immense value to employers looking to contain costs and optimize benefits in their pharmacy spend.

Partnering with employers, pharmacists provide diversified clinical services, optimizing medication management to ensure appropriate therapy for the population while controlling costs. They can assist in the design of the pharmacy benefit and identify additional savings opportunities through evidence-based changes that optimize medication use without compromising quality of care. They can also assess the effectiveness of a current PBM contract, customize formularies, and provide guidance on specialty drug management and biosimilar strategies.

Involving a pharmacist in workplace disease management programs can also have a positive impact on healthcare costs. Pharmacists are knowledgeable when it comes to designing plans that influence employee behavior and can increase engagement with programs focused

on lifestyle changes and medication adherence. With their expertise in motivational interviewing techniques, they can help fine-tune programs and further reduce population health risks. Their broad training allows them to work with the benefits and well-being team to encourage employee engagement through targeted interventions aimed at improving lifestyle factors that contribute to chronic conditions. As chronic conditions are the major cost driver for most employers, incentivizing healthy behaviors is a key strategy for preventing disease and reducing healthcare costs.

In a nutshell, pharmacists are there to identify and address employer needs. They not only review medication expenditures but can also conduct analyses of overall healthcare plan design and use of clinical programs to optimize medical and prescription-drug management.



The Next Step: Cost and Quality Accountability

Using the “Triple Aim” Approved Clinical Practice

Assessing, evaluating and evolving a medical/Rx plan can be a daunting undertaking. Defining realistic achievements as you start the process will help and suggests the need for an employer’s adaptation to a clinically acceptable process. A Triple Aim approach is one such guideline to establish quantitative and qualitative measures as you optimize your plan.

The Triple Aim was established by the Institute for Healthcare Improvement in 2008. Evaluating the effectiveness of a health plan through Triple Aim standards of care includes:

- 1. Improving the patient care experience for higher quality, safety and satisfaction.**
- 2. Improving the health of populations by addressing social and environmental determinants of health access.**
- 3. Reducing the per capita cost of healthcare.**

Utilizing this initial assessment is an effective baseline for evaluating improvement. Depending on the employer size and funding methodology selected performance standards and guarantees can be applied as a component of a carrier/vendor/third-party administrators’ accountability. Some Advanced Data Analytics platforms provide cost and quality metrics within the data sets to support an employer’s accountability measures. Success markers should align with overall established goals and key performance indicators so that continuous improvements can be evaluated, and evolving strategies fine-tuned for

maximum impact. Done correctly, plan sponsors should be able to identify those strategies that are working well, as well as any gaps or opportunities that require a shift in tactics.

All in all, faithfully monitoring outcomes through advanced data analytics ensures that multiyear cost-containment initiatives stay on track while providing valuable data to identify remediation areas and refine next steps. This may involve adjusting ineffective tactics, doubling down on successful interventions, or implementing additional plan design changes based on the data analysis. Ultimately, the remediation effort should work within the cost optimization framework and identify next steps to overcome challenges and deliver defined success metrics.

Harnessing Cost and Quality Accountability with Technology

The new healthcare transparency laws, paired with the development and use of advanced data analytics, have given employers the capacity to gain greater visibility and a deeper understanding of the minutiae that make up their medical/Rx expenses.

There are fixed expenses (e.g., administrative) which are approx-

imately 20% of total premium and variable expenses (e.g., claims), which are approximately 80% of total premium. The employer's ability to influence plan designs depends on the organization's selected funding strategies. For example, fully-insured, level funded or self-funded for the medical/Rx plans. By identifying areas which have favorable impact on claims costs, organizations can better control variable expenses.

This is paramount as variable expenses are about 80% of the pre-mium spend and can be influenced with appropriate clinical intervention. Allowing the data to drive the areas of focus improves development of a bet-

ter-informed strategy to optimize costs and work with clinical best practices for potential interventions.

Throughout this process, leveraging data to inform decisions at every stage is foundational to any successful cost optimization strategy. Advanced data analytics, including AI and machine learning, have the potential to provide unprecedented visibility into cost drivers and uncover actionable insights on wasteful spending as well as savings opportunities. These emerging tools can further project future trends and accurately model different plan design scenarios to predict their impact on overall spend. These can include innovative

strategies such as the use of healthcare price transparency data to forecast current and future healthcare costs or examining alternative funding methods across the risk/reward continuum.

Ultimately, with surging healthcare costs, employers need strategies to rein in medical and pharmacy spending without disrupting benefits. Fortunately, by leveraging advanced data analytics, they can. Now is the time to strategize the best uses of price transparency and accountability measures, funding models and specialized pharmacy solutions, setting your company up for sustainable cost containment and a healthy workforce.

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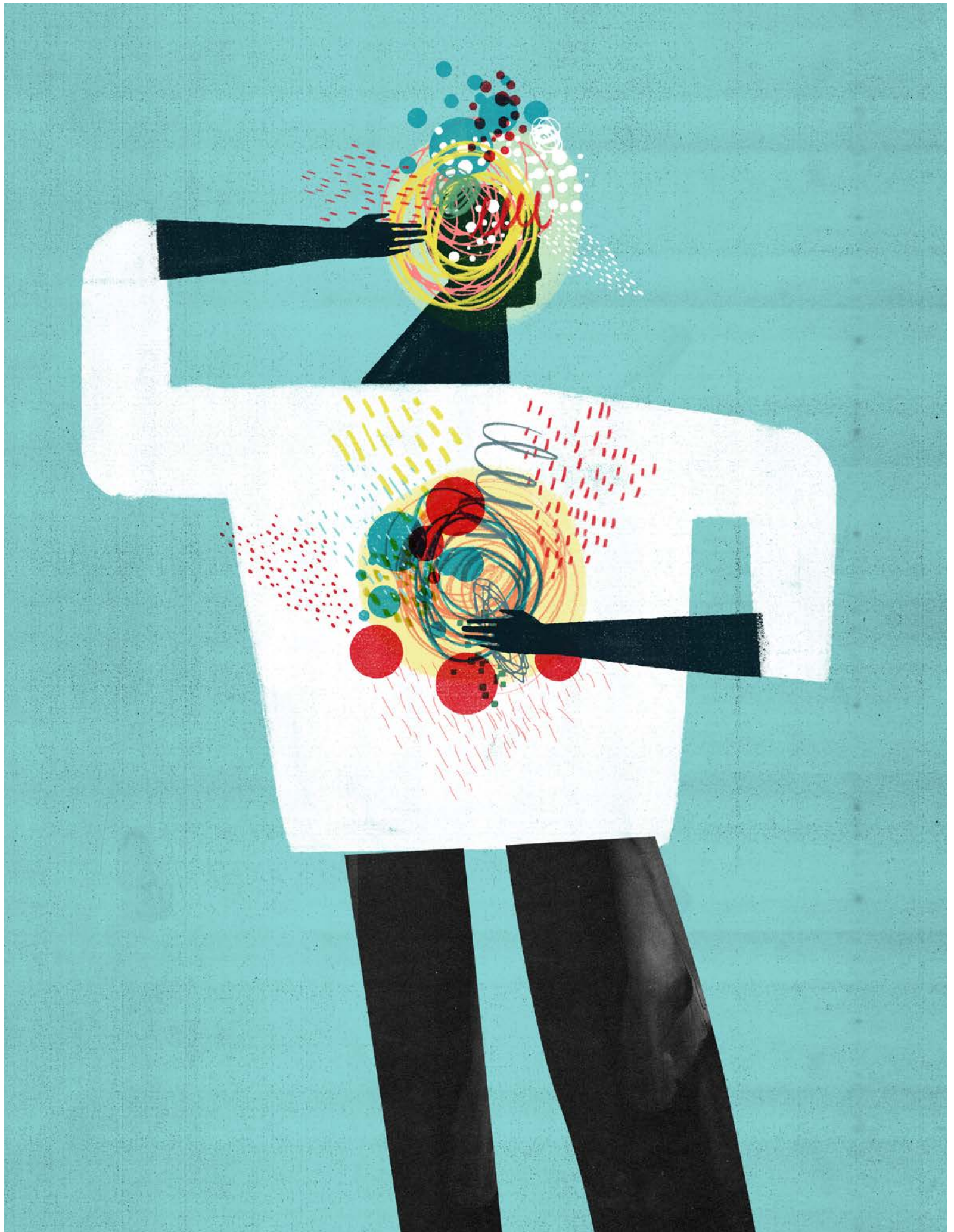
Success through Strategic Well-Being

What key elements drive an organization's success and determine its competitiveness? The Wellbeing Research Center at Oxford suggests that the standard answers to such a question emphasize components of sound financials and strong value propositions — competitive compensation and benefits come to mind. As does prioritizing organizational culture and offering upskilling opportunities.

But how often is the success of an organization associated with something as simple as happiness? If there was rigorous evidence indicating that employee well-being was a valuable business asset, would more organizations start to view employee *happiness* as critical to overall organizational success as well as to the overall health of employees?

The Pursuit of Happiness

Oxford's 2023 study "Workplace Wellbeing and Firm Performance" offers some compelling findings demonstrating that employee well-being is a powerful predictor of corporate success and financial performance. By comparing companies' work well-being scores (as gathered by Indeed) against their publicly available financial data, the study found that organizations where employees report greater well-being demonstrate higher profitability, earnings and market value compared to their competitors.¹



Well-Being Effects

The Oxford study further demonstrated that this finding applies not only to the here and now but is also a reliable predictor of future performance. That's because well-being affects performance in several critical ways, the most obvious being productivity.

As the most productive employees tend to feel healthy both mentally and physically, they are able to be more engaged and focused. An earlier study by Oxford's Saïd Business School supports this. It found that happy workers were 13% more productive and better able to resolve issues independently while having the capacity to dedicate more time to their customers.²

In addition to being productive, happy people also tend to live longer, healthier lives. As higher well-being is associated with better health, it has been shown that positive feelings predict longevity and health beyond negative feelings.³ Other research has indicated that life satisfaction and positive affect have been linked to positive health indicators and behaviors and are generally found to be reciprocal in nature: one inspires the other.⁴ This presents as lower blood pressure, improved immune system function and lower body mass.⁵

Well-being is also an important indicator of lower rates of drinking and smoking, which should come as no surprise as these coping behaviors have been shown to worsen mood over time. Furthermore, those with high levels of well-being often eat well, get regular exercise, and enough sleep each night, all of which help reduce the risk of anxiety and depression.⁶

Implications at Work

These findings have important implications in the workplace, especially when considering that poor health and lower overall well-being are also reciprocal in nature and have an opposite effect on performance and health. For example, low job satisfaction and presenteeism have demonstrable relationships to decreases in work performance, while low levels of well-being are associated with increased stress, anxiety, depression, and other mental health disorders.

For HR managers whose focus is making a business strategy work, it is essential that mental health and mental well-being become the foundation of their well-being strategy. As people are the determining factor of business success, fostering an environment where healthy, resilient employees are more engaged, productive and better able to handle stress is critical to driving business performance and success.

Well-Being Improves What HR Delivers

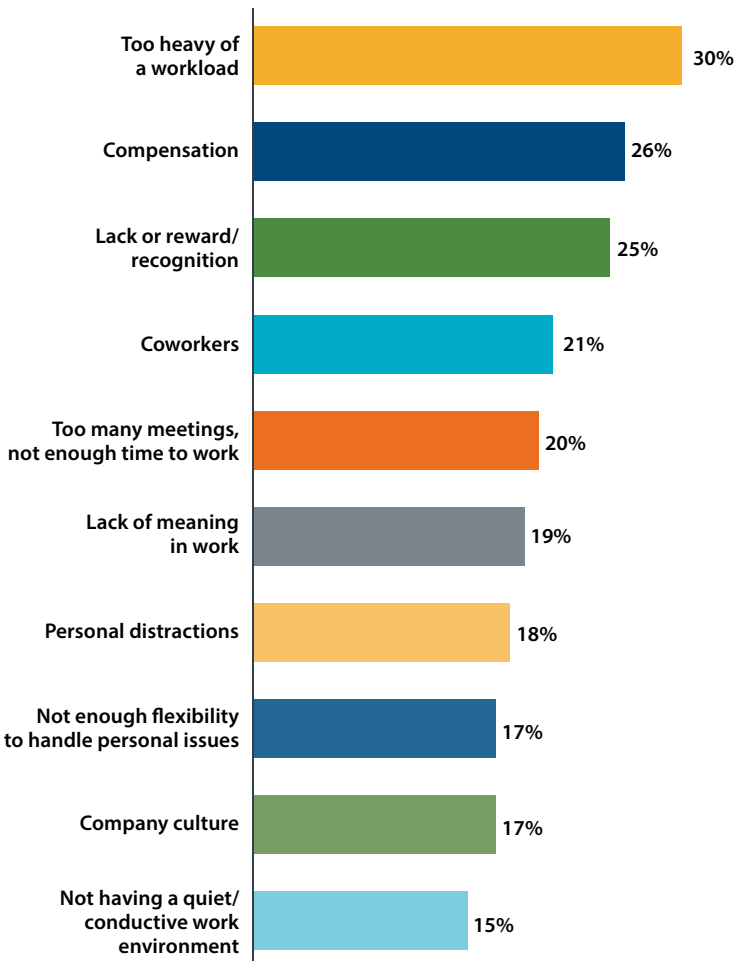
The well-being of employees permeates every facet of HR and what they deliver. For example, compensation structures that provide fair and equitable pay enable financial security essential for wellness. Programs focused specifically on financial literacy and planning empower financial well-being. Effective diversity, equity, inclusion and belonging (DEIB) programs that support a diverse workforce ensure that all demographics feel safe and supported — regardless of background, origin, experience or identity.

In essence, all aspects of HR's people operations and workplace culture collectively shape an organization's ability to foster resilient, engaged, and fulfilled workers. When done right, this has a net positive impact on an organization's bottom line. However, even when employees report that they feel supported in the workplace, many are also reporting that they are increasingly stressed by economic and societal factors. This illustrates that a holistic approach that integrates well-being to combat stress throughout the employee experience while accounting for the impact of outside issues contributing to employee concerns is essential to fully support the workforce.



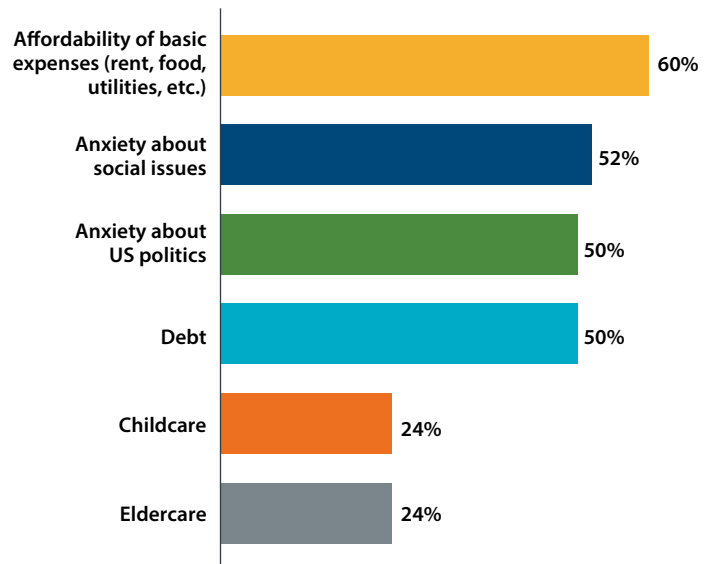
Organizations where employees report **greater well-being** demonstrate higher profitability, earnings and market value compared to their competitors.

Figure 1:
Contributions to Employee Stress in the Workplace*



*Respondents were asked to select all that apply.

Figure 2:
Issues Increasingly Contributing to Employee Distraction*
(Percentage reporting a big or small increase over the last 12 months)



*Respondents were asked to select all that apply.

Figure 3:⁷



Framework for Workplace Mental Health and Well-Being

Well-being is so instrumental to an organization’s success that it’s garnered national attention. Consider the five essential components of workplace well-being as defined by the US Surgeon General:

PROTECTION FROM HARM

Creating the conditions for physical and psychological safety and security. This includes normalizing and supporting mental health and mental well-being as well as operationalizing DEIB norms, policies and programs.

CONNECTION AND COMMUNITY

Supporting worker well-being by fostering socially supportive interactions and relationships. This is done by creating cultures of inclusion and belonging and fostering collaboration and teamwork.

WORK-LIFE HARMONY

Empowering employees to integrate work and non-work demands through autonomy and flexibility. This includes more autonomy over how work is done and acknowledgment of the boundary and overlap between work and non-work.

MATTERING AT WORK

Addressing the human needs for dignity and meaning by letting people know that they and their work matter to those around them. This is based on a culture of gratitude and recognition and can be done by connecting an individual’s work with the organization’s mission and engaging workers in workplace decisions.

OPPORTUNITY FOR GROWTH

Creating more opportunities for workers based on their skills and growth, taking into account the human need for learning and accomplishment.

This framework for mental health and well-being emphasizes the connection between the well-being of workers and the health of organizations. Creating an environment where these conditions are met helps ensure that the workplace becomes a hub for mental health and well-being and puts employers in their best position to drive optimal outcomes for both employees and the business.

The Need to Observe and Investigate

With the pieces in place, the success of any well-being effort rests on the capacity to monitor and identify when employees are mentally strong and resilient — or, as Deb Smolensky, SVP, Well-Being and Engagement, put it in her recent book, when they're "Brain On!" Bear in mind, our brains have outdated wiring that focuses primarily on keeping us safe versus keeping us happy. Therefore, well-being programs need to counter our brains' natural negativity bias and threat response to foster employee fulfillment and optimal performance. It is leadership's responsibility to keep people in a positive energy state and create workdays that are regenerative, free from barriers and obstacles, and mentally strong. For strategy's sake, leaders need to remember that:

- **A leader leads other brains.**
- **An HR team leads the collective brain.**
- **An organization transforms the collective brain.**⁸

Therefore, the actions an organizational leader takes have a direct impact on the employees and the organization as a whole. One of the more important actions a leader can take is being able to proactively identify and respond when your collective organization is in:

■ THE RED ZONE

An across-the-board high-stress environment challenging employees to keep their emotions in check. Examples of this could include tax season for accountants, end-of-year open enrollment for HR, or major holiday shopping seasons for retail workers.

■ THE YELLOW ZONE

Cumulative stress is rising across the organization, and employees are starting to show signs of fight, flight, or freeze. This could be evidenced by a rise in employee complaints or personnel issues interfering with work. Also, an increase in work hours due to new product releases or projects running behind.

■ THE GREEN ZONE

Employees have the resources, skills, and manager support to do their best work in an environment where they're recognized and ideally connected to the organization's mission and vision. Workers tend to also display pride in their work and loyalty to the organization.

This is critical to the success of any well-being initiative. Those in HR monitoring the collective well-being of the organization need to help ensure leaders know the principles and actions needed to keep their workforce Brain On! and the steps to take to pivot and respond when circumstances start flashing yellow or red.

"Rewiring our outdated brains to thrive in the modern world requires dedicated training in mental fitness," says Deb Smolensky, SVP, Well-Being and Engagement. "Brain optimization through evidence-based well-being skills training is the pathway to building the psychological resilience needed to excel at work."



This level of attention needs to be in place to combat rampant burnout, stress or the effects of a potentially negative or toxic culture. Given that HR drives employee experience and engagement by cultivating a positive, supportive work culture, helping employees understand how their brain is wired is critical in developing high-functioning habits that can transform the workday. By teaching people how to optimize their inner capacity, organizations can empower them to thrive, enabling HR to build cultures where people feel valued, connected and set-up for success.

Employees' Changing Views Over the Past 12 Months

Increased Utilization of Mental Health Services

For some, achieving mental fitness and becoming more sophisticated in our thinking and emotional regulation, is not enough. These individuals often require additional clinical mental health services. Over the last several years, employers have taken on a more active role in spotlighting the importance of mental health in the workplace. As workers continue to grapple with ongoing sources of anxiety such as personal finances, uncertainty in and outside of work, and the state of their physical and mental health, many people have turned to mental health professionals and utilize clinical care to help them deal with crisis, traumatic life events, mental health conditions and substance use disorders.

With more than 160 million people comprising the US workforce and the average employee spending more than half of their waking life at work, employers are uniquely positioned to support the mental health and well-being needs of their working population through thoughtful workplace policies, destigmatized benefits and human-centered culture initiatives.⁹ Ultimately, it's an opportunity for employers to embrace higher utilization rates in their behavioral health claims and position employees to take greater advantage of mental health services.

With burnout and stress still running rampant throughout the work environment and wreaking havoc on

employee mental health, providing adequate access to necessary care and treatment demonstrates an active interest in supporting employee mental health and well-being. Although there are costs associated with benefit design to provide such access, failing to support employees and their psychological well-being can prove even more costly.

Employers are clearly investing in mental health. However, with their low investment spend, employees continue to shoulder the brunt of the financial burden, forging a barrier to care. In addition, finding a high-quality, reliable mental health professional actually accepting new patients is increasingly difficult. This combination of unaffordable care with the limited availability of therapists is particularly troublesome. Many struggling with depression, anxiety, trauma or other conditions turn to alcohol, opioids or other substances to self-medicate.¹⁰ Ultimately, limited access to therapy or other treatment can create a void that some attempt to fill with the use of harmful substances — to the detriment of individual and, in many cases, the public's health.¹¹

According to a 2022 Gallup poll, employees struggling with their mental health miss four times more work than those with good mental health. Furthermore, employees reported that their job is more likely to hurt their mental health than support it, while over half of respondents stated that they do not have easily accessible support services.¹²

Figure 4: % of Employees that Find Meaning in Their Work

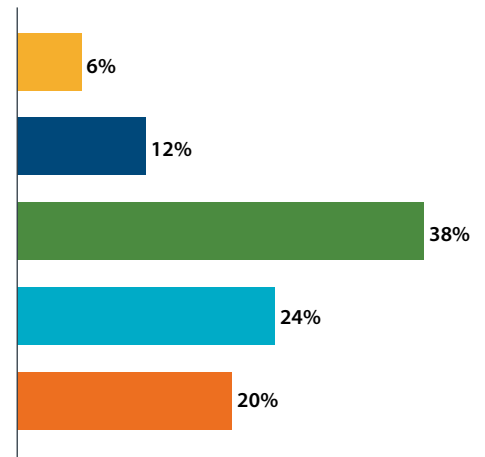


Figure 5: % of Employees that Feel Distracted by Non-Work Issues

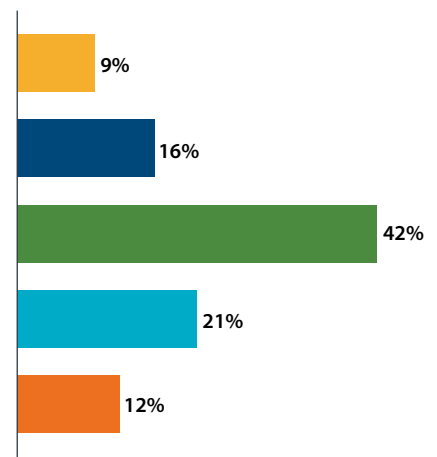
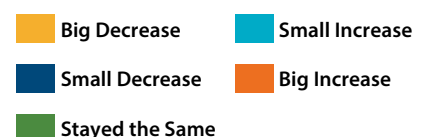
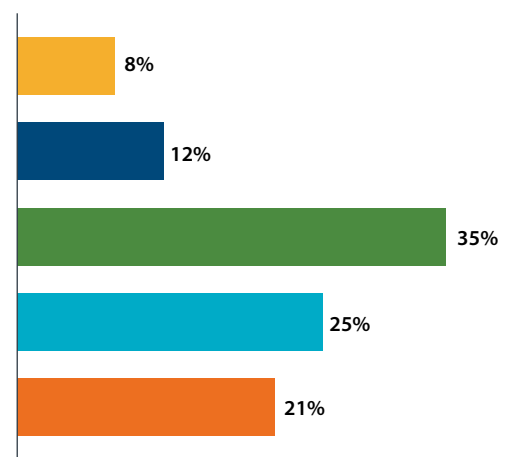


Figure 6: % of Employees that Feel Supported by Their Manager



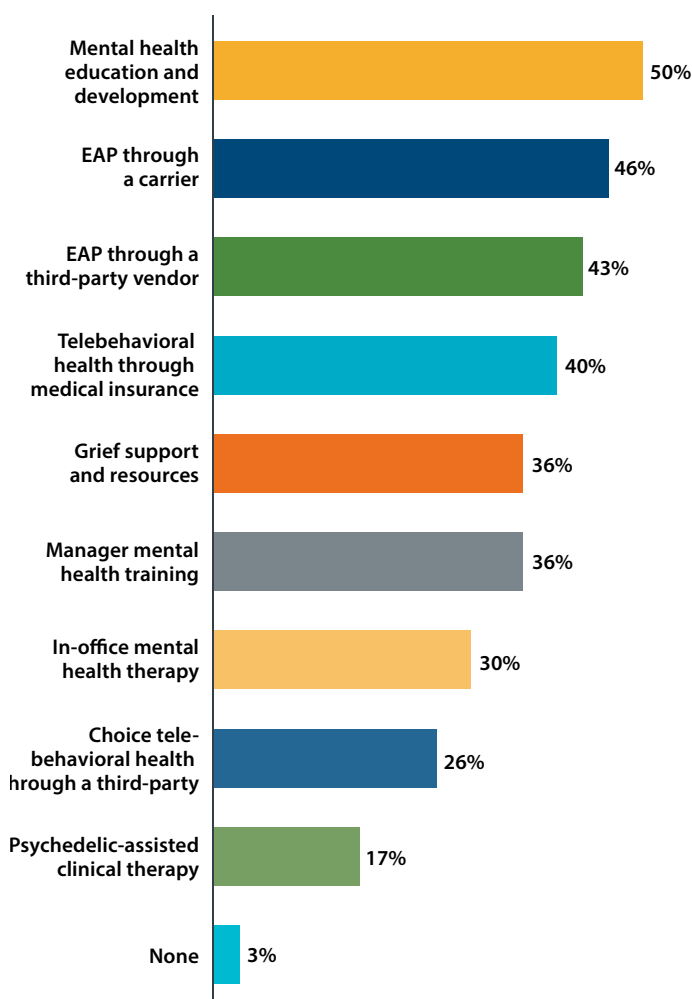
Perhaps even more damning, Gallup further reported that less than half of US workers are even aware of their employer's mental health services.

Unlike typical medical care, where reducing provider interactions cuts costs, quality mental health treatment requires consistent access and frequent

visits over time. People must have access to the ongoing care they need to thrive. With effective providers in network, weekly, evidence-informed psychotherapy or counseling is cost-effective, improving both health and productivity. With any mental health strategy, employers must take the long view — by

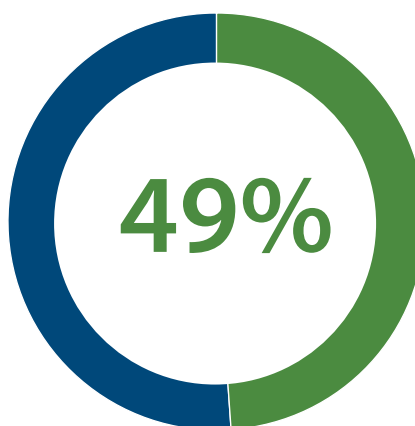
covering high-quality, robust behavioral health services, overall well-being and performance improve, which in turn offsets upfront costs. Over time, these investments in comprehensive care will pay dividends in the forms of physical health, engagement and retention.

Figure 7:
Current Investments in Mental Health*



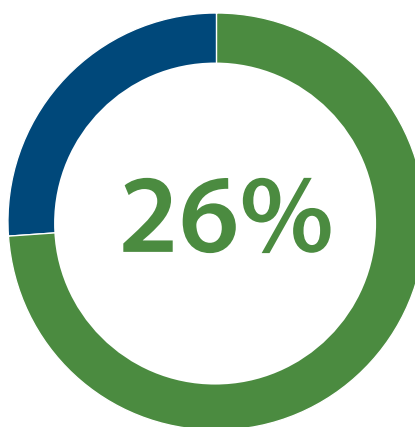
*Respondents were asked to select all that apply.

Figure 8:



about half of employees report that **out-of-pocket expenses** for mental health services **increased** over the last year.

Figure 9:



of employees reported an **average monthly spend** for clinical mental health services of **\$201 or more**

DEIB as a Pillar of Well-Being

Although healthy brains and minds are fundamental to any individual's core needs, efforts at instituting a holistic and whole human well-being program must be inclusive and equitable to support a diverse workforce.

An inclusive environment allows for every individual to feel welcome and all voices to have value. An organization can be as diverse as the entire homo sapiens species on planet Earth, but if their employees don't feel like they are heard, seen and welcome to participate, the organization will not thrive.

That means that solutions need to be in place that ensure that all people of all backgrounds, ages, income levels and positions within the organization are accounted for and fully supported. In this context, fostering equity requires providing personalized support so everyone has what they need to thrive. This includes accommodating needs stemming from race, gender, age, disability, family status and more in policies, spaces, benefits and programming.

Evaluate your workforce's demographics and needs, and structure your programs to accommodate all. Considering neurodiverse employees, those caring for children and aging parents, or even grandparental leave for valuable, experienced employees who want to spend time with new grandchildren is part and parcel of a holistic well-being strategy.

Turning Strategy into Action

Given that poor well-being precipitates chronic conditions, while good mental health boosts health, productivity, connectedness and loyalty over time, it is in the employer's best interest to incorporate a holistic well-being component into any overarching strategy.

Fortunately, employers have choices when it comes to starting down the path to prioritizing whole human well-being. By taking practical steps now, HR leaders can build flourishing cultures where organizations and individuals can reach their full potential.



Five Principles for a Holistic Well-Being Plan

Happiness is a business asset, and well-being is a pillar of workplace success — but how can we put strategy into action? In planning the future of your well-being program, consider mental health and mental fitness, the human needs for autonomy and belonging, and the importance of supporting employees' financial well-being.

Think Beyond the EAP

Mental health offerings like employee assistance programs (EAPs) have been instrumental in workplaces, supporting mental conditions like anxiety, PTSD, depression and others for decades. Unfortunately, these types of offerings only serve the 20% to 30% of people with ongoing mental health concerns who need clinical support, and even then, most realize that a three-visit EAP model isn't enough.¹³

By going beyond the traditional EAP and offering both robust mental health-care and mental well-being skills training in tandem, HR makes a clear statement about the importance of mental health, mental fitness and emotional well-being. Adopting this approach presents further opportunities to incorporate additional mental health policies and measures aimed at destigmatizing care, expanding access and nurturing resilience.

This approach creates what Smolensky calls a “Brain On!” culture, as discussed in her recent best-selling book. Along with making certain that mental health solutions are accessible and available, instituting a Brain On! mental well-being approach across the entire organization is critical to success.

As 100% of employees have brains, offering mental fitness training along with mental health care can dramatically increase mental capacity, deflect distractions, and optimize focus, decision-making, interpersonal relationships, and resilience. That’s because a Brain On! culture reaches the entire workforce by proactively developing mental strength, whereas mental health solutions like EAPs are limited to clinical support for a smaller segment of the employee population with services that are typically only

utilized when diagnosed conditions or significant life challenges arise.

Build a Brain On! Culture

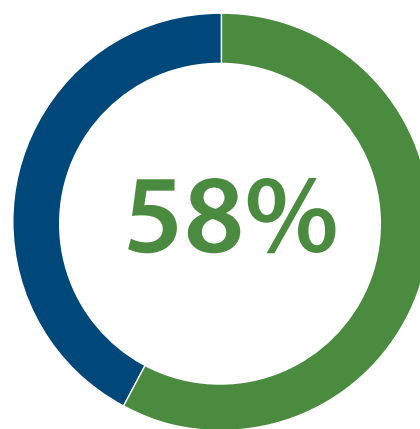
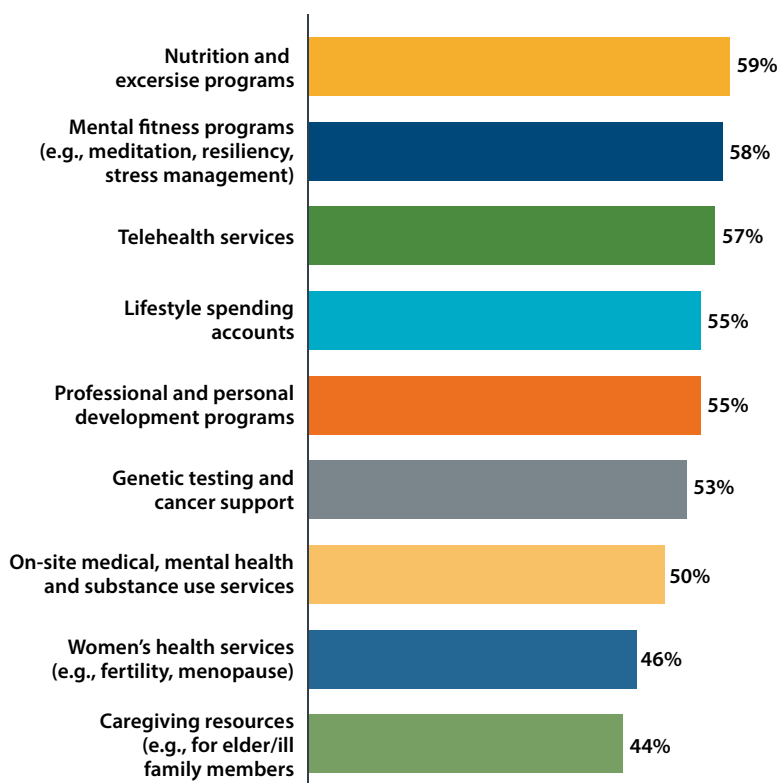
Brain On! is an approach and framework to help your workforce and your organization become mentally stronger, fit, more productive and energized at work. As our brains get easily tripped up and turned off by the daily distractions and obstacles that pop up throughout the workday, we can enter a state of overwhelm where healthy thinking comes to a screeching halt. At that moment, we default into flight-or-flight mode, which shuts down our ability to focus, leaving us vulnerable to negative or unproductive thinking.

Regardless of how smart you are, we are all susceptible to this. Our brains are simply not designed to process the

thousands of pieces of information flying at us each day. There is, however, something we can do to combat this — through mental fitness training, a form of upskilling for the brain, we can ensure that we experience the most engaging, productive, and fulfilling day possible. Through specific mental fitness exercises, anyone can be put in position to nurture a strong, healthy, resilient mindset, one that proactively prepares them to meet challenges, deflect distractions, and stay focused on what matters throughout the workday.

It’s not only imperative to focus and offer mental fitness training in a workplace, 58% of employees are asking for this and need this support in order to better handle the ever increasing complexity and challenges of work and in the world.

Figure 10:
Employee Interest in Additional Programs and Services
(Percentage who would definitely or probably use the following)



of workers are interested in **mental fitness programs**

Getting Started with Brain On!

Adapted from *Brain ON!* by Deb Smolensky.¹⁴

Although this is laid out in greater detail in the book, to set this in motion, employees must first understand how they are wired as humans to improve their performance. This is the first step towards better emotional regulation, which helps identify what makes them feel compassionately connected to and supported by their team.

In other words, this is the foundation of the Brain On! edifice that HR must erect to cultivate the energizing, high-functioning daily habits necessary to transform people's workday. There are four key steps teams need to take to facilitate this transformation.

Step 1: Initiate Brain On! for the Organization

HR must embrace their role and own the Brain On! approach in service to the entire organization. With leadership buy-in, HR can adopt this framework to fully support mental fitness and upskilling. Too often, though, HR groups operate in silos and don't come together frequently enough to facilitate such a holistic, integrated endeavor created around on the employee daily experience and making that as healthy, rewarding, energizing, and inclusive as possible.

Given that an integrated Brain On! strategy requires everyone to march to the same drum, use the same approach, and embrace the same tenets and goals, tight coordination around enabling workforce mental fitness is truly key to cultural transformation. One way of doing this is to build out an HR team calendar to aggregate and reflect communications, tasks or opportunities that touch all employees during the month.

By having a clear picture of the month-to-month employee experience, HR, as the umbrella entity, can tailor its communications to deliver a more focused message and foster deeper, rewards-based engagement. Even when the message is as complicated as launching a new payroll system, for example, providing that holistic, integrated view of what employees need to do and what the experience will look like that day, week or month provides the certainty and clarity that they need to feel cared for in a Brain On! way.

Step 2: Infuse Brain On! Throughout HR Decisions

To avoid obstacles that can derail your efforts, HR must be able to embed the Brain On! approach in strategic decisions around topics such as:

- Attracting, retaining and caring for employees.
- Products and services that HR offers.
- Leadership skills and people responsibilities.
- Organizational brand and reputation across all stakeholders and customers.
- Company innovations, products and results.
- Organizational contributions to the community and to the world.

Ensuring a Brain On! approach can be as simple as pausing purposefully before sending a companywide communication and asking such questions as:

- "Is the message clear, or will it trigger uncertainty?"
- "Will this strengthen the organization's relationship with the employee?"
- "Will it be received as a reward or as a threat?"
- "Will it elicit a brain-off, fear-based response or reaction?"

This strategy, the purposeful pause, is a critical one that will help ensure HR is known as a trusted brand, that employees appreciate, trust and can count on for providing valuable products, resources and rewards.

You can also assess how Brain On! your actions are by using deep listening skills and paying attention to the subtle shifts in the attitudes or responses of people. Do employees or leaders email HR to complain or voice their concerns about an announcement or communication you've recently sent? It could mean that you've triggered their brains to go offline.

When you've unintentionally emotionally hijacked the people in your organization with your message, direction or initiative, they won't be thinking or operating as their best selves during that time. You can monitor how serious this infraction is by the number of people who missed a critical deadline or action item like annual enrollment or compliance training.

It's not that the initiative or change shouldn't be introduced, but rather how it's communicated and perceived — as either a reward or a threat. You'll notice that threats as a collective will create anger, frustration, inaction, immobility or rigidity while rewards will create movement forward or the action or behavior you want to see.



Step 3: Provide Brain Training for All Employees

As the Brain On! team lead, HR's role is to build up people's mental strength and well-being. This requires supporting each employee with the appropriate education, tools, and resources to help them understand how their brain works and how to optimize and harness that power.

What does Brain On! training look like? The old approach of lunch-and-learns or focused trainings on emotional intelligence for managers is well-worn and commonplace. Perhaps you offer certain types of personality and behavioral assessments like Myers Briggs, DiSC, or Gallup Strengths to high-potentials or leaders. These are all very useful and a great start, but generally speaking, these trainings and assessments are often one-and-done, high-level and rarely fully incorporated into people's performance goals, daily interactions or conversations.

Expanding these types of assessments and trainings across the entire organization will help elevate and upgrade the entire company to become Brain On! That's because the Brain On! approach to training has many levels to it and is continuously building skills that are embedded in daily operations, meetings and job tasks. This is done purposefully, given that the goal is to train your entire workforce on how their brains are wired and how to build mental strength.

To create a Brain On! workplace that is high-functioning and resilient, HR should focus on incorporating ongoing training classes and tools that are tied to reducing stress and making the workday more energizing for employees. Examples of Brain On! training initiatives include:

- Growth mindset programs.
- Unconscious bias skills.
- Mindfulness training.

The key, whether building this in-house or using a vendor partner, is to offer a wide range of brain optimization topics and training as multi-level courses year-round that are inclusively designed for all learning styles (auditory, visual and kinesthetic) and delivered through various mediums (print, video, web, app, live training, audio) in bite-sized, easy-to-digest formats.

To measure the impact and efficacy of your training efforts, it's important to remember that mental well-being is a subjective measurement, and only the employees themselves can determine if they feel Brain On! and are having an energized day. Employee feedback is ultimately the best way to determine how successful your initiatives are in strengthening their brains and relationships at work.

Quick informal pulse surveys before and after each class can help measure the effectiveness of each training session. You can also survey class participants at four weeks and eight weeks after the segments end to gauge if they are still practicing and applying their learnings as well as to measure their stress levels. Make sure to include an open comment box in any survey and ask for any success stories and examples that you can use in your future communications to get more people interested and participating. Lastly, vendor utilization reports are also very helpful when determining the success of your program.

Step 4: Individualize Brain On! for Each HR Team

HR teams should emotionally regulate themselves each day while they also emotionally regulate the entire organization. A tall order, without question, but the Brain On! quality of each department's decisions, communications and conversations has the largest organizational impact on creating a culture of care and mental well-being.



*As more organizations require workers to return to offices, there is growing evidence that it is having a **negative impact** on mental health.*

Embrace Autonomy

In addition to skills training, providing employees with the flexibility and autonomy they need to better balance their responsibilities at work and home is crucial to any well-being program. Organizations committed to upskilling their employees through mental fitness training should take the time to design policies around autonomy and flexibility that make sense to the business needs of the organization as well as the mental health and well-being needs of their employees.

One of the most commonly used words in employment trends over the last several years has been “flexibility.” It is perhaps also the most commonly misused word in employment trends. Workplace flexibility essentially refers to the idea that employees can be productive whether they are working from home or in an office, thus a three-day-a-week in-office mandate would constitute a flexible schedule. However, what employees really want is *control* over when, how, and where they do their work, which crosses over into workplace autonomy.

Giving employees autonomy essentially means giving them the freedom to work in a way that best suits them as an individual. The more an employer can provide this within the constraints of the job requirements and the teams’ needs, the more it will enable employees to become independent-thinking, creative problem solvers who drive innovation and effectively collaborate on productive teams.

A recent American Psychological Association survey reported that eight out of 10 respondents reported being either very or somewhat satisfied with the amount of control they have over how, when, and where they do their work. Perhaps more importantly, those who reported satisfaction with their level of control were much more likely to report that their overall mental health level was good or excellent (79%) compared with those who reported being unsatisfied with their level of control (44%).¹⁵

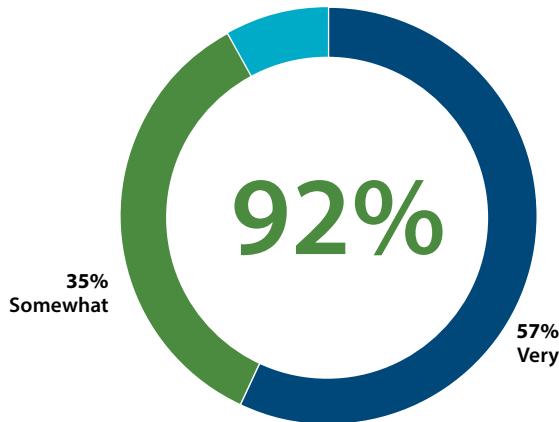
As more organizations restrict flexibility and autonomy and require workers to return to offices across the country, there is growing evidence that it is having a negative impact on mental health. According to a recent Conference Board survey, 34% of workers said that their self-reported level of mental health was lower than it was six months prior.¹⁶ In addition, 37% reported that their level of engagement was lower than it was six months prior.¹⁷ These statistics suggest

that in the return-to-office era, many workers are struggling with their mental health, and it’s having a tremendous impact on their performance.

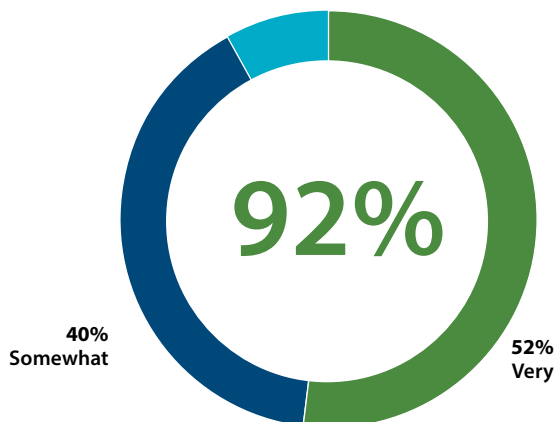
For about half of these workers, having access to flexible or hybrid schedules or the ability to work from home or anywhere they would like are the top things reported that could help their mental health.¹⁸ For employers implementing full-time return-to-office policies, these findings suggest that they may want to find ways to allow for some flexibility and autonomy in how employees perform their work. Otherwise, mandatory office policies may not only lower productivity and engagement instead of improving them, but the policies may also create circumstances where employee mental health and well-being decline to such a degree that they feel compelled to disengage completely and begin searching for employment with more favorable work arrangements.



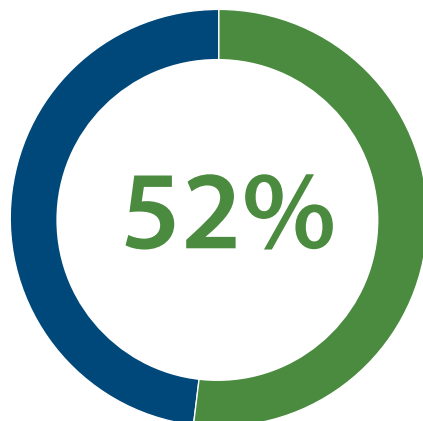
Figure 11, 12, 13, and 14:



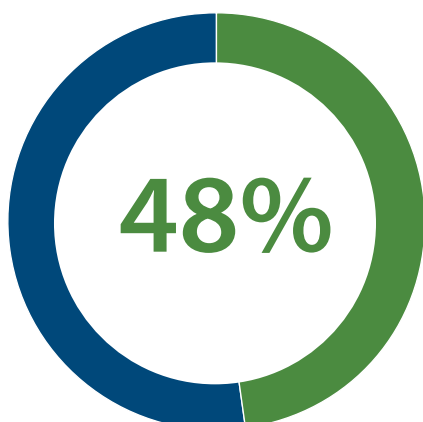
of workers said it is **very** or **somewhat important** to them to work for an organization that values their **emotional and psychological well-being**¹⁹



of workers said it is **very** or **somewhat important** to them to work for an organization that provides support for **employee mental health**²⁰



of workers said that **flexible/hybrid** work schedules would help their **mental health**²¹



of workers said that being able to **work from home/anywhere** would help their **mental health**²²

Figure 15:
Creating an Employee-Centric Workplace

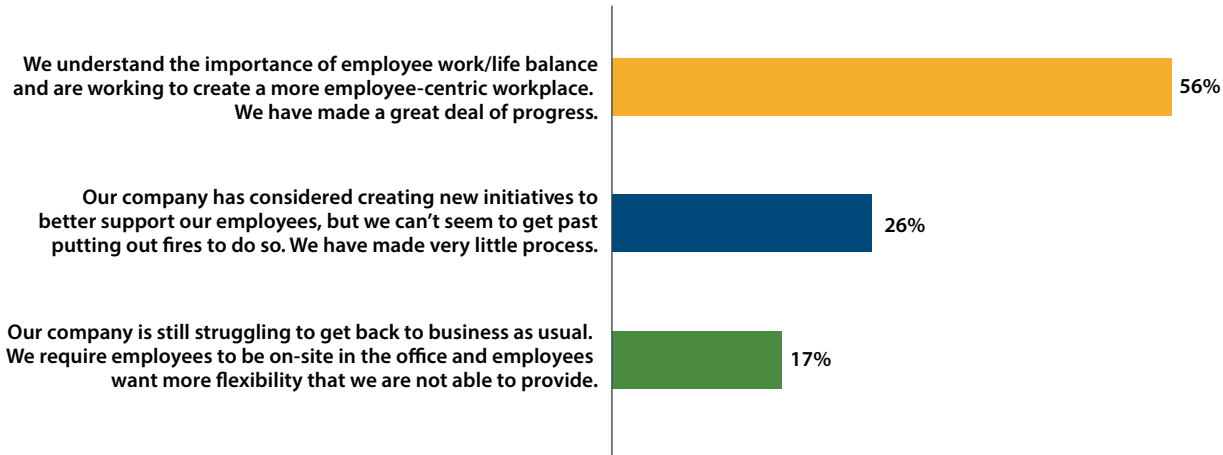
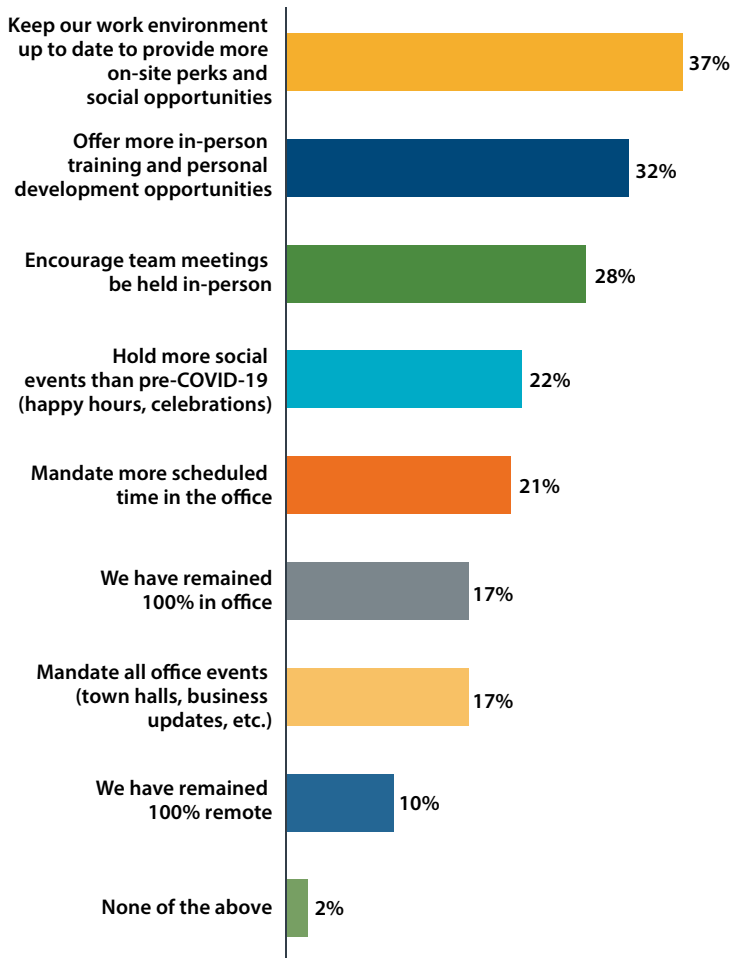
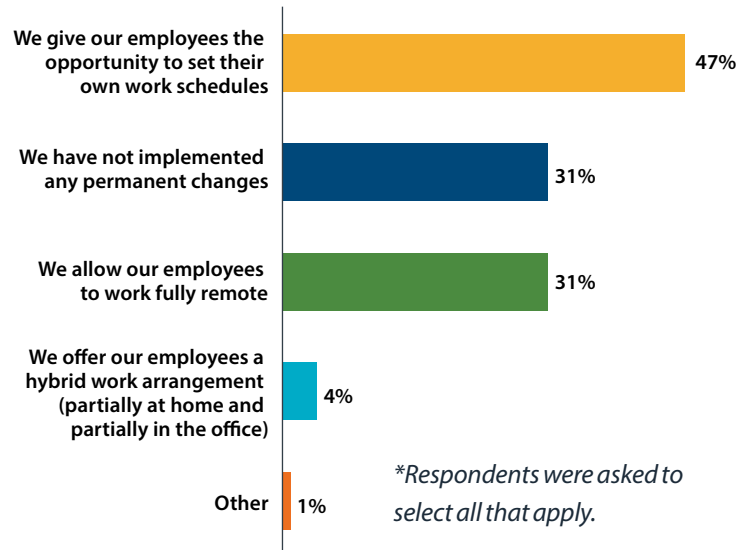


Figure 16:
Back-to-Office Strategies*



*Respondents were asked to select all that apply.

Figure 17:
Back-to-Office Trends*

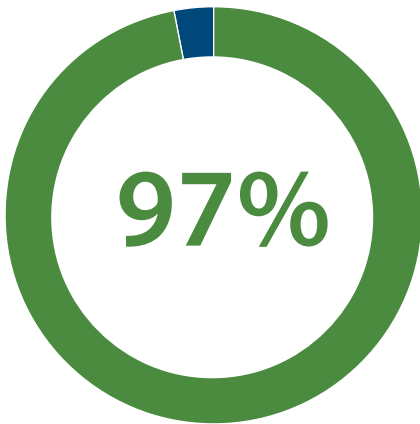


*Respondents were asked to select all that apply.

Support Financial Well-Being

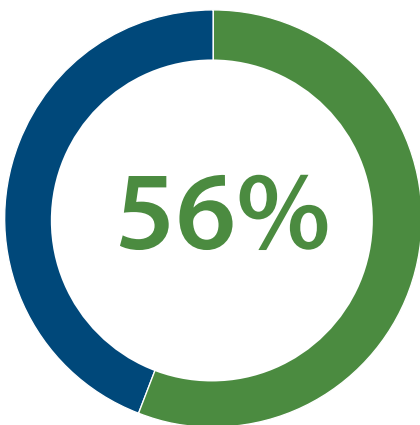
Our findings indicate that the percentage of employees who feel financially well continues to slide. With 97% of employees at least slightly concerned about the economy, more than half of them report that financial concerns will impact their benefits selection this year or they will have to choose lower cost or fewer benefits. For companies

Figure 18:



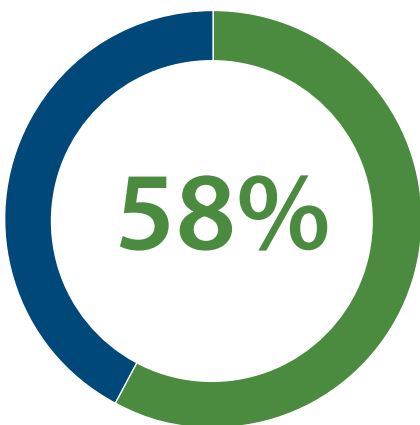
of employees are at least **slightly concerned** about the **economy**

Figure 19:



of employees state that **financial concerns** will affect their **benefits** selection

Figure 20:



of employees state that they will have to choose **lower cost or fewer benefits**

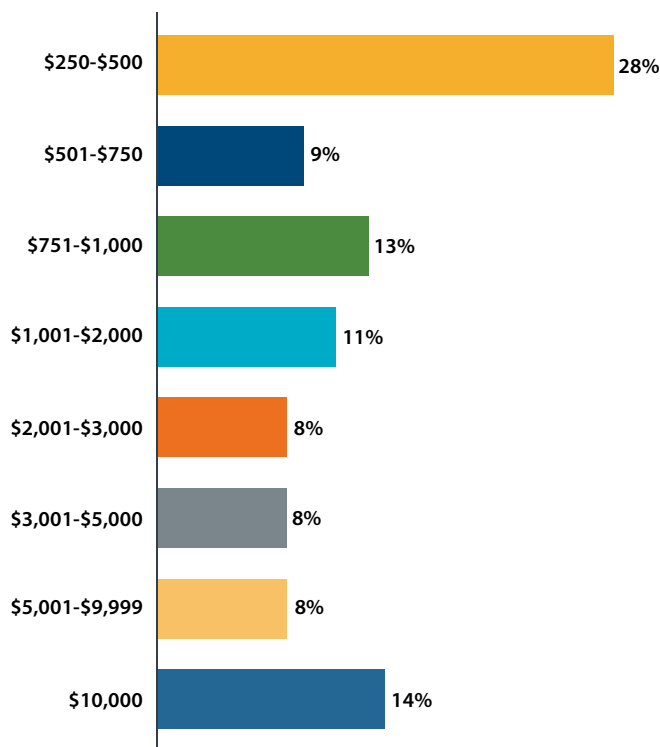
concerned about employee financial well-being, taking action to help them make better financial decisions is crucial.

With clear indications that workers continue to be stressed about their finances, employers should focus on designing programs that educate workers on budgeting, debt management and retirement planning. As inflation and economic uncertainty compound financial stress, offerings like financial literacy courses, access to advisors and student loan assistance have the potential to enable employees to gain some semblance of control over their money matters.

This is especially salient as a component within a holistic well-being framework. Remember that financial stress does more than just hamper employee focus and efficiency, which can lead to increased absenteeism or accidents in the workplace. Monetary strains and worries can also exacerbate mental health disorders like anxiety and depression, contribute to poor health behaviors in general, and drive addictive behaviors disguised as coping mechanisms. When people are continuously worried about making ends meet, they tend to carry that distraction and distress with them wherever they go, including to their jobs.

In a nutshell, financial stress not only negatively impacts work performance but also has the potential to perpetuate a vicious cycle of deteriorating physical and psychological well-being. To combat this, forward-thinking employers are establishing financial education and voluntary benefits as essential to their overall well-being offering. After all, helping employees gain confidence and the competence necessary to manage budgets and shore up savings tends to lower distractions and encourage greater engagement and excellence at work, which is a boon to workers and the organization alike.

Figure 21:
Employee Savings Levels



Prioritize Diversity, Equity, Inclusion, and Belonging (DEIB)

As it is well known that embracing diversity of perspectives and experiences gives organizations a competitive edge, effective mental health and well-being design should always be viewed through a DEIB lens. This edge manifests through strengthened collaboration, innovation, recruitment, retention, customer service, and employee engagement, as well as the overall business performance of companies that have woven their DEIB programs into the fabric of their organizations being. The very premise of DEIB is to foster a culture where all employees, regardless of background, can thrive and realize their full potential and, therefore, do their best work and

make meaningful contributions to the organization's overall success.

However, given the complexity of the modern workforce, there are some segments of the employee population that are at risk of falling through the cracks. Notable are older workers such as grandparents and those with predominantly non-apparent conditions such as women experiencing menopause, neurodiverse workers (with autism spectrum disorder, ADHD, etc.) and marginalized populations. Designing benefits to attract, retain and care for these often overlooked groups of employees can not only reduce unconscious biases that affect these workers but also enable these valuable and underutilized talent pools to shine with their strengths and skills.

Offering Grandparental Leave

With more older employees delaying retirement, innovative employers are offering grandparental leave to attract, retain and care for mature talent. By providing paid time off to grandparents for bonding with their new grandchild, organizations can really demonstrate their commitment to providing valuable benefits for all members of their workforce. Although a new benefit, this idea is gaining traction across the country. According to the 2024 NFP US Leave Management and HR Trend Report, 35% of employers are open to providing this benefit within five years as labor force participation continues to grow for those 75+.²³

Providing Menopause Support

Though menopause impacts over one million women annually, open support in workplaces is mostly limited despite approximately one third of women having reported moderate to severe work difficulties due to symptoms.²⁴ Despite limited attention to this reality, there are many initiatives that employers can adopt to assist employees going through menopause. Chief among them are benefits designed to ease access to hormone therapy and counseling.

Employers can also drive awareness through corporate policies, dedicated health resources and open conversations within a women's employee resource group, which can help destigmatize this natural transition. From a business perspective, employees who are going through menopause are among your most valuable in terms of wisdom and years of experience; in fact, they are the pillars of the workplace. Contrasting the cost of replacing them versus simply supporting them, it becomes clear that money spent on supportive initiatives means money in the bank (and keeping the best talent on the team).

Valuing Neurodiversity

Overall, 15% to 20% of US adults have a neurodivergent condition such as autism spectrum disorder, dyslexia or ADHD.²⁵ This creates a scenario where, even if it's not acknowledged, neurodiversity is already present in the workplace. Unfortunately, given the lack of attention to this reality, many neurodivergent

workers are unaware of how commonplace their condition is. Exacerbating this problem, a 2023 survey found that about half of all neurodivergent workers want to quit their jobs or already have because they don't feel valued or supported by their employer.²⁶

This creates new opportunities for employers to develop an inclusive workplace and benefits and well-being offerings. As neurotypical workplaces can frustrate neurodivergent employees to the point where they feel alienated, their immense talents can often remain untapped. In general, the working world lacks the understanding, flexibility and accessibility that this talent pool needs. As a result, organizations that commit to benefits designed to accommodate these workers and position them as key players within the organization will be in the best position to effectively utilize this segment's unique strengths and perspectives.

For many organizations, this will require a redesign of processes ranging from screening and hiring to onboarding, training and performance management. Furthermore, providing accommodations based on individual needs so employees can be their most productive will be paramount in many cases. Ultimately, efforts in building and supporting this segment of the workforce will require fresh perspectives that can focus on cultivating new strengths rather than enforcing old, outdated or rigid norms. In addition, the path forward should be paved with the idea that it's not those who think differently that need to change. Instead, it's the struc-

tures and mindsets of others holding this group back that need to change.

Cultivating Your Competitive Advantage

Effective well-being design requires a holistic approach spanning mental health care, brain fitness, financial security, and, above all, an inclusive culture. As people are the heart of any business, prioritizing their whole health through brain-centric and human-focused well-being strategies is both an ethical and competitive imperative. Furthermore, by investing efforts into ensuring that every segment of your employee population is enabled to reach their full potential, your entire company can flourish at its highest level.



Investing in People, Investing in Success

Well-being initiatives, in and of themselves, are not cost-mitigation tools. On the contrary, they are part of an investment strategy focused on optimizing the health and well-being of an organization down to the individual worker. A robust well-being offering is a potent component in an employer's revenue and success-generating formula designed to demonstrate care and promote healthy behaviors across the physical, mental, social and financial space.

Critical insights into talent metrics such as job satisfaction, employee sentiment, retention rates, productivity and engagement can help leaders assess the effectiveness of their well-being

programs and fine-tune their people strategy. Tracking these relevant metrics provides tangible evidence that well-being initiatives deliver measurable results across HR, finance and other operational objectives.

Organizations that want to promote higher job satisfaction, loyalty, engagement and productivity should take bold action to improve the holistic health and well-being of their employees. In doing so, companies not only create a flourishing culture but also gain a strategic advantage in attracting and retaining top talent.

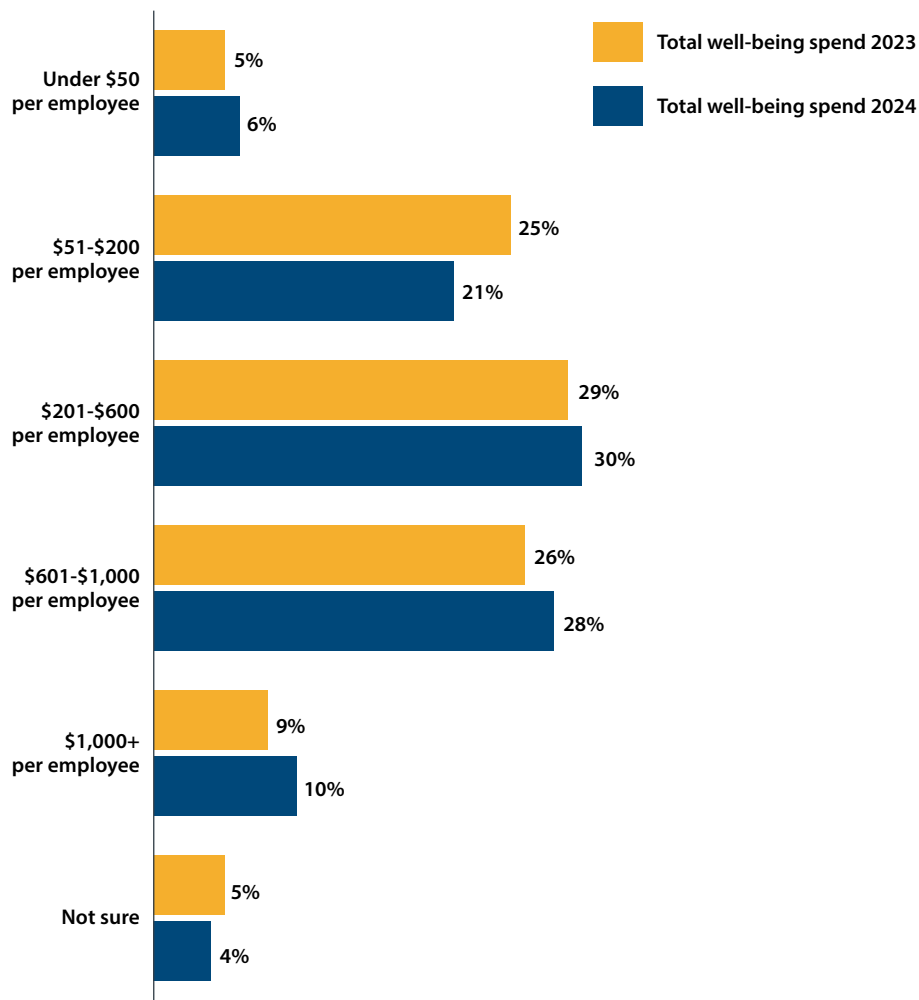
Forward-thinking companies are going even further to focus on caring — adapting their people experience strategy to ensure employees are treated with compassion, empathy and support. This means embedding care, DEIB, mental health and mental well-being, and financial well-being throughout the entire employee experience. From hire to retire, caring ensures the foundation of a workplace environment that recognizes and supports employees as unique individuals who contribute to increased net earnings and overall organizational profit. The business case for human-centric investments is clear.

However, despite the importance and impact of employee well-being, close to a third of employers invest less than \$201 on the well-being of each individual and are planning to decrease that investment in 2024.

Value On Investment

Comprehensive, integrated well-being programs demonstrate to employees that they are valued as individuals, but they also demonstrate line-item value in the company’s overall financials. Consider the cost of attrition, for example. There are direct, observable

Figure 22:
Well-Being Spend Today and in the Future



costs associated with the search for new candidates and the hiring process when a team member leaves the organization, but there are also camouflaged costs that are less discernible yet still have an economic impact.

The High Cost of Attrition

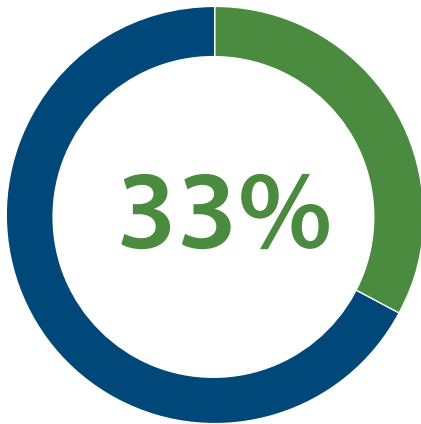
Everyone knows that the cost of attrition is high. This is especially true when, out of the blue, key team members leave and take their organizational knowledge and experience with them.²⁷

Employee well-being serves as the thermometer for organizational

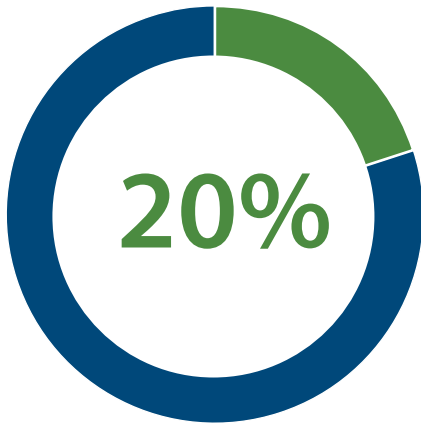
health and can act as an early warning system for turnover risk. Employees who are under pressure at work, be it from a heavy workload, lack of social support or lack of communication, tend to display symptoms indicating a risk for burnout or potential turnover. Just as checking a person’s temperature provides critical insights into their physical health, monitoring employee well-being allows leaders insight into the collective health of their workers and the organization.

When well-being deteriorates, it’s typically a warning sign of larger

Figure 23:
Turnover Expectations



of employers expect **10% or fewer employees to leave for another company** in the coming year



and **20% of employers** believe that 11% – 20% of employees are likely to **exit the company** in the coming year

issues brewing in organizational culture. On the macro level, this could be measured in decreased engagement, performance or retention rates across the company. On a personal level, signs such as exhaustion, sadness, anger, irritability or cynicism could be indicative of declining mental well-being and a warning that burnout is imminent.

In a caring environment, the latter could be addressed by attentive managers looking out for behavioral cues and opportunities to respond with empathy. For the organization at large, initiatives that track factors like stress, belonging, purpose, and growth should position leaders to act when there is any negative change to the pulse of the

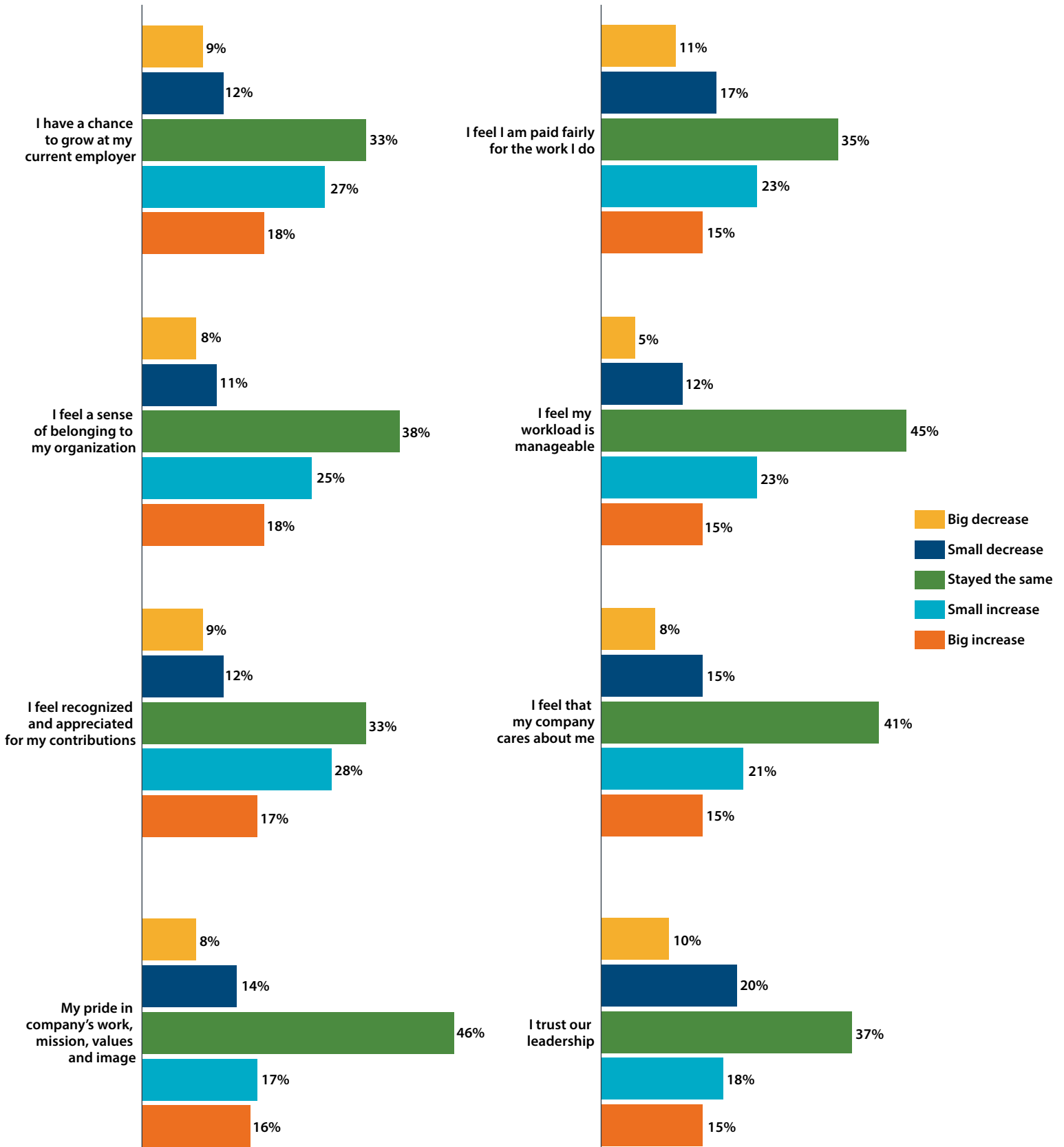
organization. Left unaddressed, any cultural issue will potentially fester and ultimately hamper any hopes of long-term well-being success.

Ignoring well-being issues comes at a price. According to 2022 SHRM benchmarking data, the total cost to hire a new employee can be three to four times the position's salary.²⁸ With 20% of employers expecting that as much as one-fifth of their workforce is likely to leave their company, investing in well-being initiatives – even for no other reason than to increase retention – can help employers avoid the high costs of attrition. With the value-add that many employees consider well-being programs “must haves,” holistic health investments that retain, attract and

care for talent are strategic imperatives for overall organizational success.

Warning bells go off when employee views around key indicators such as pay (28% feel more negatively than before) and trust in leaders (30% feel more negatively) start moving in the wrong direction. This is the time for intervention — creating a positive change to boost well-being and prevent morale from slipping.

Figure 24:
How Employees' Sentiments have Changed in the Past 12–18 Months





Initiatives that track factors like stress, belonging, purpose, and growth should **position leaders to act** when there is any negative change.

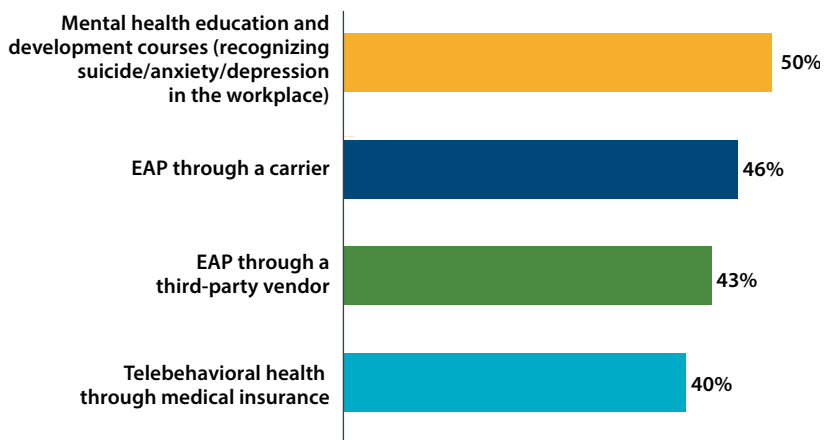
Knowledge Worker Mental Health and Agility

In this knowledge worker era, we all use our brain to create work and think for a living. As such, their mental health and well-being have a direct impact on their capacity to solve complex problems, develop products and services, or perform any other sort of cognitively demanding work. Given this reality, their mental agility – the ability to respond flexibly to events and be able to shift between different ideas, emotions or actions as needed – is critical for success.

To maintain mental agility, workers need to be able to focus, regulate their emotions, and manage a reasonable cognitive load. If these capacities are impeded in any way, individual performance and well-being can suffer, which has a direct impact on organizational performance. As so much depends upon employee’s mental agility in a knowledge economy, it is in the company’s best interest to proactively intervene and provide the support employees need to maintain their mental health and overall well-being.

From a clinical perspective, this means investing in mental health solutions that can support knowledge workers.

Figure 25: Education courses and EAPs are the most commonly-offered mental health resources.*



*Respondents were asked to select all that apply.

Figure 26:

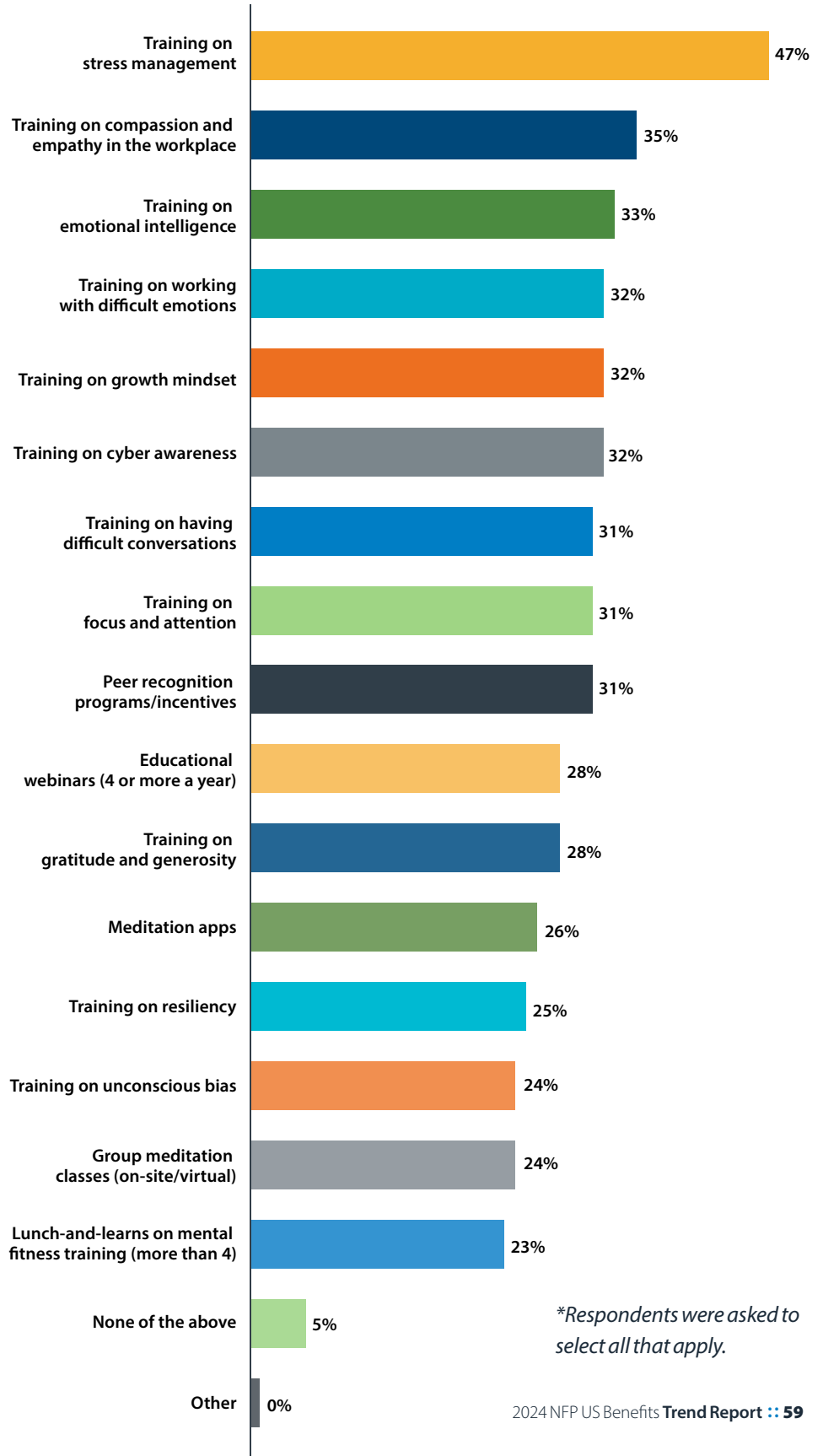


About **1 in 3 employers** have spent **\$0 to \$1,500** on **employee mental health**.



About **2 in 5 employers** have spent **\$1,501 to \$3,000** on **employee mental health**.

Figure 27:
Well-Being Offerings*



We promote annual physicals, but do little to nothing to ensure we have a mental health check-up as well with a trained therapist or doctor.

The data we're seeing this year indicates that employers are investing in mental health solutions for their employees. However, it's often in the form of low-cost solutions which only have minimal impact.

Given that building and maintaining a mentally strong, resilient, and productive workforce relies on investment in mental well-being and brain optimization skills training, it is encouraging to see employers investing in programs like stress management and emotional intelligence. However, there is still room for improvement. As brain optimization training has the potential to benefit 100% of employees by empowering them to become more sophisticated in their thinking, boost their ability to manage their emotions and improve their relationships with others, such training is trending towards becoming a standard component of employee development budgets.

**Respondents were asked to select all that apply.*

Financial Well-Being

Another way to demonstrate your care is to invest additional effort into the structure, function and communication of financial well-being programs beyond the 401(k). As employee health and well-being are significantly impacted by persistent inflation, potential financial crises, and unusually high interest rates, the impact can be felt by employers in the form of lowered productivity, output and engagement, alongside increased physical and mental health concerns and their corresponding costs.

Given that financial pressure tends to be the most common cause of stress, more employees are looking to their employers for help. As such, it's in the employer's best interest to aggressively pursue ways to help employees better manage their finances, create budgets and map out a plan.

Remember that somewhere between 60% and 80% of employees report living paycheck-to-paycheck or, as one expert put it, "The problem is that there is more month at the end of the money."^{29,30} For younger employees, household budgets are squeezed by surging housing, food and child-care costs, combined with higher interest rates on credit card debt and loans while older employees are concerned with whether or not they'll be able to retire. The fact that companies are tightening their budgets and lowering headcounts in response to

the same financial pressures only adds more stress to the equation.

Because financial well-being can have a positive effect on multiple fronts including healthcare costs, retention, recruitment and performance, it should be instilled in the workforce that it is just as important as physical and mental well-being. Even framing the issue of having access to financial well-being resources in the same vein as having access to a physical therapist or psychologist can instill a sense of urgency, destigmatize the idea of seeking out financial help and encourage utilization of the benefit. In fact, linking financial well-being to physical and mental well-being while empowering employees to address money concerns through trusted workplace resources further demonstrates a commitment to caring for the whole person in a compassionate, holistic way.

Not One-Size-Fits-All

However, financial well-being resources must be customizable so that all segments of the employee population can take advantage of it. Sure, an employer can create a financial well-being benefit and at least on paper, state that it's offering employees the chance to improve their financial circumstances, but, if the program is not taking into account that everyone's circumstances are a little different, it's not going to be effective at helping them manage their money, nor will it help employer bottom line.

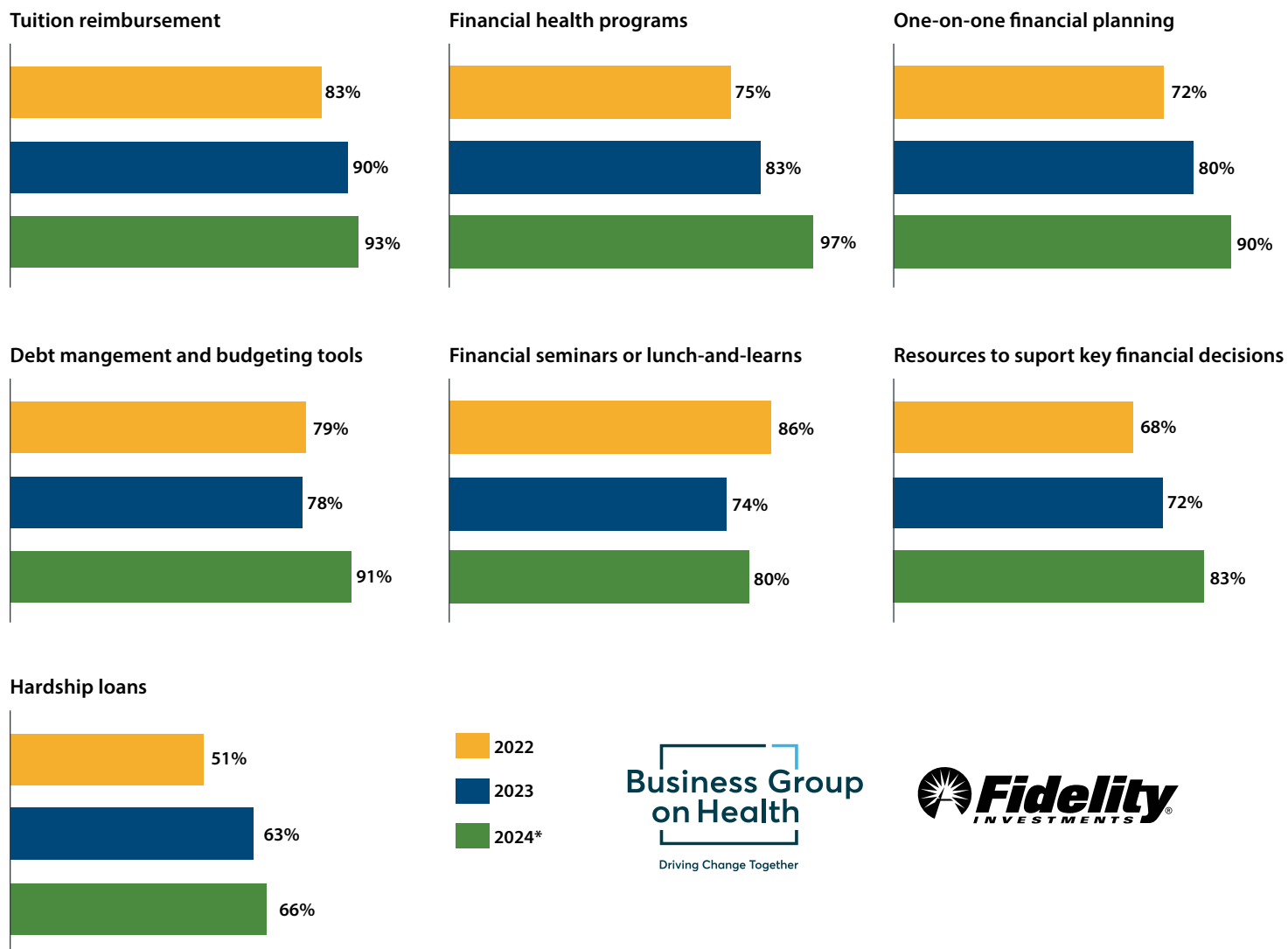
With multiple generations of workers from a wide variety of backgrounds all accessing the same total rewards offerings, we must account for the differing relationships people have with money and the current level of their financial education. As demonstrated by the Business Group on Health (see figures 28 and 29), employers are keen on adding a wide variety of financial well-being support tools to support the disparate members of their workforce.

Even going beyond traditional financial well-being programs by offering a wider array of programs can significantly enhance and improve an individual's financial and overall well-being.

After all, a millennial married employee with two young kids is going to have different financial considerations than a Generation Z employee fresh out of college or an executive-level baby boomer about to have their fourteenth grandchild. With the understanding that personal financial needs and current budget restrictions are as different for individual employees as their varied backgrounds are, employers can tailor resources based on generational life stages and where their workers are in their careers and life paths.

Figure 28:

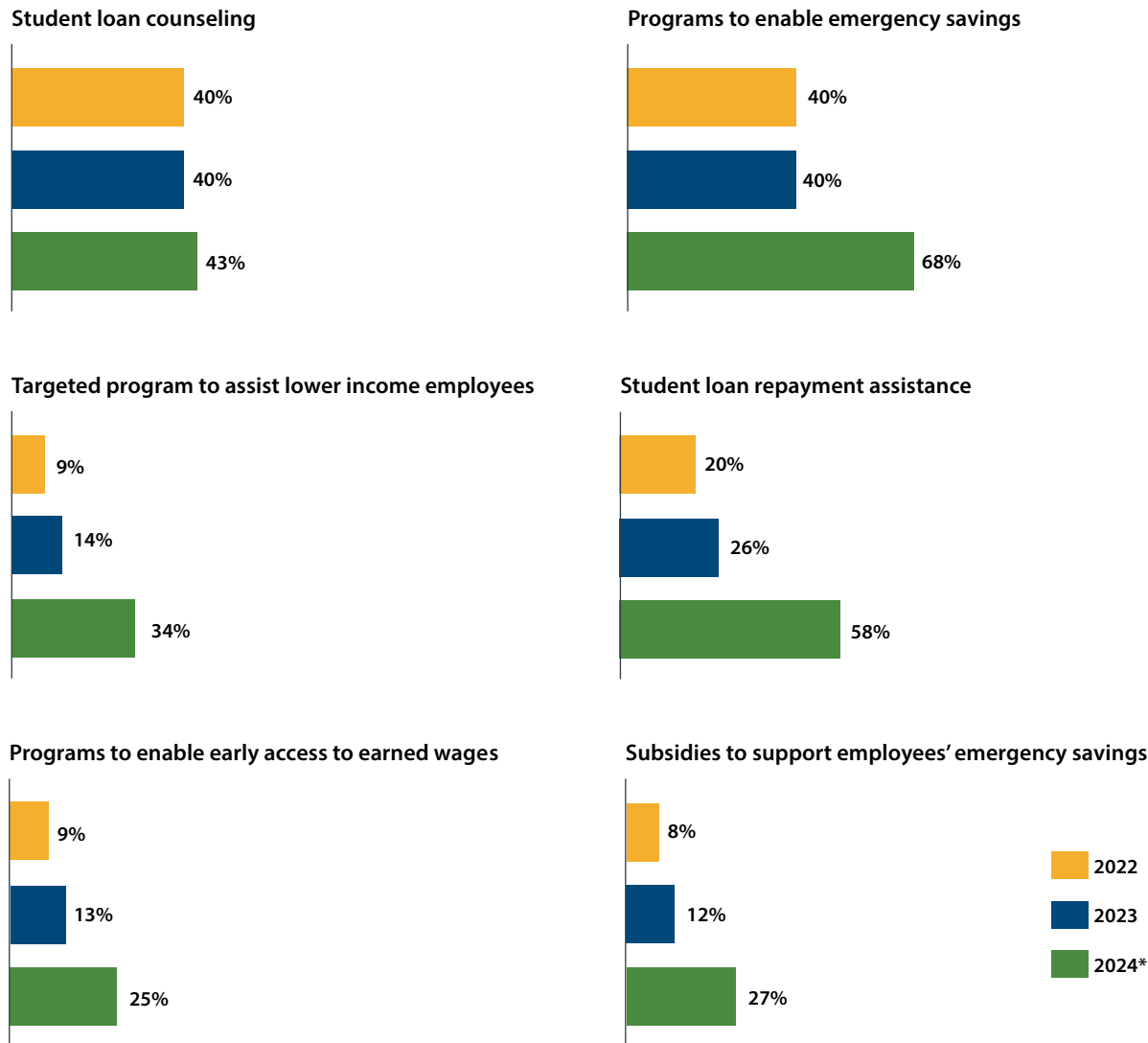
Employers' Financial Well-being/Wellness Initiatives, 2022-2024
 Employers continue to add financial well-being supports, such as financial planning an debt management and budgeting tools. N=171



*2024 represents those employers that already have the programs in place and those who are considering add programs for 2024.
 Source: Business Group on Health, Employer Sponsored Health and Well-Being Survey, 2023



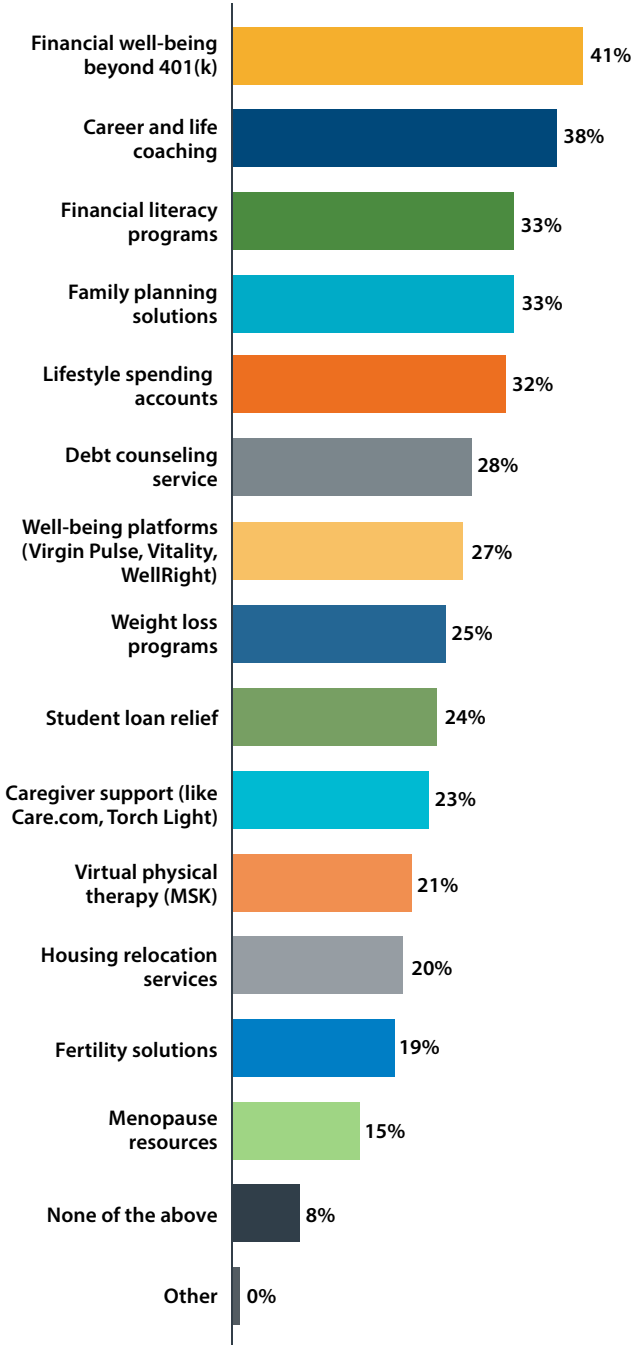
Figure 29:
Employers' Financial Well-being/Wellness Initiatives, 2022-2024 (Continued)
Across financial well-being initiatives, there are varying levels of interest –
with emergency savings programs a top focus area. N=171



*2024 represents those employers that already have the programs in place and those who are considering add programs for 2024.
Source: Business Group on Health, Employer Sponsored Health and Well-Being Survey, 2023



Figure 30:
Non-Traditional Benefits Offerings*



*Respondents were asked to select all that apply.



*An equitable financial well-being program must account for **systemic inequities** and provide customized support to underserved groups.*

Equitable Access

Bear in mind, that although financial insecurity affects everyone, it can be exacerbated for marginalized or under-represented groups. According to a 2020 report from the Federal Reserve, white families on average have about eight times the wealth of Black families and five times the wealth of Hispanic families.³¹ This illustrates that people of color tend to be disproportionately affected by economic hardships and lack of access to wealth-building resources. An equitable financial well-being program must account for these systemic inequities and provide customized support, education, and tools to underserved groups.

This may include:

- Offering equitable compensation and growth opportunities to enable financial security.
- Conducting financial health assessments to identify and understand employees' needs.
- Employing insights to design targeted programming that provides relevant support.
- Getting creative with benefits like student loan repayment or "lifestyle" funds.
- Making financial guidance accessible through digital tools.
- Going beyond the 401(k) to offer personalized options like menopause resources or caregiver support, and considering employees navigating religious or cultural factors as they save.
- Choosing adaptable partners that meet evolving needs.
- Addressing disconnects between current offerings and employee priorities.
- Supporting an inclusive workforce facing varied challenges.³²

Ultimately, these efforts will further drive engagement, lower stress levels, increase retention and attraction initiatives, and demonstrate that the organization genuinely cares for all of its employees. Implementing them is a sign of a company that recognizes the connective

tissue between employee satisfaction, diversity, equity, inclusion, financial stability and overall business growth.

As most people's lives are tied to work, organizations have a vested interest, perhaps an obligation, to ensure that employees are financially well and cared for, similar to the care put forth in their mental health and well-being. Doing so puts companies in their best position to be productive, innovative and successful. As resilient employees are of the most valuable employees, reducing stressors that may exist for vulnerable groups, races, genders or identities is a business imperative. Ensuring equitable access to financial solutions and educational tools for these same groups can significantly help people feel valued while improving their financial stability.

Growing for the Long Term

While investments in mental health and well-being programs require an upfront budget allocation, the long-term returns in the form of healthy, motivated, Brain On! employees far outweigh the costs. As people are key to creating and sustaining long-term growth, profit and overall success, caring for their holistic well-being through comprehensive support is the wisest investment an organization can make.

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Opportunity



in a

Challenging

Environment

Voluntary benefits are becoming an integral component of a comprehensive employee benefits offering. In the midst of ongoing economic concerns, many organizations are searching for ways to continue to provide quality coverage options without significantly increasing costs. As NFP survey data indicates, with few employers planning to make cuts to benefits, compensation or staffing levels in the coming year, supplemental benefits will likely play a more significant role in strategy than they have in the recent past.

Considering the financial stress employees are feeling, strategic voluntary benefits further present affordable income protection and risk mitigation vehicles for employees whose household budgets are under pressure. By offering access to financial safeguards designed to provide stability in overwhelming situations, organizations can alleviate pressing worries linked to broader economic troubles and provide employees some much-needed peace of mind.





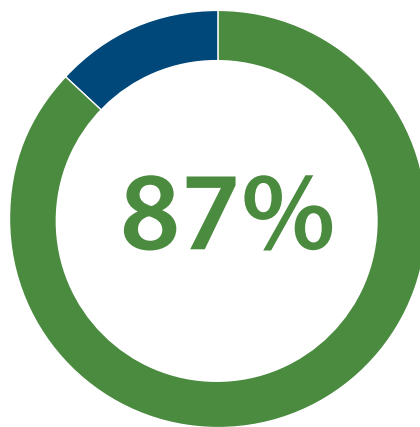
Compensation alone will not guarantee happiness, retention of current employees or recruitment of new talent.

What Employees Want

Given the generational diversity of modern workforces and the growing demand for personalized benefits, enabling employees to choose coverage that goes beyond the fundamentals to address their lifestyle and life stage needs is vital. This becomes more apparent when considering generational needs.

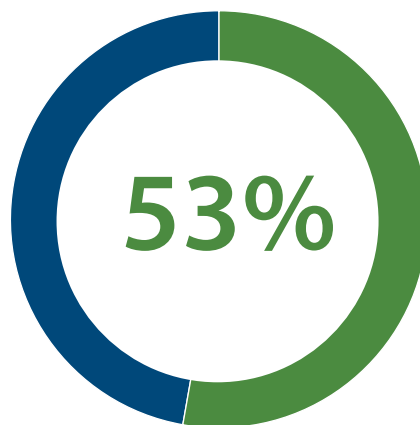
Although Gen Z, millennials, Gen X, and baby boomers can work together within the same organizational culture, their benefit requirements are typically quite different. With a little less than half of employees reporting that their benefit offering does not effectively meet their needs, the opportunity to create a package that resonates across all generations is clearly there for the taking.

Figure 1:



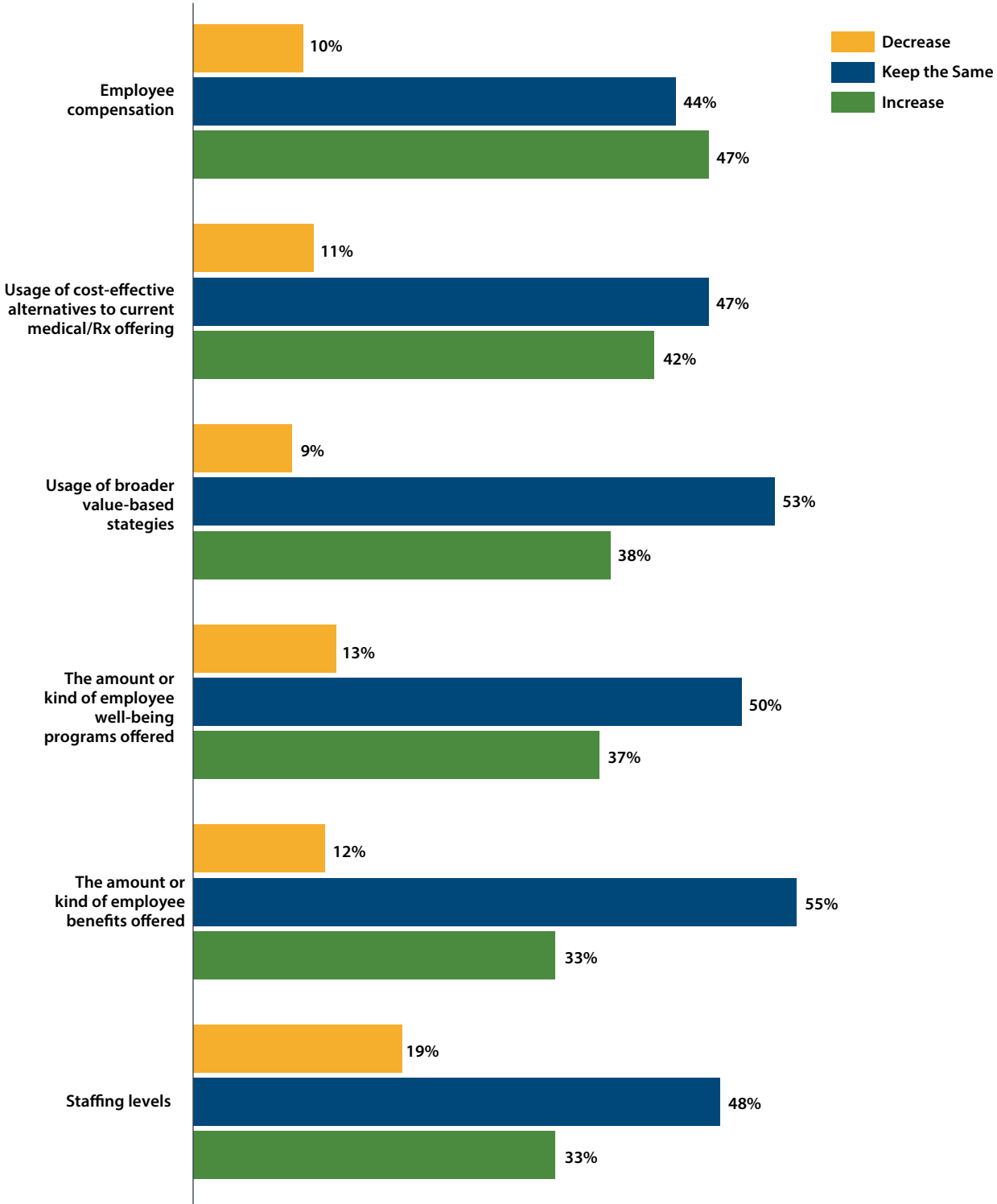
of employers are at least **moderately concerned** about the economy

Figure 2:



of employees are **very or extremely concerned** about the current US economic situation

Figure 3:
Impact of Economic Concerns on Company Plans
 Few employers are planning to make cuts to benefits,
 compensation or staffing levels due to economic concerns.



In recent years, employees have been more vocal about the types of benefits they want. Obviously, every worker in America would like to get paid more than they currently make, but compensation alone will not guarantee happiness, retention of current employees or recruitment of new talent. Workers are looking for competitive pay, certainly, but they're also demanding benefits that support their physical, social, mental, and financial health.

Employees want benefits that can help alleviate the stress of uncertainty — how to cover an unexpected medical expense or injury requiring significant time off from work, for example. They want help to plan for a safe and smart financial future, one where they can achieve major life goals while providing financial security for their family today and all the way through retirement. They want to know that their employer is invested, and cares about them and their overall well-being. And lastly, they want their entire benefits experience to be seamless, as though they were interacting with social media or ordering a package from Amazon.

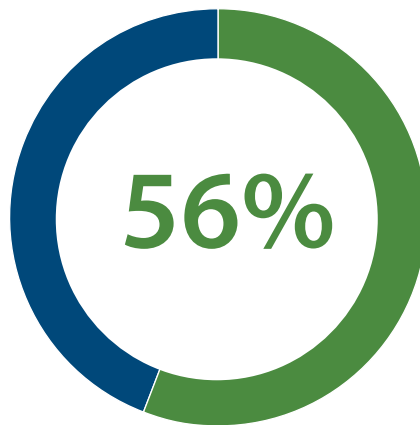
In the end, companies that listen and learn from the evolving priorities of workers will invest in benefits that alleviate stress, help facilitate life goals, and provide peace of mind, regardless of generation. By giving employees

what they're asking for, and keeping that all-important focus on crafting offerings with the end-user experience in mind, companies will better foster satisfied workers who feel cared for, secure and supported, and therefore better suited to deliver bottom-line organizational gains.

Voluntary Benefits Strategy

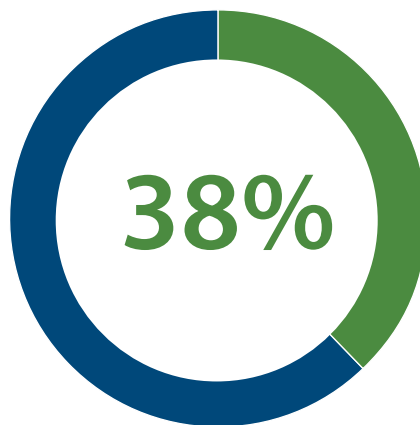
Providing a diverse selection of voluntary benefits can further help manage expenses. Since these options do not involve direct costs for employers, companies can make such in-demand choices available while preserving a reasonable balance of cost-sharing with

Figure 4:



of employees note that **economic concerns** will **impact** their benefits decisions

Figure 5:



of employees feel that **economic concerns** will cause them to choose a **lower cost plan**

staff through employee-paid premiums. As they also share the distinction of being the best way to create customized and personalized offerings for any engaged employee, a robust voluntary benefits package that checks all the boxes is ideal for both the workforce and benefits strategy.

Benefits of Offering Voluntary Benefits

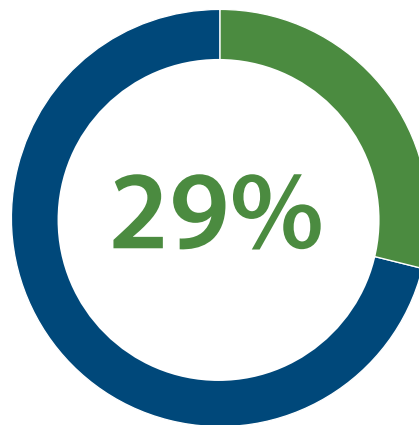
In fact, offering voluntary benefits comes with a number of advantages that impact employees directly. For staff, these options have the potential to promote better health through things like gym memberships, which demonstrate not only that the company cares about worker health and well-being beyond the four walls of the office, but also that it is invested in empowering employees to show up as their best selves each day. Furthermore, supporting fitness can bring colleagues together around shared health goals and progress through vehicles like video conferencing and water cooler conversations.

Voluntary benefits can also alleviate worries by providing coverage for unexpected issues like identity theft. After all, having sensitive personal data like Social Security numbers, credit card accounts or personal health information compromised strikes fear for good reason. Identity theft can not only cause lasting financial hardship if fraudsters exploit stolen information but can also cause deep personal stress and long-lasting distrust.

Employees can also enjoy increased job satisfaction when their benefit plans go beyond the basics to include helpful extras like free legal consultations, unbiased financial planning guidance or access to grief counseling. Having these types of supportive resources to navigate personal matters can provide comfort and much-needed

Figures 6 and 7:

Employees Reporting Benefit Offering Meets their Needs

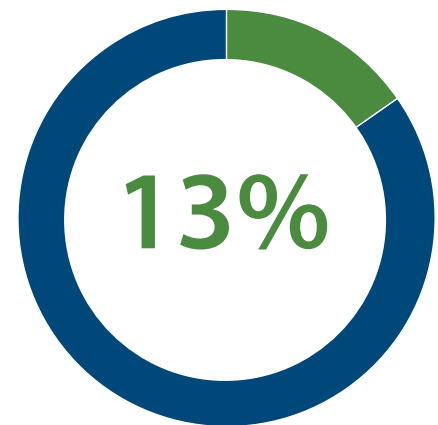


Somewhat

help in times of stress. Additionally, when employees feel that their employer has their back in challenging situations (whether making major financial decisions, working through the loss of a loved one or preventing legal disputes from escalating), they tend to reciprocate with stronger workplace engagement, productivity and loyalty.

Additionally, emphasizing these voluntary protections aids recruiting efforts by demonstrating an organization truly cares about employees' complete well-being, both personally and professionally. Robust voluntary offerings give candidates confidence they'll have useful support systems to grow within and beyond their core role while current staff can appreciate that their lives outside of work are recognized, making them more likely to refer new hires and potentially become brand ambassadors.

Overall, voluntary benefits keep people happily working with peace of mind that they are covered when the unexpected occurs. This leads to greater workplace satisfaction, lowered stress



Not too well or not well at all

and better retention. With the right supplemental benefits, employers facilitate employees who both want to work and are happy in their roles. Investing time and effort into a strategy to get this balance right pays off in the form of mutual benefit. With more empowered, productive and loyal team members, business goals are more readily achievable, and the overall health of the company — revenue growth, debt ratio, customer satisfaction and other performance indicators — can remain strong.

Inherent Customization and Affordability

Voluntary benefits uniquely meet the strategic goals of boosting engagement and retention while controlling costs due to their inherent customization and affordability. Their value stands out staunchly, especially when considering the backdrop of economic uncertainty and a generationally complex workforce with wildly differing needs.

Employers seeking an empowered, stable staff must reevaluate existing

offerings in light of these challenges. By taking inventory of gaps in personalization and piloting new targeted options to address them, companies who invest in adaptive solutions for individual needs will sustain productive cultures and stronger bottom lines regardless of external stressors.

As the workforce continues diversifying, creative supplemental benefits must meet the demand for choice. Organizations filling this demand will be the ones who see the greatest return on investment.



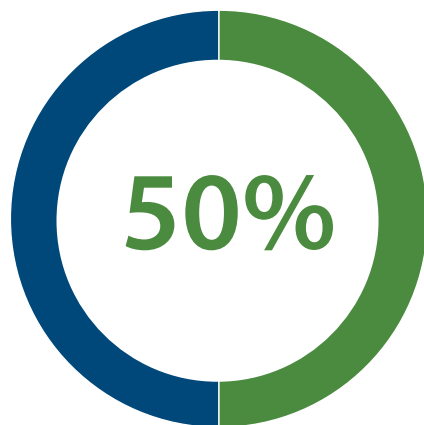
High Deductibles and the Modern Worker

By some estimates, more than half of workers in the US are covered by high-deductible health plans (HDHPs). Although for many employees, HDHPs are certainly the right choice for their coverage needs, for others, the high out-of-pocket costs associated with these plans can make accessing care challenging.

Fortunately, voluntary benefits can work together with an HDHP to offset coverage gaps created by significant out-of-pocket medical

costs. While HDHPs offer affordable premiums, their sky-high deductibles and maximum out-of-pocket expense limits can deter many workers from care, essentially invalidating the point of providing employer-sponsored coverage. Although initially designed to reduce spending and encourage employees to be better consumers of healthcare services and procedures, with ever-increasing pricing from health systems and carriers alike, employees are often locked out of the care they need completely.

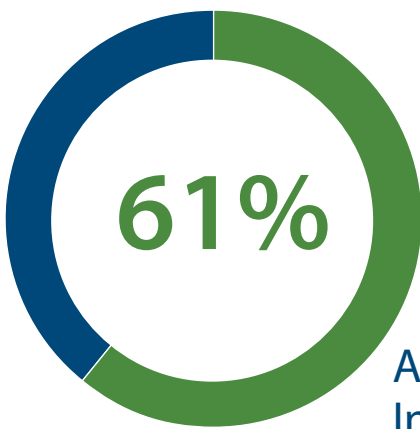
Figure 8:



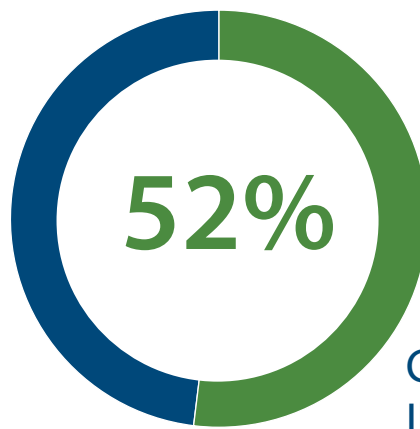
of employees have **\$1,000 or less** in savings for a **catastrophic medical expense**

Figures 9, 10, 11 and 12:

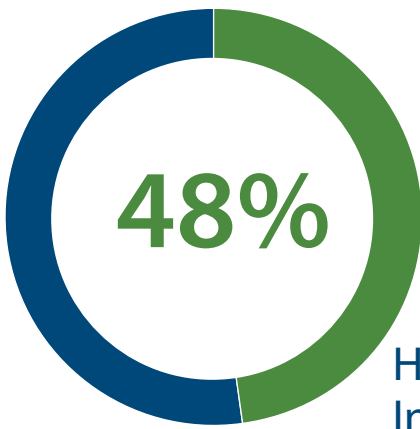
Percentage of Employers that Offer



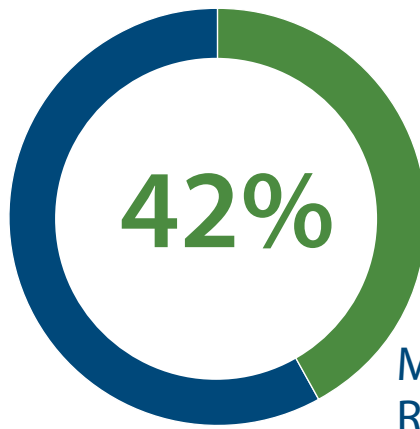
Accident Insurance



Critical Illness



Hospital Indemnity



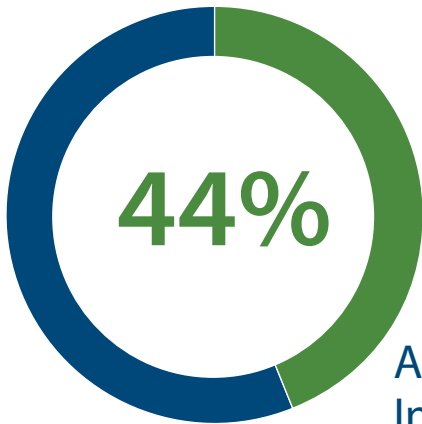
Medical Debt Repayment Programs

Close Gaps with Voluntary Benefits

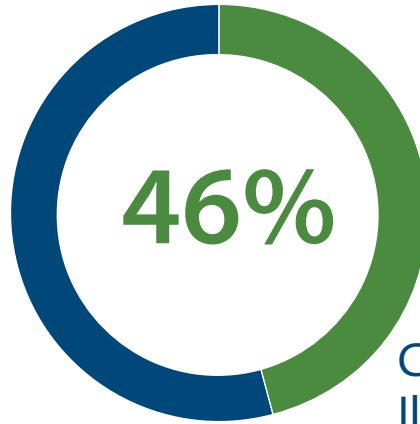
Even with the right combination of savings arrangement and HDHP, the most diligent employee can still experience significant gaps in financial protection. For example, out-of-pocket expenses might still deter access to care or lead to billing strains after savings accounts are exhausted. An unexpected medical emergency might leave employees unable to cover costly hospital stays,

treatments or medications. This is where supplemental insurance can fill the holes in coverage through set cash payouts triggered by hospital stays, high-cost conditions and other essential services as long as employees meet eligibility terms. With this added layer of protection, the combined structure makes the most of core coverage and financial reinforcement.

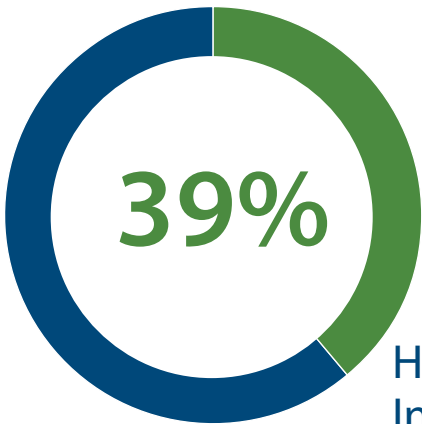
Figures 13, 14, 15, 16 and 17:
Percentage of Employees Who Prefer their Employer Offer



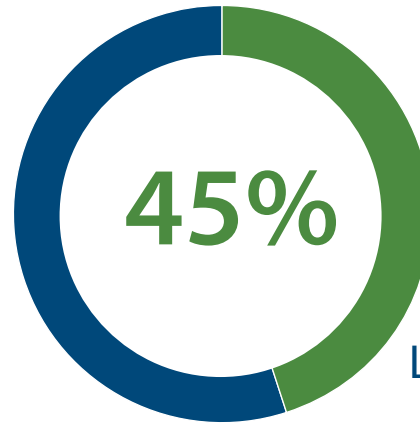
Accident
Insurance



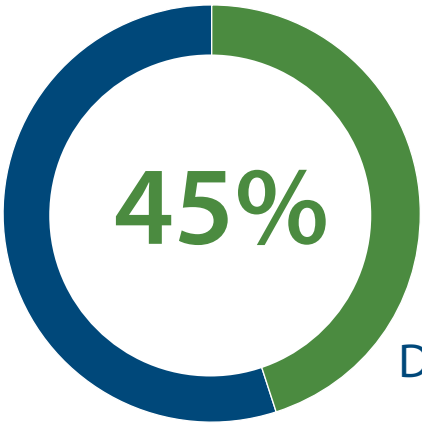
Critical
Illness



Hospital
Indemnity



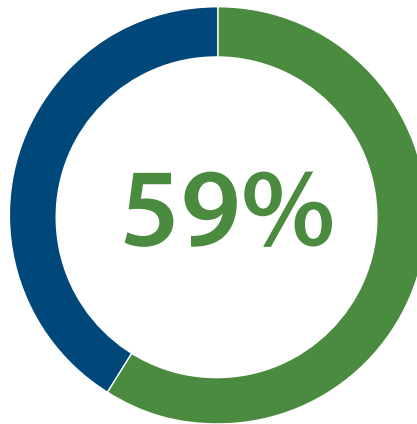
Life



Disability

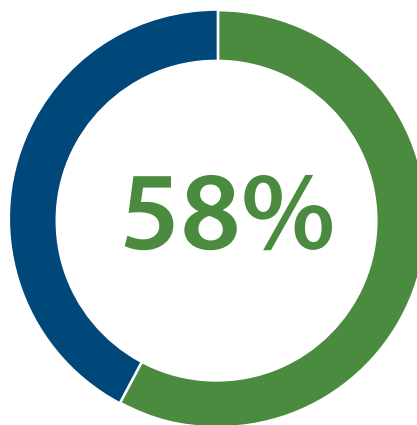
While voluntary benefits can cover out-of-pocket expenses associated with healthcare, they can also help with day-to-day expenses, depending on the situation. Given that these coverages are offered through payroll deduction and come at little to no cost to employers, voluntary options present low-risk, high-reward enhancements to an overall offering. As mentioned previously, they further allow organizations to craft truly personalized benefit packages by enabling each employee to select supplemental protections tailored to their individual priorities and lifestyles.

Figure 18:



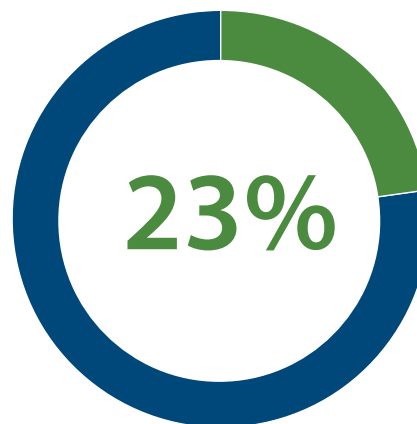
of employees would consider enrolling in **voluntary life insurance** products that included financial protection for **long-term care related expenses**

Figure 19:



of **employers** believe employees effectively utilize **supplemental benefits**

Figure 20:



of **employees** believe that they maximize use of **supplemental benefits**

Types of Voluntary Benefits

Accident Insurance

Provides cash payments to help cover medical and incidental expenses associated with accidental injuries, hospital stays, transit or death/dismemberment.

Critical Illness Insurance

Delivers lump-sum cash payments upon diagnosis of major medical conditions (e.g. heart attack, stroke, cancer) to pay for uncovered treatment costs and daily bills.

Hospital Indemnity Insurance

Offers fixed dollar payouts for hospital-related expenses like confinements, surgeries, critical care and other inpatient services, offsetting deductibles and other cost-sharing.

Cancer Insurance

Helps policyholders manage costs tied to cancer care, covering expenses not reimbursed by medical plans for screening, treatment, therapies and experimental regimens.

Supplemental Disability Insurance

Provides additional income replacement beyond base employer-paid disability coverage to help maintain a standard of living during injury/illness.

Long-Term Care

Coverage for individuals aged 65+ or with chronic/disabling conditions, providing nursing home care, home health care and adult daycare.

Vision and Dental Insurance

Helps foot the bill for major services and preventive eye/dental visits not covered by traditional medical plans.

Life Insurance

Allows employees to purchase extra term life insurance beyond any employer-provided baseline death benefits.

Permanent Life Insurance

Life insurance that doesn't expire and often has a death benefit and savings component.

Legal and Identity Protection

Offers access to attorneys and financial/credit assistance for personal matters, including estate planning, identity theft response, tax audits, property disputes and more.

Pet Insurance

Helps employees pay for their pets' medical bills. Provides financial assistance for expenses related to pets' accidents/injuries, illnesses, surgeries, hereditary conditions and more that primary insurance may not fully cover.

Family and Reproductive Health Support

Offers access to fertility benefits, surrogacy and adoption support, preconception and pregnancy support. Specialized benefits that support lactation, high-risk pregnancies and menopause treatment are increasingly valued supplemental offerings.

Education and Communication

While voluntary benefit offerings provide clear utility, driving enrollment and participation remain separate and significant challenges requiring ground-up benefits literacy and general promotion.

As ongoing employee benefits education fosters engagement, cost-conscious choices and optimal utilization, designing a well-thought-out education and communication plan is mutually beneficial to both workers and the business. However, as more than half of employers believe that their employees could have a better understanding

of their benefits, and about one-third of employees are either somewhat or not too confident in their ability to make the best benefits decisions, any attempt to begin an education initiative should begin with greater clarity.

Figure 21:
Employer Perception of Employees' Understanding of Benefits

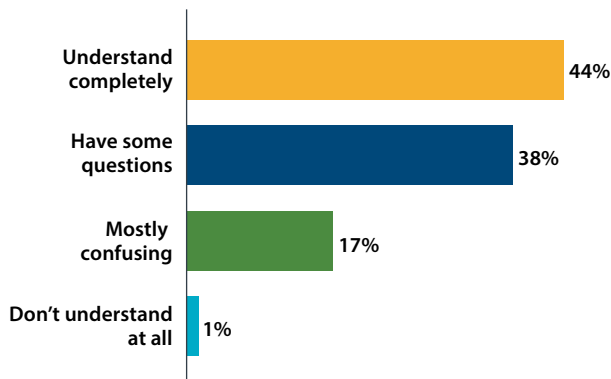
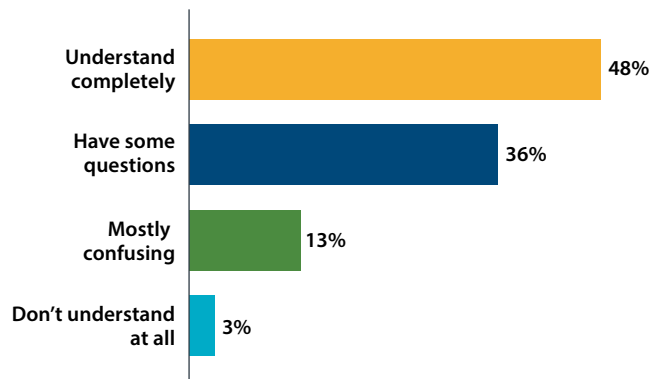


Figure 22:
Employees' Self-Reported Understanding of Benefits





About a third of employees do not feel confident in their ability to select the best benefits for themselves and their families.

Employers should consider focusing on communicating the overlooked value of voluntary benefits and how they work together with their health plan to provide comprehensive protection. An emphasis on showing exactly how certain products like accident, critical illness or identity theft protection can fill specific gaps in their main coverage, can go far in demonstrating their use.

Economic concerns will certainly play a role in anything that employees invest their money in. As a result, focusing on the value and long-term potential of these benefits is critical to the success of any communication endeavor.

Remember that persistent inflation has led to tighter household budgets. So, employers need to design their communications for a cost-conscious audience. Before spotlighting the low upfront costs associated with voluntary benefits, it may make for a more compelling message to emphasize the potential costs that can arise from medical issues or unexpected life events. As people are generally motivated by avoiding consequences, demonstrating the power of protection today to alleviate financial stressors tomorrow tends to resonate.

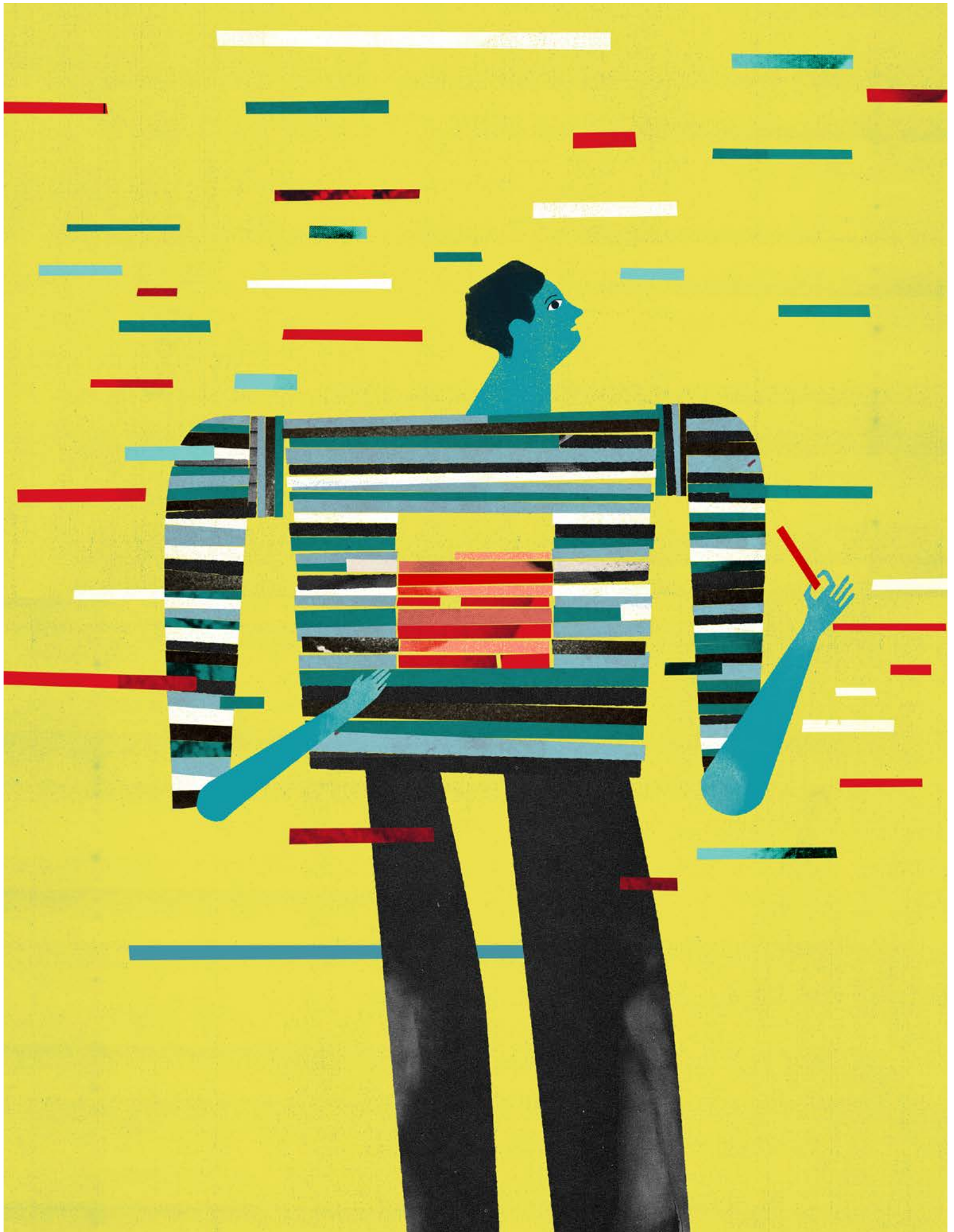
Know the Audience

Successfully appealing to a diverse workforce requires knowing the audience. The most remarkable supplemental benefits package means practically nothing unless it matches employee wants and needs. Carefully constructed pulse surveys, candid benefits conversations during open enrollment and regular communication can foster useful insights that inform supplemental benefit design. Furthermore, listening inclusively to all voices allows organizations to take the pulse of priori-

ties across all generations, backgrounds and life stages. With that information, teams can design cost-effective personalized offerings that demonstrate genuine commitment and care for each individual.

Offer Decision Support Tools

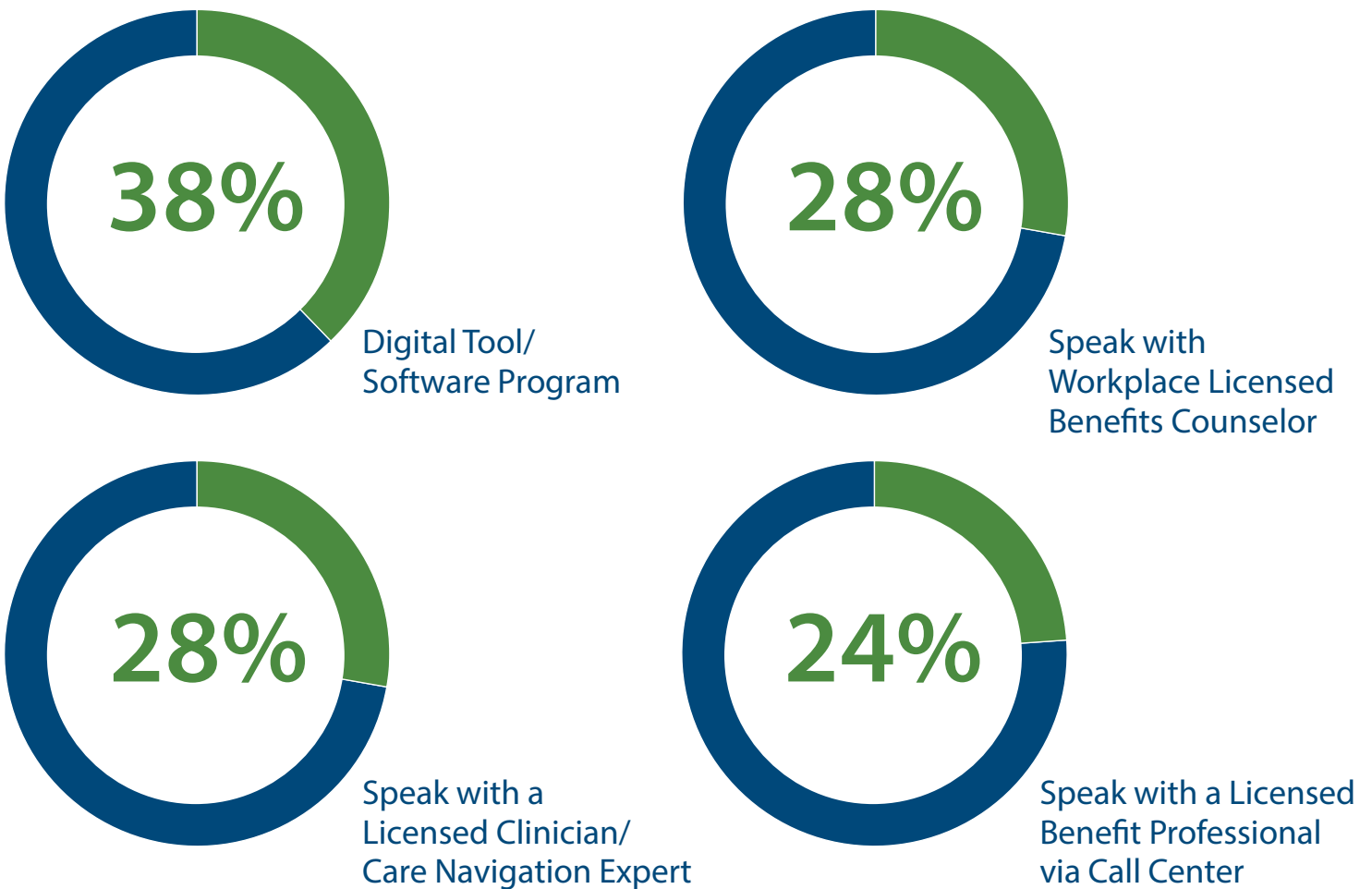
Most employees are open to using a decision-support tool of some type. Although there is little consensus on a single most valuable tool, employees are generally open to offerings like decision apps or access to experts. Complementing a robust education and communication design, decision support tools can provide the missing link needed to convert benefit awareness into confident personalized selections.



While quality enrollment communication should remain a baseline, additional channels can further demystify options to instill benefits literacy and drive sound voluntary benefit decisions. Improving existing print and digital materials with plain language and clear cost-to-benefit ratios can certainly promote better comprehension. By the same token, exploring advanced support like AI-powered chatbots to provide personalized guidance at scale can be especially helpful to in-office and hybrid employee populations.

Many organizations have found call center navigators and care advisors effective for those craving human interaction. Given that the process of benefits personalization is somewhat complex, designing access to multi-prong preparation, assistance and follow-through channels can help employees customize protections aligned to their wants and needs, strengthen benefits literacy and match them with their optimal choices for not only financial health but overall well-being.

Figures 23, 24, 25 and 26:
Resources Employees Would Use to Aid Benefit Selection

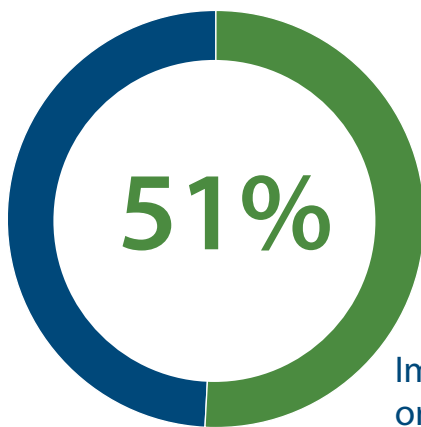




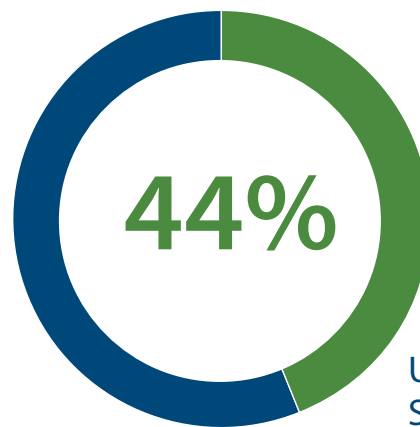
Exploring advanced support like AI-powered chatbots to provide **personalized guidance at scale** can be especially helpful to in-office and hybrid employees.

Figures 27, 28 and 29:

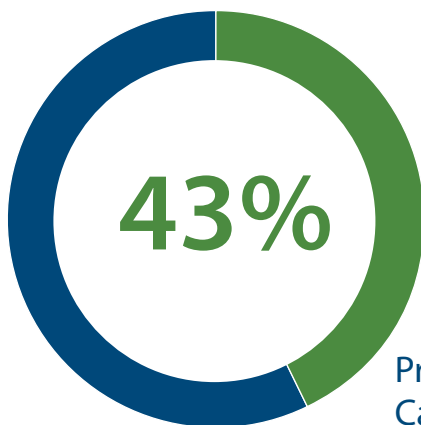
Steps Employers Would Consider Taking to Improve Benefits Literacy



Improve Printed or Digital Materials



Use AI-Based Decision Support Tools



Provide Call Center or Care Navigation Services

Benefits that Fit

With voluntary benefits, employers can offer a low-cost, high-reward solution that caters to both business goals and employee needs. With these types of benefits rising in popularity over the last decade, more and more companies are offering a mix of affordable, group-priced supplemental options designed to meet the needs of diverse multi-generational workforces who expect personalized protection.

By aligning these benefits through payroll deduction/opt-in models where enrolled employees shoulder some or all premium costs, employers can make remarkable expansions to their offering without overextending their benefits budget. The outcome of this is to maximize coverage per dollar and concentrate expenses on active benefactors. In doing so, companies can achieve the ideal balance where added protections address employee risks and needs while tight cost controls remain aligned with organizational realities. In many ways, this is the very business case for offering supplemental benefits.

Pricing

Pricing for supplemental offerings can fluctuate depending on the chosen products and carriers. According to Forbes, these costs generally land between 0.5% and 1.5% of salary per individual.¹ Given this low up-front cost, coupled with the fact that employees typically shoulder the burden themselves, organizational funding constraints don't have to impede an expansion of the benefit offering. In fact, for employers wanting to offer something outside of budget constraints, they can set employee cost-sharing metrics to keep benefits accessible while keeping corporate resources in balance.

The Future

The future of voluntary benefits rests on recognizing potential gaps in protection and offering solutions to fill them at minimal costs through modern channels. As budget restrictions need not factor into the equation, offering the right supplemental assortment can allow companies to forge expanded benefits ecosystems and meet cross-generational needs while prioritizing benefits spend with a focus on broader goals.

The path ahead calls for fiscally balanced voluntary expansion that lifts employer and employee outcomes in tandem. Those seizing this promise today have the potential to become the model benefits providers of tomorrow.

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About the Data

The 2024 NFP US Benefits Trend Report draws on data from NFP's US Employee Benefits Survey 2023 and NFP's US Employer Benefits Survey 2023. Any other sources are as referenced throughout. For full information on the methodology for each NFP survey, contact marketing@nfp.com.

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Kim is executive vice president, head of Health and Benefits at NFP, where she directs the overall strategy and operations for NFP's national employee benefits practice. With more than 30 years of experience in the employee benefits industry, Kim is an influential thought leader in the corporate benefits space. She graduated from Indiana University's Kelley School of Business with a Bachelor of Science in finance and has a Master of Science degree in management from Indiana Wesleyan University. Kim also holds the Certified Employee Benefits Specialist® (CEBS) designation from the International Foundation of Employee Benefit Plans.



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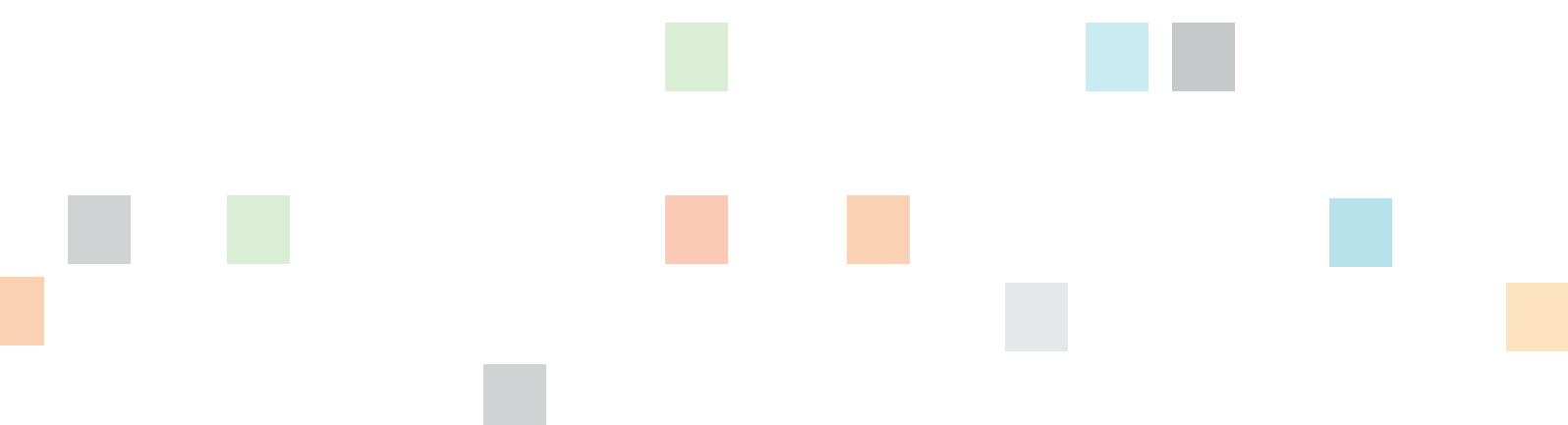


Nelly Rose

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