insights from the experts

2025 NFP US Benefits Trend Report

NFP
An Aon Company

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Welcome to the 2025 NFP US Benefits Trend Report

As we begin 2025, most employers find themselves at the intersection of complex and rapidly evolving economic, legislative and political landscapes. This environment presents unique challenges for employers striving to offer competitive benefits while effectively managing their fiduciary responsibilities and healthcare expenditures.

The 2025 NFP US Benefits Trend Report focuses on practical and strategic solutions to your most pressing benefits challenges. In this year's annual report, we examine how organizations are:

- Strengthening oversight of pharmacy benefits and healthcare costs through innovative network strategies and enhanced fiduciary governance.
- Streamlining leave management to reduce administrative burden while ensuring compliance with related federal and state law.
- Addressing employee wellbeing needs strategically, particularly in mental health and caregiving support, by focusing resources where they'll have the greatest impact.
- Making smarter decisions about benefits investments through enhanced data analytics and program evaluation.

The challenges of 2025 will require employers to be proactive, adaptable and innovative in their approach to employee benefits and healthcare spending, while at the same time remaining vigilant in their fiduciary obligations. The trends and strategies outlined in this report are designed to help guide employers through those processes so that they can effectively manage costs while providing valuable benefits that support and engage their workforce.

As you review these insights, know that our team of consultative experts stands ready to help you navigate these challenges and implement solutions that work for your organization's specific needs and goals.

All the best,

Kim Bell

EVP, Head of Health and Benefits
NFP, an Aon company

Key Takeaways

Cost Containment and Price Transparency Compliance

Growing fiduciary risk requires employers to implement comprehensive evaluation processes for health/welfare vendors.

Organizations are leveraging price transparency tools and data analytics for **better cost management** and mitigation of fiduciary risk.

74% identify data analytics as important or very important.

Rx

70% of employers prioritize **controlling** prescription drug spend.

Employers are moving toward **carve-out** pharmacy arrangements (64% choosing either direct PBM carve-out or coalition participation).

Wellbeing

Mental health support is **expanding** to include pediatric/dependent care services.

Comprehensive caregiving support is growing for the **"sandwich generation"** who are managing both children and aging parents.

Leave Management

71% of employers spend more than four hours per leave request on **administration**.

Two main solutions are emerging: **technology-supported** internal administration and outsourced administration.

Healthcare: Cost Containment and Price Transparency Compliance

Mitigating Growing Health and Welfare Benefit Plan Fiduciary Risk

Employee benefits management is undergoing a fundamental transformation, largely driven by increased scrutiny of fiduciary responsibilities and cost containment pressures. However, having navigated these challenges in retirement benefits management, HR teams should be well positioned to address similar oversight and accountability demands for their health and welfare benefit plans.

Recent legal actions stress the importance of employers as plan sponsors to establish proper fiduciary oversight. In comparison to the retirement landscape, the timeline for emergence of legal action has been greatly condensed for health and welfare litigation. The escalation of class action lawsuits is primarily attributed to technological capabilities. Attorneys are leveraging social media to promote employee dissatisfaction with an employer's selection process of their health and welfare vendors. This is prompting the need for employers to expedite their development of a comprehensive evaluation process for selecting their health and welfare benefit vendors.

To protect both plan participants and the organization at large, HR teams must begin implementing comprehensive evaluation processes now to ensure compliance with fiduciary responsibilities while also optimizing plan performance and cost management. Through a well-designed review process, this growing fiduciary risk can be mitigated.

The Fiduciary Role of a Plan Sponsor

A plan sponsor's role as a fiduciary comes with significant responsibilities and legal obligations. Any party with discretionary decision-making authority over the plan or plan assets must adhere to ERISA fiduciary standards and responsibilities, including acting solely in the best interest of plan participants and beneficiaries, carrying out their duties prudently, following plan documents and ensuring only reasonable plan expenses are incurred.

Various pieces of transparency legislation have significantly expanded and further identified for plan sponsors additional areas requiring oversight to meet their fiduciary responsibilities. There are various pieces of transparency legislation governing the healthcare delivery system, including purchasers and payers of healthcare. Specifically, the federal Consolidated Appropriations Act strengthens oversight by prohibiting gag clauses in service provider contracts and requiring plan service providers to disclose both direct and indirect compensation. It also mandates comprehensive reporting requirements for pharmacy benefits and ensures parity in coverage for substance abuse and mental health benefits, broadening the scope of fiduciary obligations.

These rules apply to all employer-sponsored plans regardless of the funding methodology selected, whether fully insured or self-insured. Industry surveys identify the growing migration of smaller and mid-market employers from fully insured to alternative forms of level-funded or self-funded plans with appropriate stop-loss protection. Employers recognize that changes in the stop-loss market, including the growth in the use of captives, now allow an employer greater participation in cost containment and quality of care initiatives, while mitigating their financial risk. Annual evaluation of funding options should be an integral part of an employer's fiduciary due diligence and evaluation process.

How to Mitigate Plan Sponsor Risk

Organizations must begin by designing and implementing a structured evaluation process for their health and welfare benefit strategy, and the vendors selected to deploy those strategies. Qualitative and quantitative metrics are necessary to:

1. Perform comprehensive claims analysis, including integrated price transparency data.
2. Develop financial stability assessments.
3. Validate vendor and provider performance.
4. Monitor overall plan effectiveness.

Establishing these fundamental metrics creates the framework for effective ongoing plan management.

To support this type of evaluation process, organizations should focus on developing robust data analytics capabilities appropriate to their size and resources. This includes integrating multiple data sources such as claims data, provider pricing information and quality metrics. Modern analytics platforms can help track network utilization patterns, identify cost outliers and monitor quality outcomes. Price transparency tools have become particularly crucial, enabling real-time cost comparisons and helping to identify opportunities for steerage and plan design optimization. Larger employers can enhance their monitoring protocols by adopting fraud monitoring systems, along with prepayment audit processes and post-adjudication review procedures (when contractually available), creating a 360-degree review to make better informed decisions.

Funding Options

Employers recognize that changes in the stop-loss market, including the growth in the use of captives, now allow an employer greater participation in cost containment.

Figure 1:
Documentation Process of Selection and Due Diligence

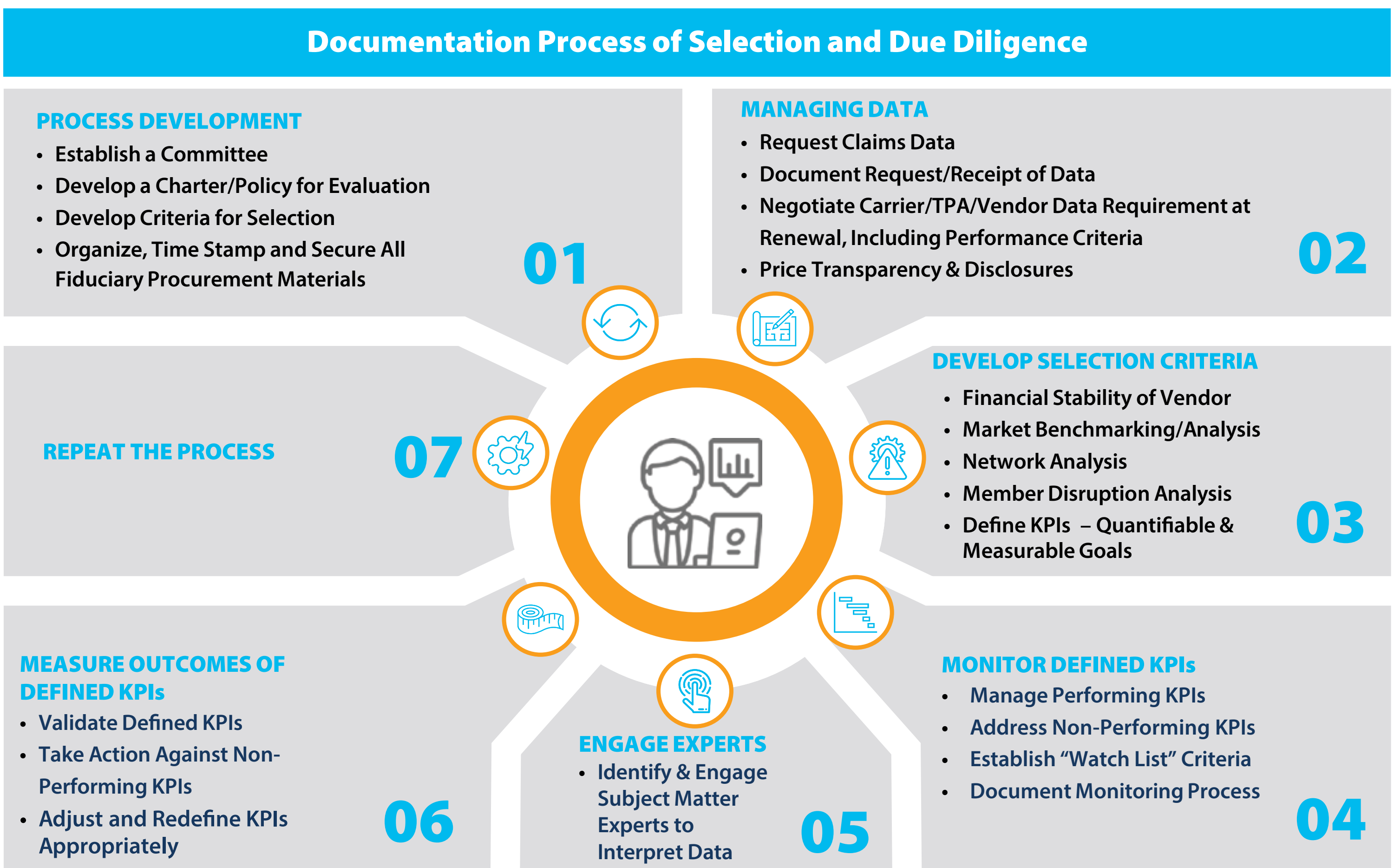


Figure 2:
Plans for Medical/Rx Renewal

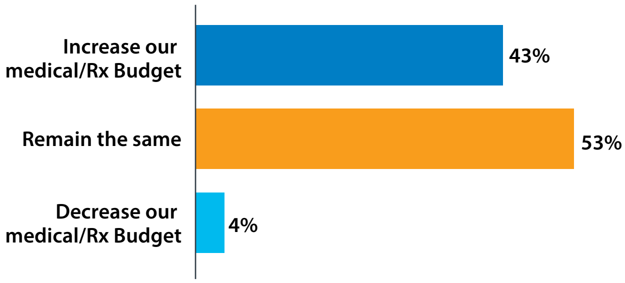
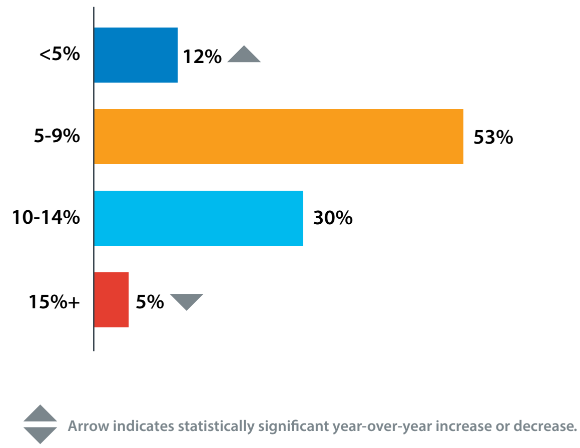


Figure 3:
Percentage Increase Planned
(Among those planning to increase medical/Rx budget)



Vendor Contract Review and Compliance

Regular vendor contract reviews to ensure compliance to contract terms improves cost containment provisions of the plan and are essential to proper plan oversight. Organizations should establish clear protocols for contract review, focusing on both cost and quality accountability by monitoring the reasonability of administrative fees, adherence to performance guarantees and member-level service metrics within the agreement. Documentation of the review process, findings and follow-up actions should be maintained, with clear escalation procedures for addressing identified issues.

Industry Response and Employer-Driven Solutions

Employers recognize the value their medical/Rx benefit plan has on recruiting and retaining employees. Figure 2 shows that 53% of employers are maintaining their current budget, while 43% will increase their budget. However, in response to mounting pressures, organizations are exploring innovative approaches to maintain quality and member satisfaction while pursuing alternatives to controlling costs.

Through the price transparency legislation, employers are empowered to take greater responsibility and control of their medical/Rx spend by visibility into the procedural unit cost of care. This is evidenced in Figure 4. 56% of employers strongly agree/agree in their ability to control medical/Rx expenses than trust in the government to bring market alternatives.

There is further market evidence of this trend observed in the growth of employer-driven coalitions which are gaining traction as powerful negotiating entities, particularly in regional markets where they can leverage collective bargaining power.

Figure 4:
Have Greater Trust in Ability to Control Medical/Rx Expenses than Trust in Government to Bring Market Alternatives

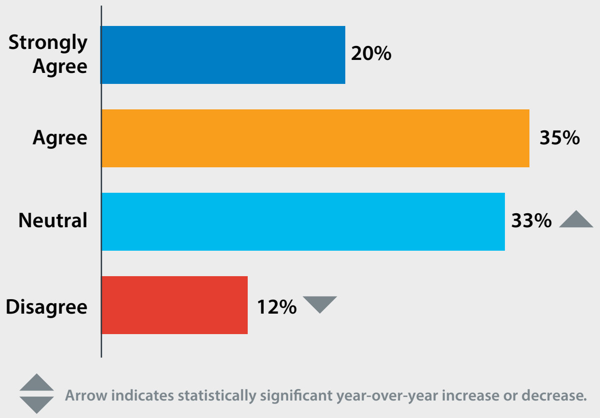


Figure 5:
Considerations for Offsetting Costs
(Among those planning to keep costs the same)

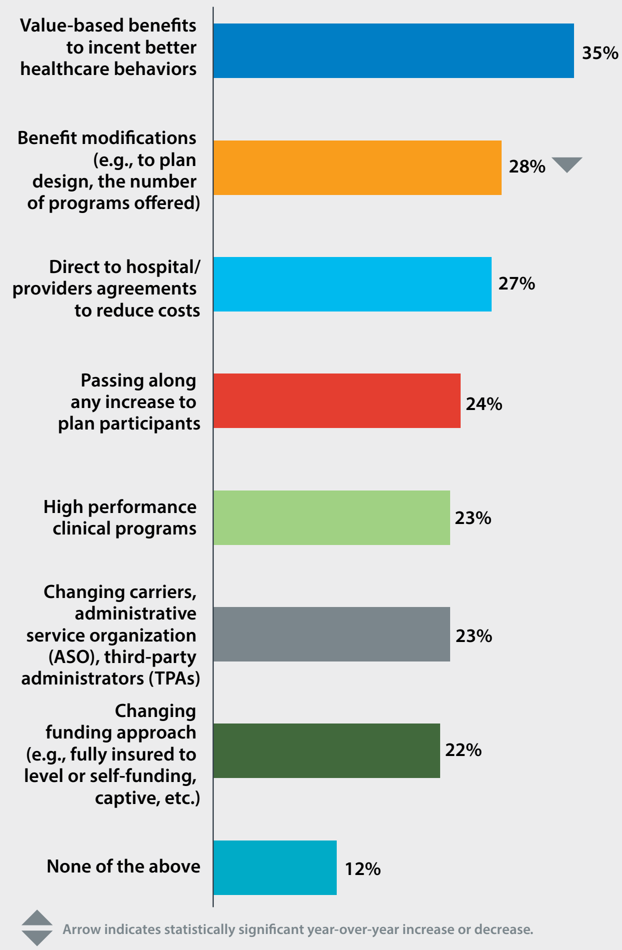


Figure 5 shows that employers are also choosing innovative solutions like value-based benefits and direct-to-hospital/provider agreements to reduce costs versus modifying employee benefits. Many of these coalitions are pioneering direct-to-employer arrangements with major health systems, demonstrating promising results in both cost control and quality management.

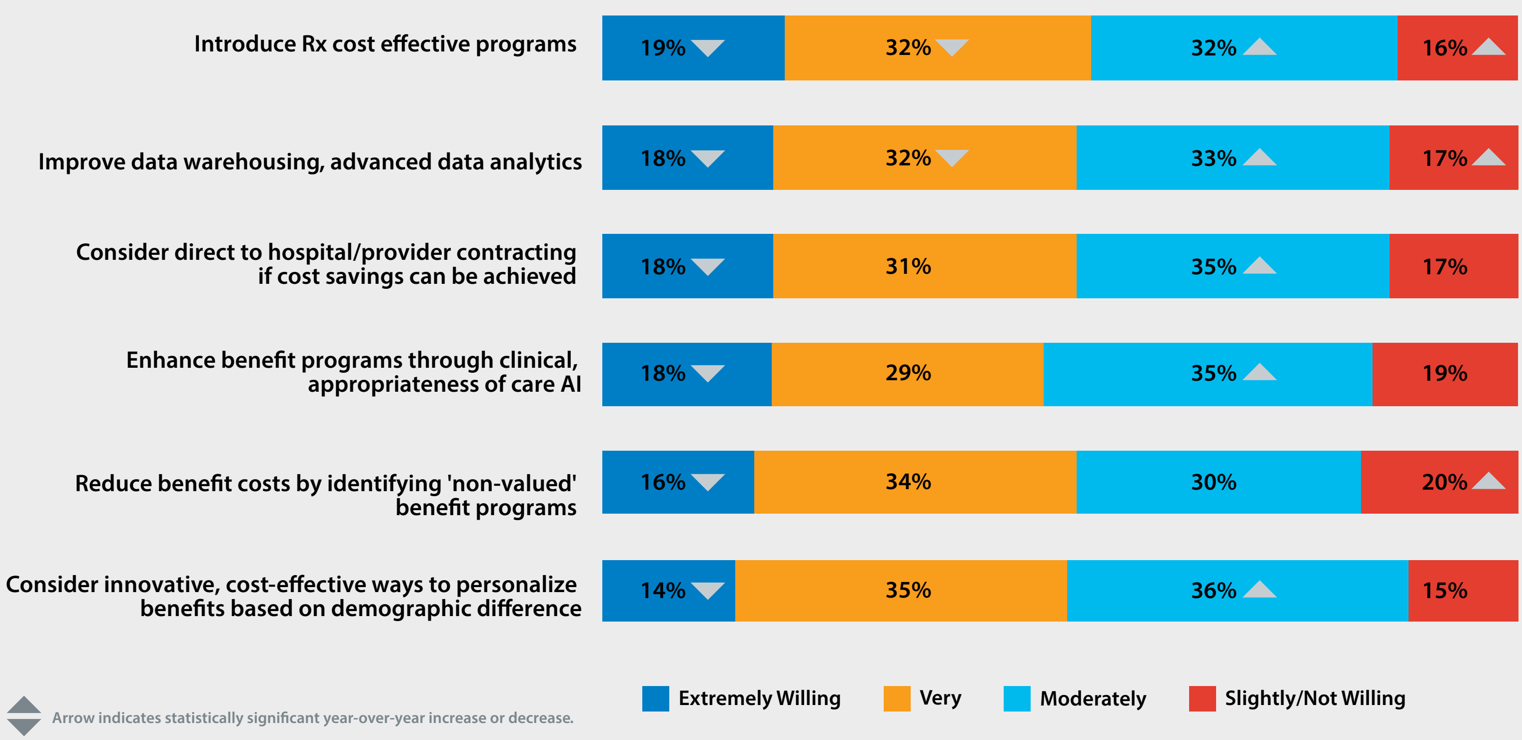
For self-funded plans, direct-to-employer limited scope hospital bundles represent another strategic approach to cost containment. These arrangements establish fixed pricing for defined episodes of care while maintaining quality through integrated metrics. The success of these programs depends heavily on clear service definitions, robust quality measurement protocols and thorough provider readiness assessments for the impacted market.

Through price transparency legislation, Figure 6, clinical quality is growing as an employer-driven strategy. Evidence-based provider appropriateness of care quality measurements is now a reality. Powered by AI, providers are being scored based on their treatment practices. These modern quality measures are becoming an integral component of the cost containment mechanisms being considered by plan sponsors.

Innovative Network Designs

Employer-driven cost containment strategies are utilizing innovative network designs like high-performance and narrow networks. Organizations exploring a narrow network and/or high-performance network strategy must undertake a comprehensive

Figure 6:
Likelihood to Consider Cost Containment Mechanisms*



evaluation of key factors to ensure successful implementation. Effective execution requires robust resource capabilities (internal or externally contracted), including advanced analytic tools for network adequacy analysis and geo-access evaluations. Infrastructure to assess quality metrics and analyze member impact is essential to align network strategies with organizational goals and member needs.

When executed effectively, narrow networks utilizing high-performance providers can yield considerable benefits. Organizations often experience facility cost reductions of 15% to 25%, driven by focused provider partnerships and optimized resources. These strategies also enhance quality metrics and foster improved data

*Due to rounding conventions, data may not add to 100%. For more details about the data, see Page 46 or contact marketing@nfp.com.


XIBLE STAINLESS STEEL
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transparency and reporting, positioning organizations for stronger negotiations in future network arrangements. By addressing challenges and leveraging strategic resources, organizations can achieve both immediate cost savings and long-term competitive advantages.

The transition to alternative network arrangements including high-performance networks may present some challenges to members. Member perception and engagement require transparent and proactive communication strategies to build trust and understanding. Some effective strategies have used clinical coaching to support members toward high-quality, low- or reasonable-cost providers.

Narrow Networks

When executed effectively, narrow networks can yield considerable benefits, such as facility cost reductions of 15% to 25%.

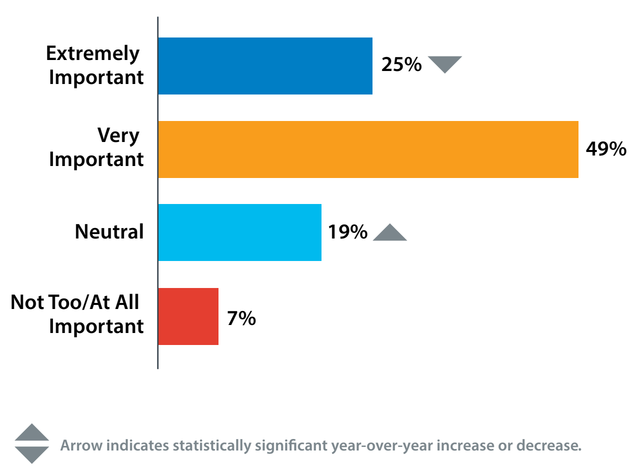
Tools to Support Employer-Driven Solutions

The market innovation necessitates adoption of advanced analytical capabilities, which has become an essential tool in this new landscape. Figure 7 demonstrates that 74% of employers recognize data analytics is very/extremely important. With publicly available data, modern platforms can provide real-time access to the unit cost of care for a procedure, through the price transparency data. Utilizing price transparency data allows employers to perform an independent network evaluation of their medical/Rx vendors to determine the best negotiated pricing for their members.

Plan sponsors can now monitor these innovative solutions in a new way. These modern platforms integrate quality measures with procedural cost data, analyze clinical appropriateness and benchmark against Medicare rates. This comprehensive approach enables organizations to make better informed decisions about network design, provider selection and benefit structure.

To support employer-driven initiatives toward both cost and quality accountability, NFP continues to improve upon our price transparency capabilities through a proprietary tool called TPNet (Transparent Pricing and Network Analysis). Contact your NFP representative to see how this tool can power your efforts and meet some of the necessary fiduciary requirements.

Figure 7:
Importance of Having Access to Data Analytics



Implementation and Engagement Considerations

While many of these employer-driven strategies offer significant potential benefits, successful implementation requires careful attention to employee and member change management. These challenges can be overcome through effective stakeholder communication and education, maintaining strong provider relationship management, and ensuring robust member engagement and feedback systems. Careful planning and resource allocation utilizing integrated technology and advanced data analytics are necessary to ease the burden of change and validate the value of the approach to management.

Measuring Success — Expert Engagement and External Resources

As part of a comprehensive health and welfare benefit program, organizations must implement broad risk mitigation strategies across all aspects of their health and welfare benefit programs. Frequently, this requires the engagement of subject matter experts (SMEs) and external resources. Due to the complexity of the price transparency regulations, engaging appropriate expertise is recommended.

Regardless of the specific health and welfare, cost containment, and quality approaches chosen, proper oversight and governance are essential to meet fiduciary obligations and manage the financial and legal exposure. A comprehensive risk management framework provides the foundation for the successful implementation of any cost and quality accountability initiative while ensuring compliance with regulatory requirements. This includes detailed financial impact measurements and member satisfaction metrics to ensure both cost efficiency and program effectiveness. Provider participation and engagement levels should be closely monitored to maintain network stability and quality. Quality outcome indicators help validate care delivery effectiveness, while operational efficiency metrics ensure smooth program administration. Regular review of these measures enables organizations to adjust strategies as needed and demonstrate program value to stakeholders.

Moving Forward

As healthcare costs continue to rise and fiduciary responsibilities expand, organizations must balance effective cost containment with their obligations to plan participants. Success requires a methodical approach that combines robust oversight, quality-of-care measures supported by data-driven decision making, and strategic partnerships.

Data Impacts

Modern analytics platforms can help track network utilization patterns, identify cost outliers and monitor quality outcomes.

Controlling Prescription Drug Spend: Strategic Analysis

In today's workplace, controlling prescription drug spend has become a critical priority, with 70% of employers rating it as very or extremely important. Rising costs are driving organizations to seek more sophisticated approaches to pharmacy benefit management.

Fiduciary Risk Management in Pharmacy Benefits

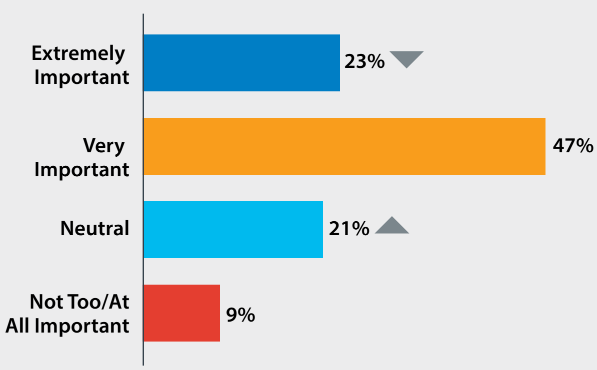
Recent high-profile litigation involving major employers has heightened awareness of fiduciary obligations in pharmacy benefit management. Given the ever-shifting nature of pharmacy benefits administration as well as new insights into legal prudence, these responsibilities are becoming increasingly scrutinized.

The scope of fiduciary duty in pharmacy benefits extends far beyond basic cost management. Much like overseeing the medical plan, plan sponsors must demonstrate that their pharmacy benefit decisions prioritize participant interests while maintaining prudent oversight of pharmacy benefit manager (PBM) relationships. This includes ensuring transparency in drug pricing, evaluating formulary decisions and monitoring the implementation of clinical programs.

What Fundamental Strategies Help a Client Meet Their Fiduciary Responsibility?

We are seeing three fundamental strategies designed to help employers optimize their pharmacy benefits spend: pharmacy benefit arrangements, cost control products and programs, and comprehensive audit frameworks. Each approach offers distinct advantages and, when implemented cohesively, can create a robust foundation for managing prescription drug costs while maintaining high-quality patient care.

Figure 1:
Importance of Controlling Rx Spend

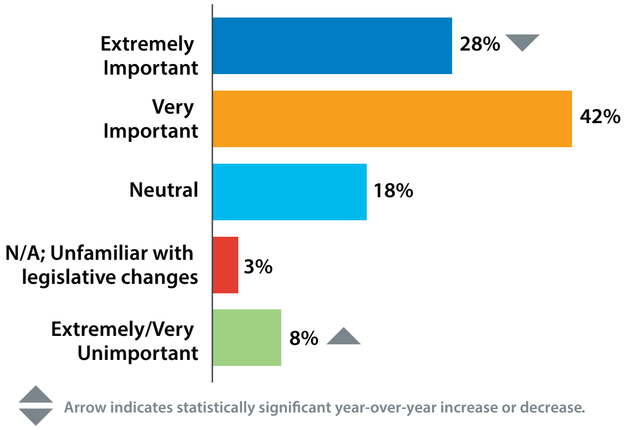


Arrow indicates statistically significant year-over-year increase or decrease.

Figure 2:
Pharmacy Benefit Arrangement Used

Figure 3:

Importance of Establishing Continuous Improvement/Best Practice Policy for Medical/Rx Plan Selection in 2025*



Carve-Out Strategy

The pharmacy benefit management landscape reveals a growing shift toward independent benefit management, with 64% of employers now choosing either direct PBM carve-out (27%) or coalition participation (37%). This trend reflects increasing recognition of the value in stand-alone pharmacy strategies, while 36% maintain traditional carved-in relationships with their third-party administrator or carrier. The market's evolution demonstrates employers' growing preference for models that offer greater control and specialized pharmacy management, including a more robust set of tools allowed for both cost control products and programs and auditing.

Implementing a carve-out strategy allows employers to gain greater visibility and control over their prescription drug spend. Recent legislative policies and litigation have highlighted the critical need for transparency in drug pricing data, making the separation of pharmacy from medical carriers increasingly important. By peeling away pharmacy benefits from medical coverage, organizations have considerable opportunities to enhance their pharmacy benefits by better utilizing their data. While organizations are increasingly recognizing the value of analytics in identifying cost-saving opportunities, many have yet to fully embrace the potential positive effect a fully data-driven approach can have on their pharmacy spend.

Cost Control Products and Programs

Value-based pharmacy products represent a novel shift in how organizations are approaching pharmacy benefit management. These partnerships leverage innovative management tools to create more sustainable and effective models for controlling drug spend.

With 70% of employers prioritizing the establishment of best practice policies for Rx plan selection, these value-based partnerships are becoming increasingly common. By leveraging pharmacists' comprehensive consulting expertise in drug information, industry trends and emerging therapies, clients are using cost avoidance strategies to lower per capita care costs.

The core structure of these products and programs are based on performance-based contracting. This approach has gained significant traction, with 98.3% of NFP clients reporting that their Rx contract negotiations are focused on optimal pricing and contract terms. These contracts often incorporate quality metrics and financial risk-sharing frameworks, creating a balanced approach to cost management while mitigating the risk of stale or uncompetitive pricing that can lead to higher downstream premiums.

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Comprehensive Audit Framework

Contract compliance reviews serve as a foundation for maintaining accountability and transparency in pharmacy benefit management. These reviews not only ensure all stakeholders fulfill their contractual obligations but also provide organizations with valuable insights into their PBM relationships. Regular monitoring and evaluation of contract performance helps identify opportunities for optimization, supports more effective negotiations and ultimately contributes to better cost management outcomes.

Figure 4:
Satisfied with Client Pricing Negotiations

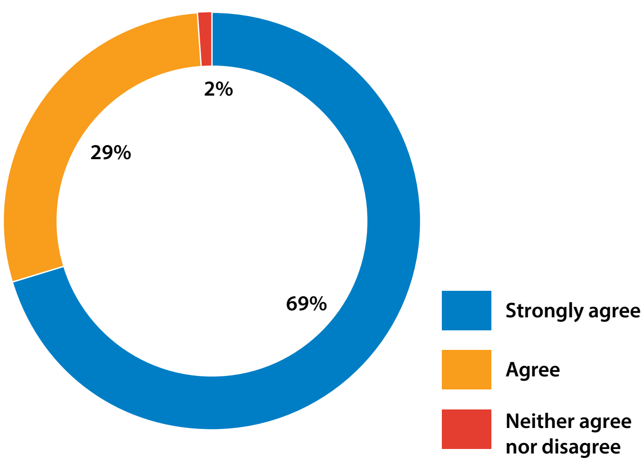
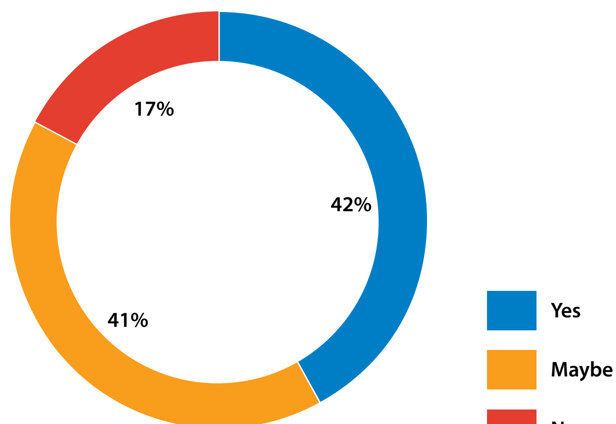


Figure 5:
Interest in Medical Drug Utilization Review



Client Medical Drug Utilization Services

The foundation of trusting but verifying is leading to robust oversight of PBMs. 83% of NFP clients respond that they would be interested in even greater options to audit their pharmacy benefit partners, and 83% of clients would want to have greater scrutiny of the prescriptions covered under their medical benefit.

Client Audit Services

A robust audit strategy begins with sophisticated data analytics capabilities. The importance of this capability is underscored by the fact that 94.9% of NFP clients report that their Rx teams help provide greater transparency and access to PBM data and reporting. This real-time data transparency enables organizations to quickly generate actionable insights, identify trends, implement cost mitigation strategies and address potential issues before they become significant problems.

Figure 6:
Interest in Audit Services

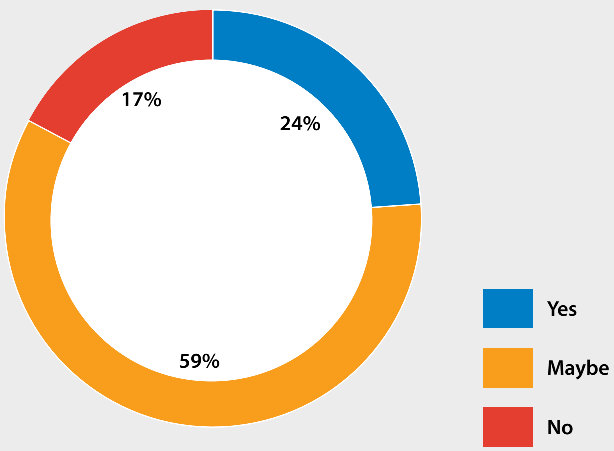
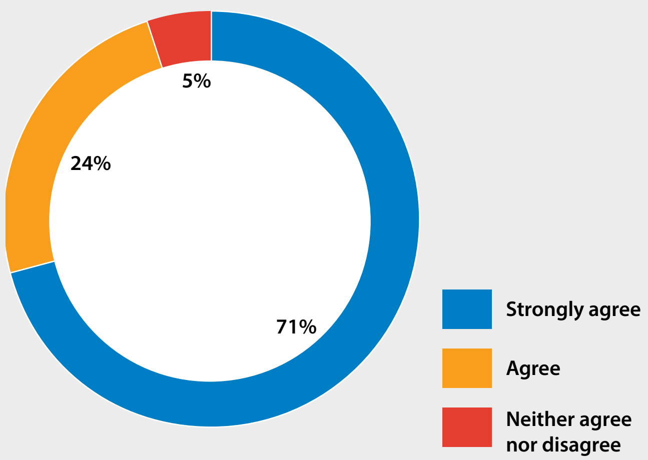


Figure 7:
Satisfied with Data Transparency and Reporting



Taking Action

To control drug spend, organizations must take a multifaceted approach to managing their pharmacy benefits. The data clearly shows that employers who implement comprehensive strategies – from carve-out arrangements to robust audit frameworks – are better positioned to control costs while maintaining high-quality benefits for their employees.

Key Action Items to Bridge the Gap

Leverage Expert Guidance

- Partner with pharmacy benefit consultants who can provide market insights and negotiating leverage
- Utilize specialized expertise for contract reviews and performance guarantees
- Access broader market data and benchmarking through consulting relationships
- Tap into consultant resources for ongoing program optimization and trend monitoring

Strengthen Cost Control Mechanisms

- Assess your current PBM arrangement against market alternatives
- Consider whether a carved-in, carved-out or coalition model better serves your organization's needs
- Evaluate performance-based contracting opportunities with your PBM
- Review formulary management strategies and specialty drug protocols
- Consider implementing targeted disease-state programs for high-cost conditions

Enhance Data Analytics Capabilities

- Establish regular reporting cycles for key performance metrics
- Implement drug utilization reviews to identify cost-saving opportunities
- Develop dashboard monitoring for prescription drug spending trends
- Create alerts for unusual spending patterns or utilization changes

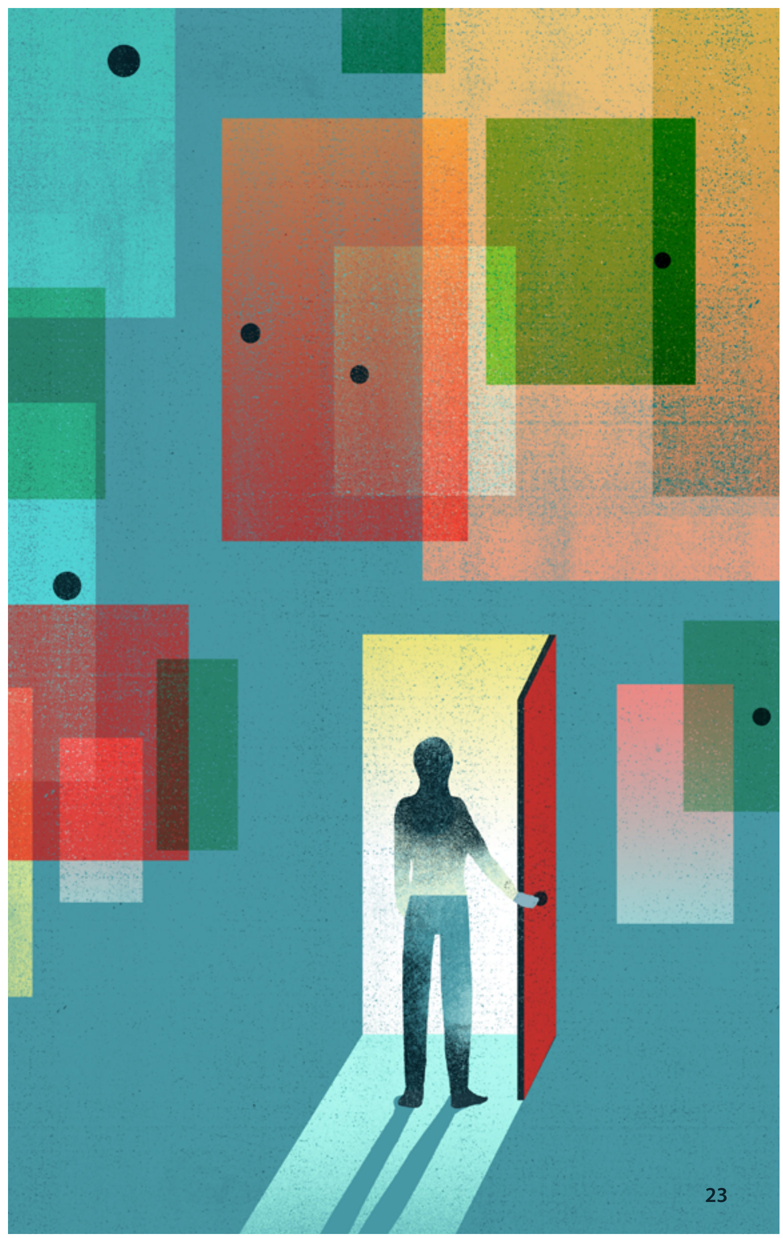
Fortify Compliance and Risk Management

- Schedule regular contract compliance reviews
- Document formulary decision-making processes
- Update policies and procedures to reflect current regulatory requirements
- Maintain clear records of fiduciary oversight activities

Plan for Future Optimization

- Set specific cost management targets with measurable outcomes
- Develop a roadmap for implementing best practice policies
- Create a timeline for regular program evaluation and optimization
- Build in flexibility to adapt to emerging market trends and regulatory changes

By taking strategic, connected steps, organizations can work toward creating sustainable and effective pharmacy benefit programs. Success in managing prescription drug spend requires ongoing commitment, regular evaluation, and willingness to adapt as market conditions and regulatory requirements evolve. The investment in comprehensive pharmacy benefit management today will pay dividends in both cost control and improved health outcomes for years to come.



Mind the Gap: Wellbeing Trends for 2025

Today's employers face an increasingly complex landscape in managing employee wellbeing. Beyond dealing with point solution fatigue – where numerous niche benefits lack scalability and holistic integration – organizations must contend with economic pressures, disjointed hybrid workforces and an ongoing mental health crisis. With employees facing an unprecedented blend of personal, mental and financial health challenges, they're seeking more from their employers than ever before.

Beyond traditional benefits and compensation, employees now require comprehensive support and tools to thrive both professionally and personally.

To accommodate this and effectively move the employee needle, organizations should strategically identify and address critical wellbeing gaps in their benefits offerings. A systematic evaluation framework can help in this endeavor by prioritizing initiatives in four key dimensions:

Figure 1:
Evaluation Framework in Four Key Dimensions

Universal Solutions that Serve the Entire Workforce
- Social Wellbeing
- Mental Wellbeing

Targeted Programs Addressing Gender-Specific Needs
- Women's/Men's Health
- Family Caregiving

Interventions for Prevalent Health Conditions
- Mental Health
- Weight Management/Loss

Support Strategies Tailored to Different Cohorts
- Caregiving
- Women's Health

Such an approach ensures resources are allocated to populations with the highest potential impact while aligning with organizational priorities and maintaining comprehensive support across the workforce.

The wellbeing trends discussed in this report – mental health and mental wellbeing, caregiving, physical health and social wellbeing – are key areas where employers can close wellbeing gaps. By focusing on these trends, organizations can enhance employee wellbeing, increase satisfaction and drive broader financial wellness for employees and the organization at large.

Figure 2:
Mental Health Resources Offered

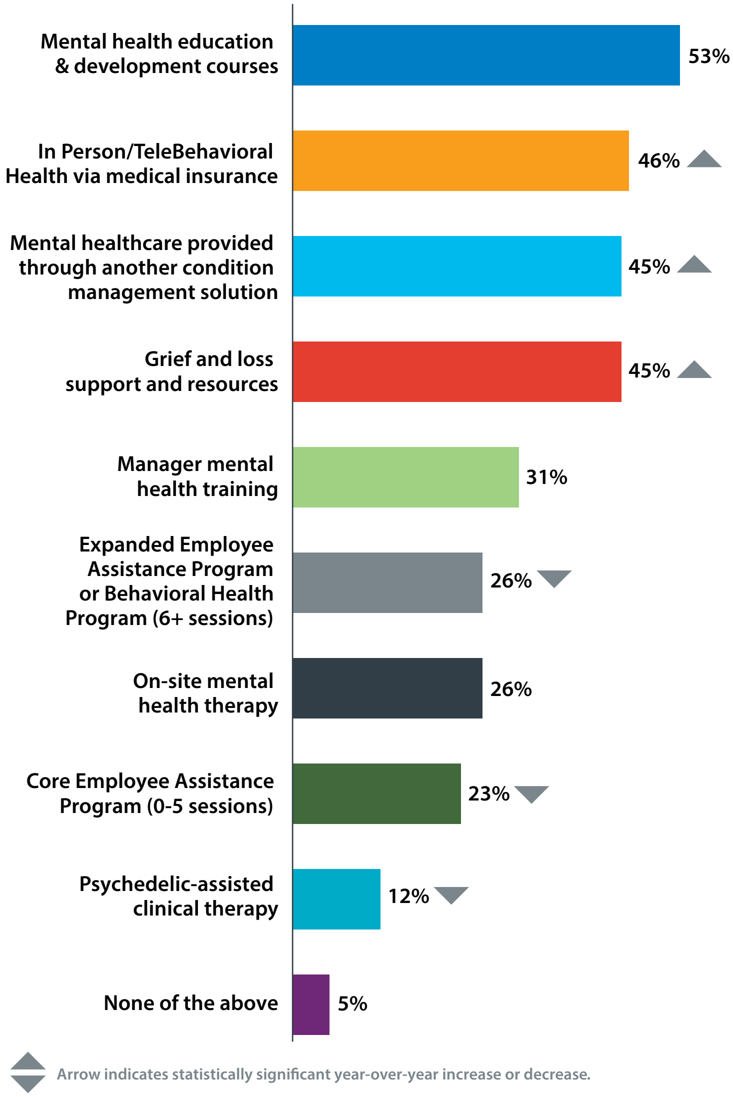


Figure 3:
Mental Wellbeing Programs Offered

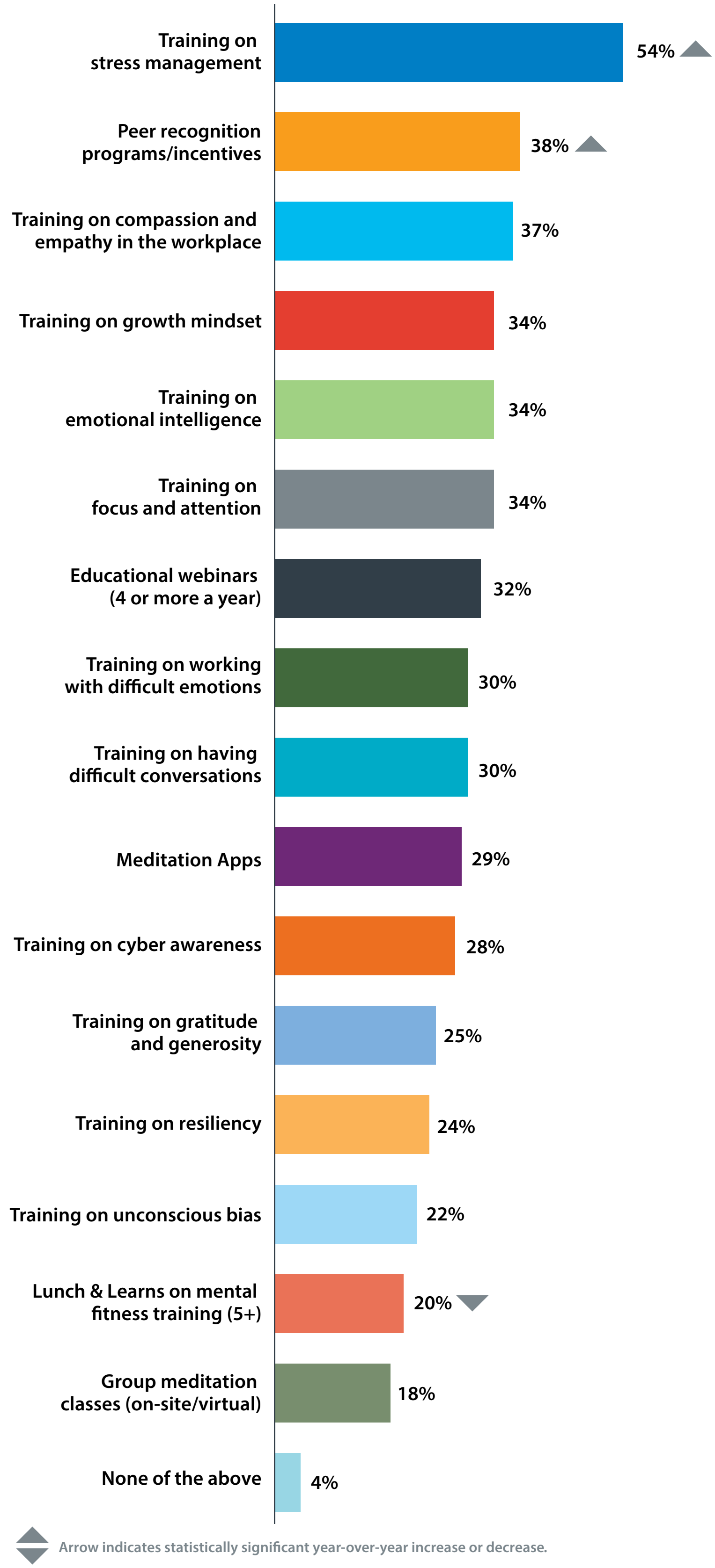
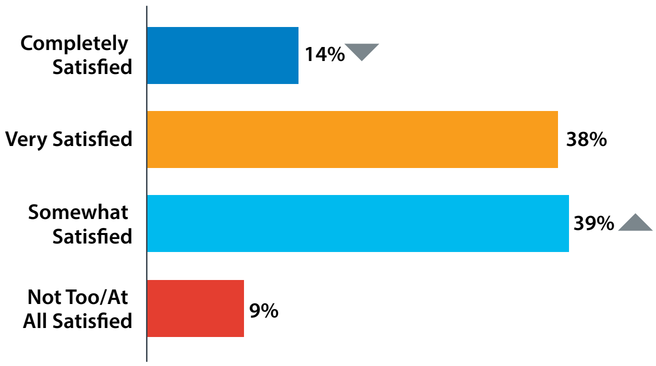
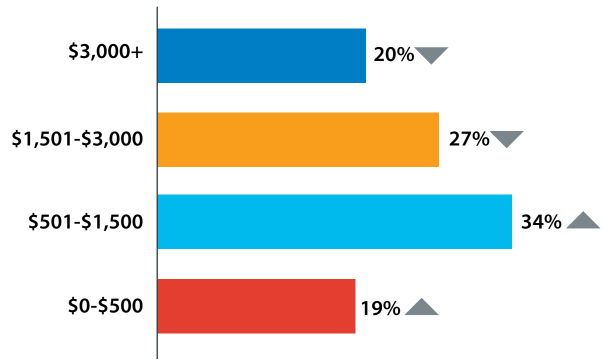


Figure 4:
Satisfaction with Employee Engagement in Wellbeing Programs and Benefits



Arrow indicates statistically significant year-over-year increase or decrease.

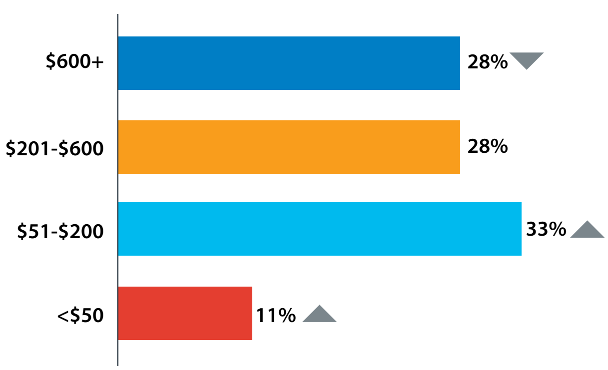
Figure 5:
Per Employee Spend on Mental Health Resources



Arrow indicates statistically significant year-over-year increase or decrease.

Note: Mental health resources have shifted from EAP-based to other solutions, likely contributing to lower spend per employee on mental health resources.

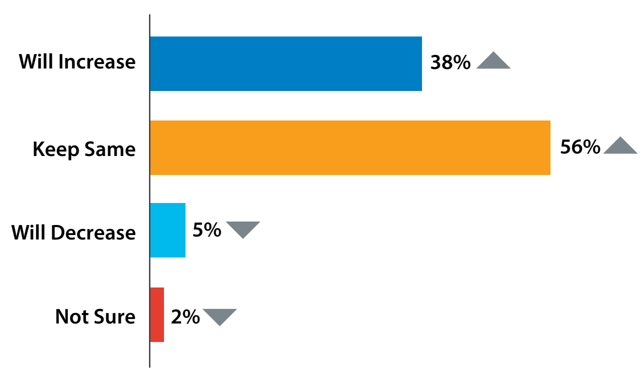
Figure 6:
Per Employee Spend on Mental Wellbeing Programs (Annual)



Arrow indicates statistically significant year-over-year increase or decrease.

Note: Mental wellbeing programs appear to be a more common benefit in the workplace, though the annual per employee spend appears to have dropped slightly from last year.

Figure 7:
2025 Plans for per Employee Spend on Wellbeing Programs*

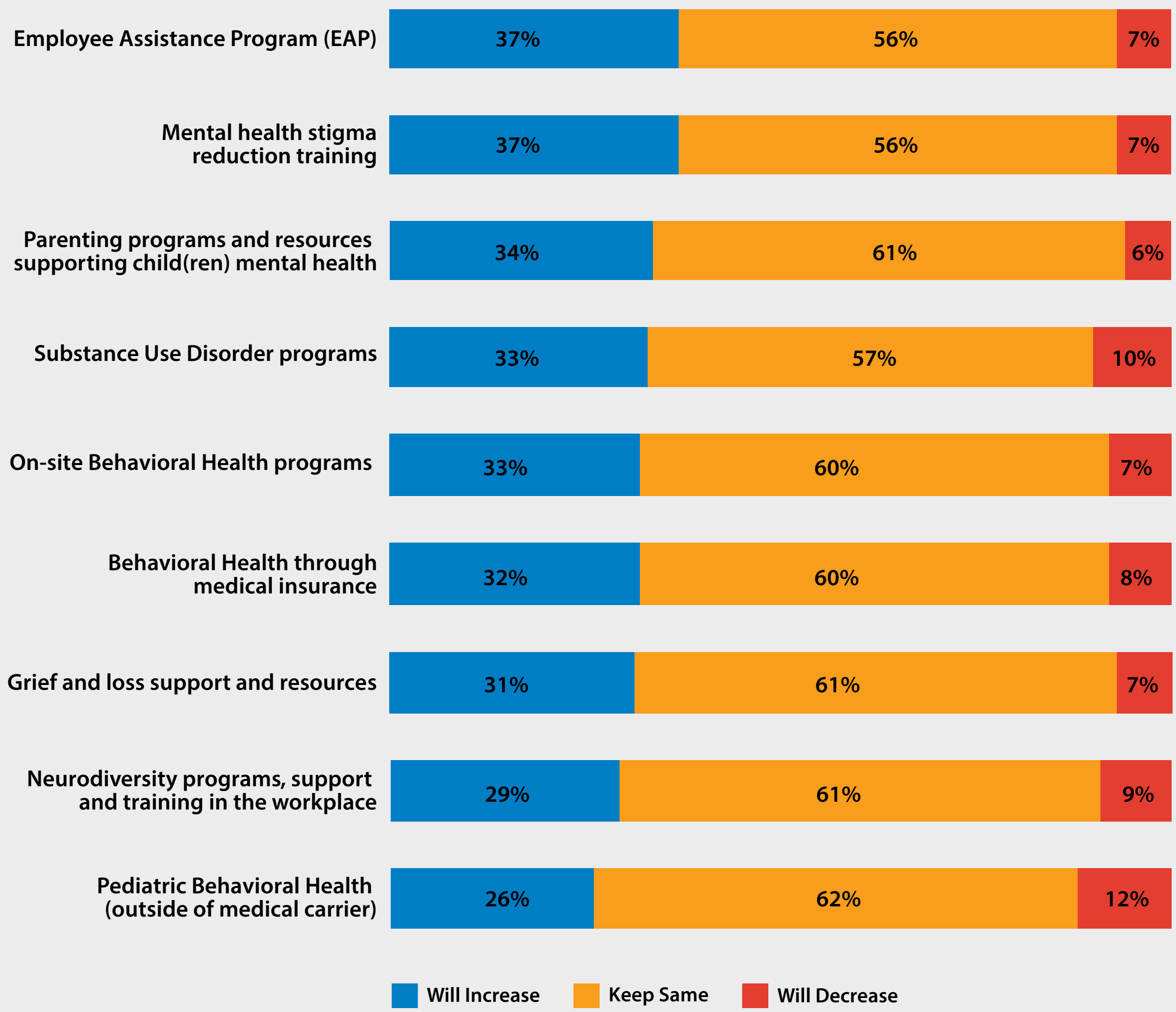


Arrow indicates statistically significant year-over-year increase or decrease.

*Due to rounding conventions, data may not add to 100%. For more details about the data, see Page 46 or contact marketing@nfp.com.

Figure 8:

2025 Plans for Benefits Support/Programs



Mental Health and Mental Wellbeing

Organizations are expanding their mental health support strategy through three critical dimensions. First, employers are prioritizing pediatric and dependent-children mental health services, recognizing that these increasingly needed solutions are harder to find and crucial for workforce wellbeing. Services like ReThink Health and Torchlight provide targeted mental health resources for dependent children, helping parents manage their children's mental health needs while maintaining workplace productivity.

Second, while there's a shift toward integrating mental health support into condition management platforms – such as incorporating counseling into cancer care or cognitive behavioral therapy into fertility programs – this trend raises concerns. Some employers are reducing direct mental health spending, viewing this integration as

Figure 9:
Workplace Stressors

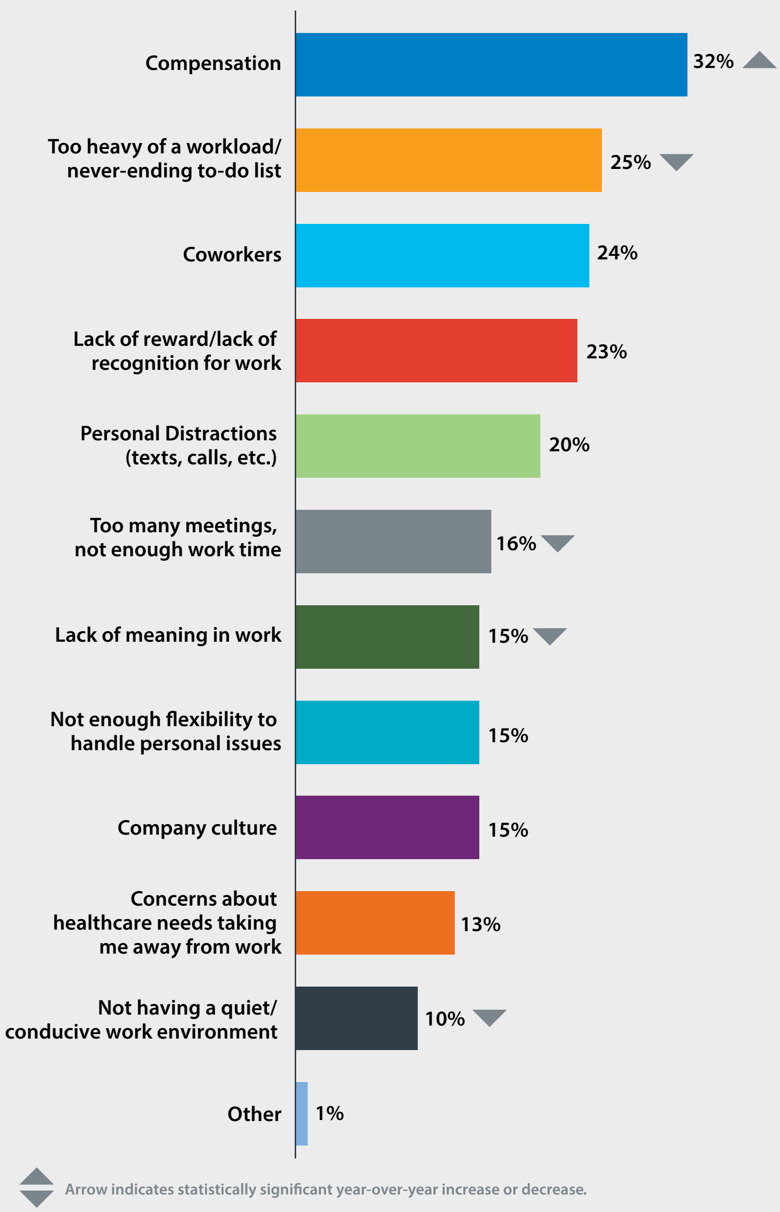
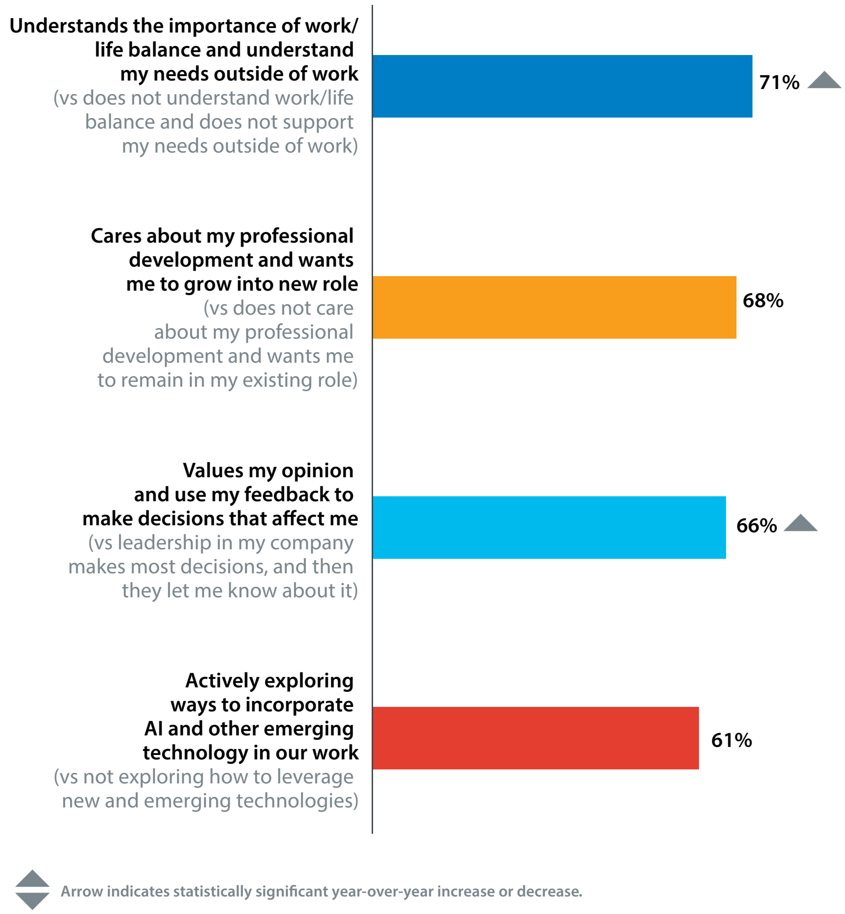


Figure 10:
Employee Perception of Employer



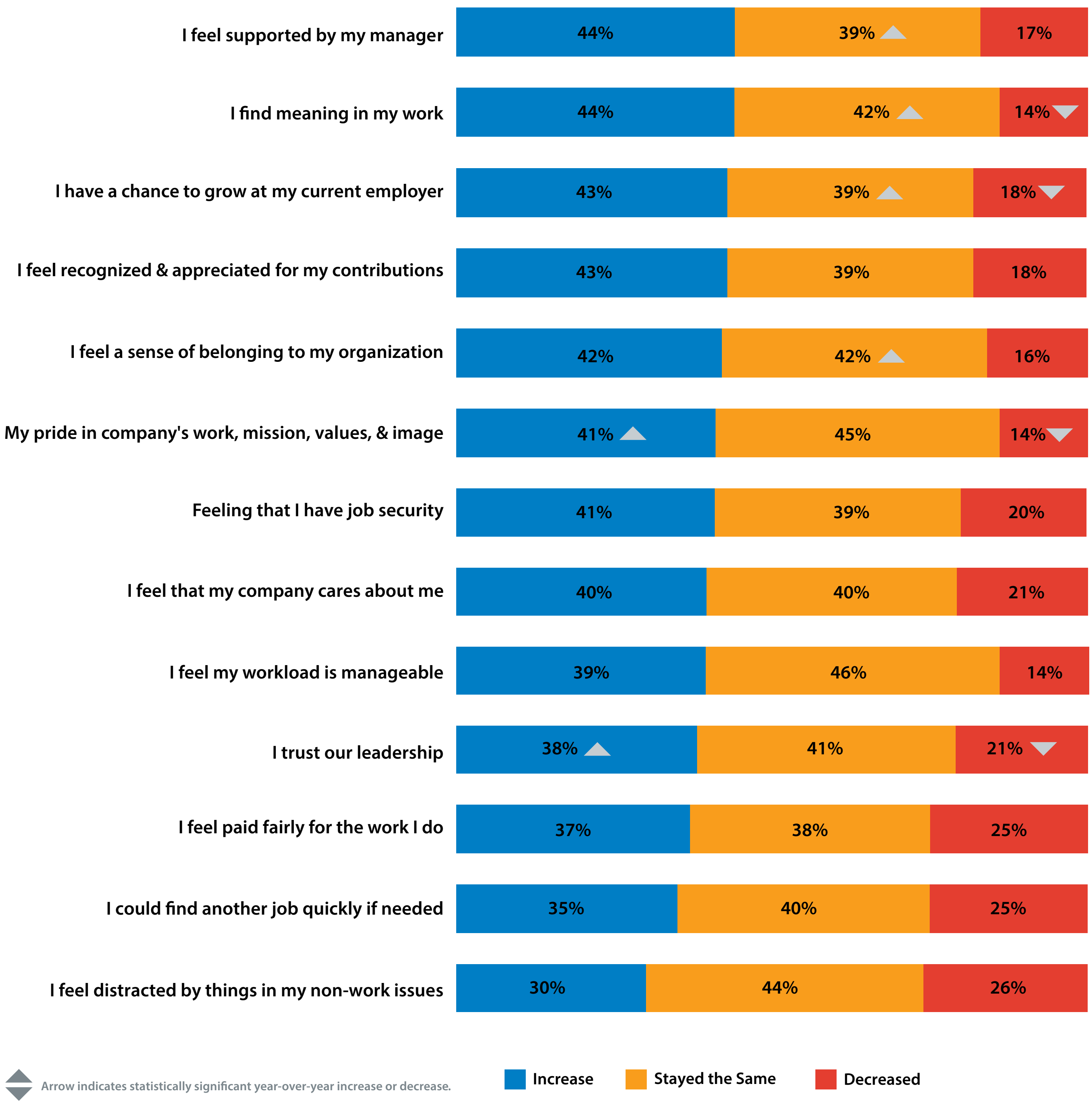
Note: Employees maintain strong perceptions of employers, with growth in feeling that employers value their opinion and understand the importance of maintaining a positive work/life balance compared to last year.

sufficient coverage. However, with nearly 25% of adults and 20% of teens experiencing mental health conditions,* and with substance use disorders on the rise, mental health demands dedicated attention and resources. While integrated support can be valuable, it shouldn't replace comprehensive, stand-alone mental health solutions. Mental health is a distinct health condition requiring focused interventions beyond what's available through physical health programs.

Third, and perhaps most critically, organizations are confronting a significant care gap in addressing workplace mental wellbeing, particularly burnout. Unlike clinical mental health conditions, burnout is not found in the DSM or recognized with a current procedural terminology code — it's a condition created by and best addressed through workplace environment and culture interventions.

*Mental Health America. "Prevalence of Mental Illness 2024," mhanational.org.

Figure 11:
Changes in Workplace Engagement in the Past 12-18 Months



Note: Employee engagement appears to increase across key metrics, including pride in the company's work and trust in leadership.

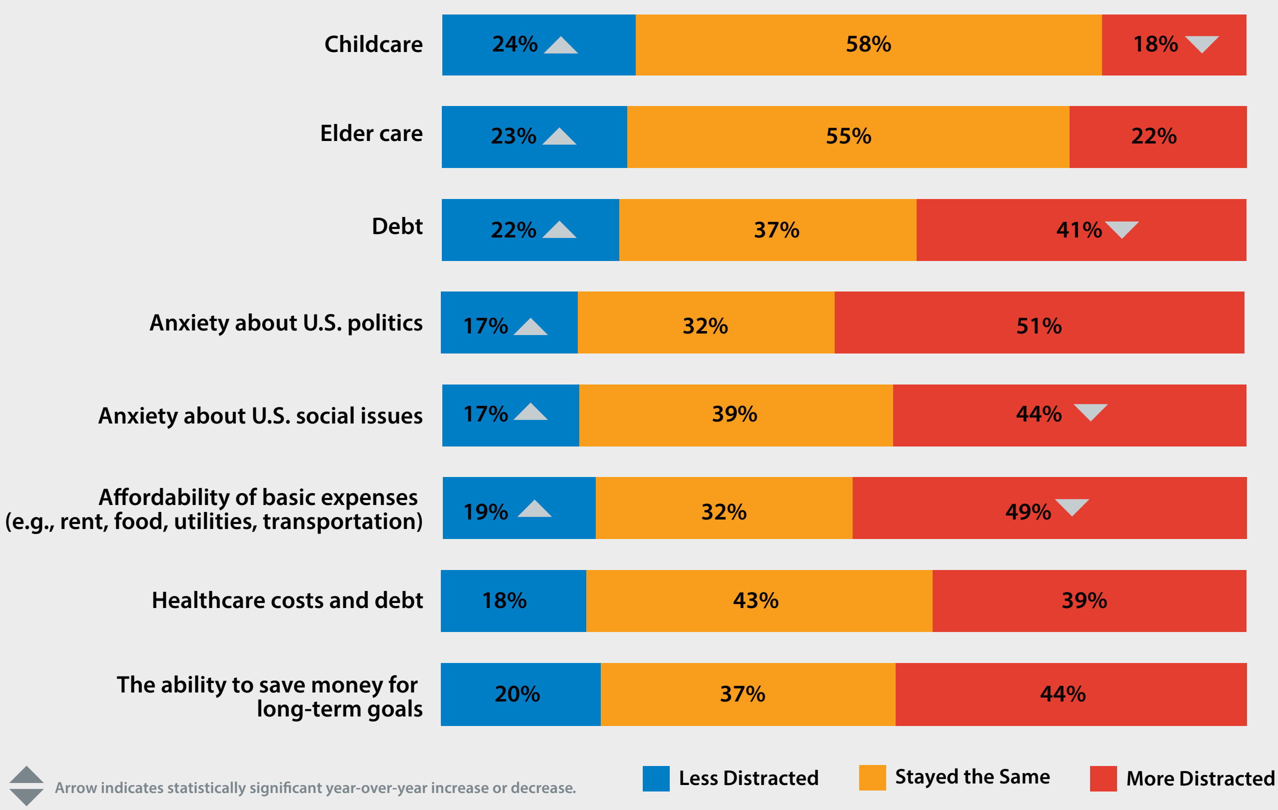
Caregiving Support

The growing "sandwich generation," that cohort of adults caring for both their aging parents and children, faces their own set of distinct challenges. Organizations are responding with comprehensive support strategies that go beyond basic flexibility. While expanded leave policies and remote work options remain foundational, employers are implementing dedicated caregiving resources that enable employees to maintain career momentum while better managing family responsibilities.

This support is demonstrated through specific resources that focus on the core aspects of caregiving. Financial counseling helps employees navigate the economic impact of caregiving, while respite care options provide crucial breaks to prevent burnout. Eldercare navigation tools assist with complex healthcare decisions and age-related challenges. These comprehensive support systems are mutually beneficial in that they help reduce the mental and emotional burden on caregivers while maintaining workplace engagement and productivity.

Figure 12:

Changes in Non-Workplace Distractions in the Past 12 Months



To further enhance caregiver support, organizations are implementing sophisticated productivity tools and concierge services that streamline caregiving management. As digital platforms provide secure, centralized storage for caregiving notes, appointments and documentation, they allow family caregivers to collaboratively manage care responsibilities. Some platforms are complemented by access to geriatric social workers who provide expert guidance on critical decisions regarding disease progression, living arrangements and age-related challenges such as hearing loss and mobility issues. Centralizing these resources and providing professional support is a novel approach to helping caregivers navigate complex healthcare and financial decisions, all while maintaining focus and productivity at work.

Physical Wellbeing

Physical wellbeing initiatives are broadening their scope to focus on two critical areas: comprehensive health and weight management. In the women's health space, organizations are expanding their benefits to support employees throughout their entire health journey. This includes comprehensive coverage for reproductive health, fertility treatments and menopause support. By offering solutions like women's health telemedicine services, fertility treatments, pelvic floor physical therapy and menopause coaching, employers can boost engagement and retention while reducing the physical and emotional impact these health challenges have on their workforce.

In the men's health space, employers are recognizing that fertility challenges affect a significant percentage of couples worldwide, with about half of the cases attributed to male factor infertility. Solutions like Posterity Health are helping organizations take an inclusive approach to fertility support, ensuring equitable benefits for all employees.

The rise of GLP-1 medications for weight management has renewed the importance of fundamental wellbeing practices, including hydration, nutrition and physical activity. While these medications offer promising results, organizations recognize the need to support all employees in their weight management journey, including those who may not be eligible for GLP-1 drugs. To fill this gap, increased investment in holistic wellness programs that emphasize sustainable lifestyle changes through nutrition education, exercise programs and overall wellbeing support have emerged as sustainable, long-term solutions.

Social Wellbeing

Organizations are strengthening workplace connections and company loyalty through a dual approach to social wellbeing. First, employers are strategically leveraging on-site wellbeing events to encourage office returns while fostering organizational pride and connection. These events, including health fairs,

Figure 13:
Strategies Leveraged for In-Office Worktime

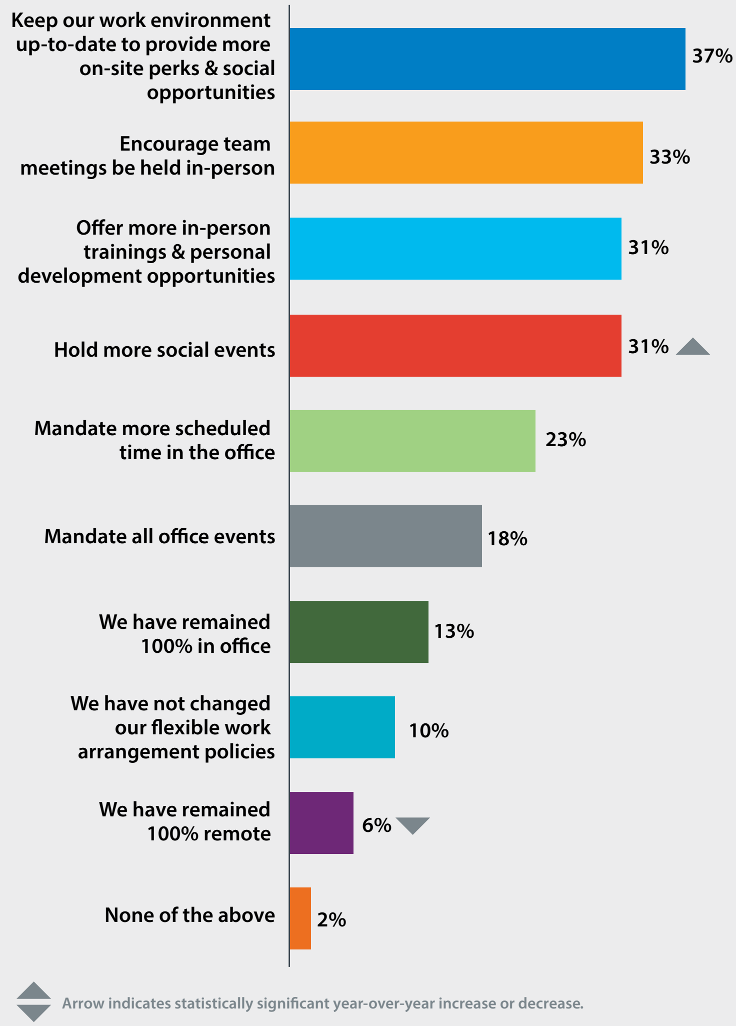
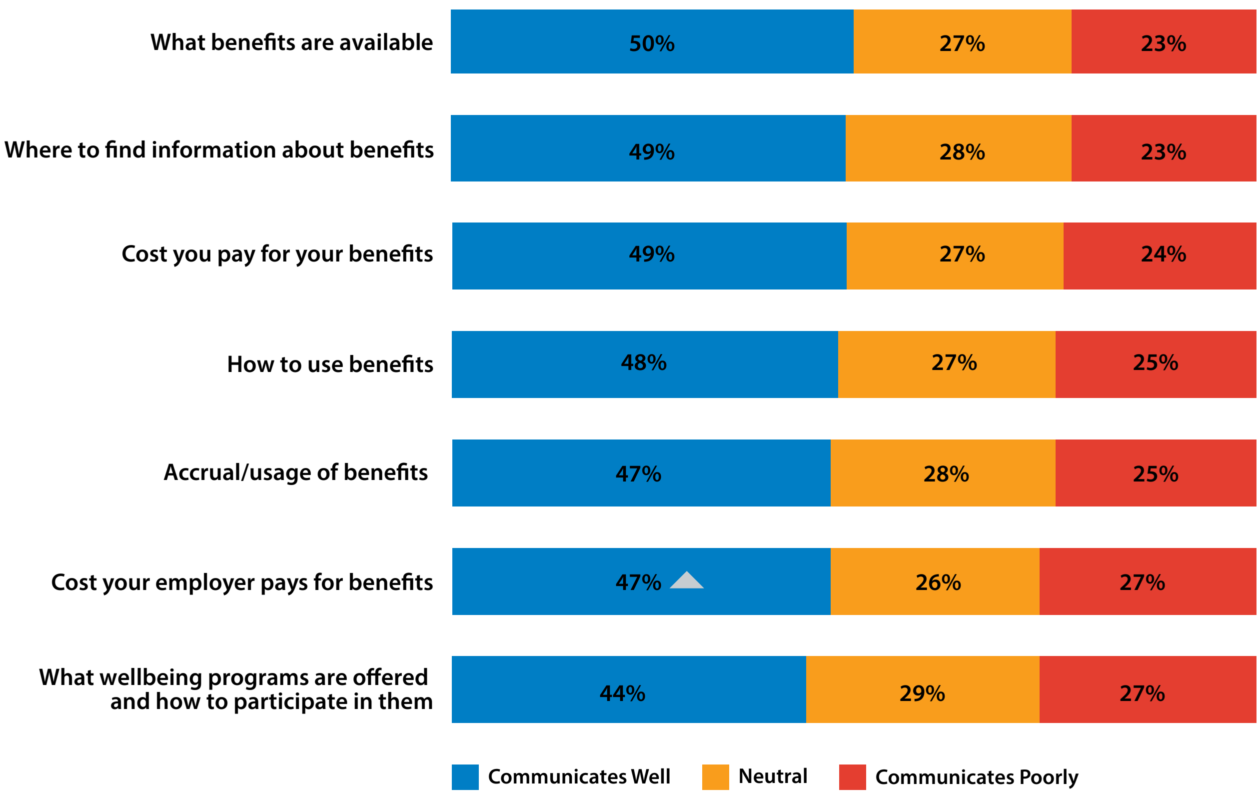


Figure 14:
Effectiveness of Employer Benefits Communication



biometric screenings and preventive health clinics, serve dual purposes: they address immediate health needs through vaccines and screenings while creating organic opportunities for employee interaction. This approach reinforces a culture of care and community, strengthening the shared sense of purpose within the organization.

Second, companies are revitalizing their digital wellbeing platforms to unite both remote and in-office employees. These comprehensive platforms facilitate social connections through engaging activities like team challenges, friendly competitions and achievement leaderboards. By gamifying health initiatives, organizations have the chance to create an inclusive environment that encourages interaction and mutual motivation across all work arrangements. These digital tools have proven effective in promoting both physical health goals and social connections, creating a unified workplace culture regardless of employee location.

Ultimately, focusing on these key trends – mental health and wellbeing, caregiving, physical wellbeing and social wellbeing – can not only enhance employer wellbeing offerings but also strengthen employee engagement and organizational connection. While financial wellbeing isn't explicitly highlighted, each initiative contributes to employees' financial health through reduced healthcare costs and improved productivity. Tracking and communicating these outcomes remains essential for demonstrating the holistic value of wellbeing programs and their impact on organizational success.

Note: Posterity Health is an NFP-owned venture portfolio company.

Leave Management Is Complex and Employers Need Help

With the ever-growing spider web that is leave of absence laws, keeping up with and managing leave requests can be overwhelming. While these laws provide valuable support to employees, spanning from job and health benefit plan protection to wage replacement benefits, the resources needed to stay up to date and administer them can be a significant administrative burden on employers.

Unpaid and Paid Leave Laws

Unpaid leave:

Unpaid leave laws primarily ensure an employee's job is protected in the event they need to be away from work for a qualifying leave reason. These laws are rooted in the federal Family and Medical Leave Act (FMLA) which protects eligible employees for up to 12 workweeks (26 weeks for military caregivers).

States can make their own laws that add to the federal FMLA. Possible changes include expanding the reasons for taking leave, providing additional job-protected time and lowering the eligibility requirements.

Paid leave:

In addition to job protection, some laws provide paid leave. These are most often at the state level but could also be at a city/municipal level.

Paid sick leave laws provide benefits that are typically for shorter-term absences, while mandated state disability or paid family leave benefits cover leaves for longer-term absences (serious health conditions). When discussing leave management services and solutions, paid sick leave laws are generally excluded.

Company-Specific Leave Plans

Beyond federal and state leave laws, employers can create their own leave policies. These policies are often crafted to provide additional job protection; support leave beyond FMLA or applicable state laws, include paid benefits, etc. While company policies can expand on existing protections, they cannot take away or remove any entitlement or protection otherwise provided by federal or state law.

Figure 1:
Types of Leave Offered

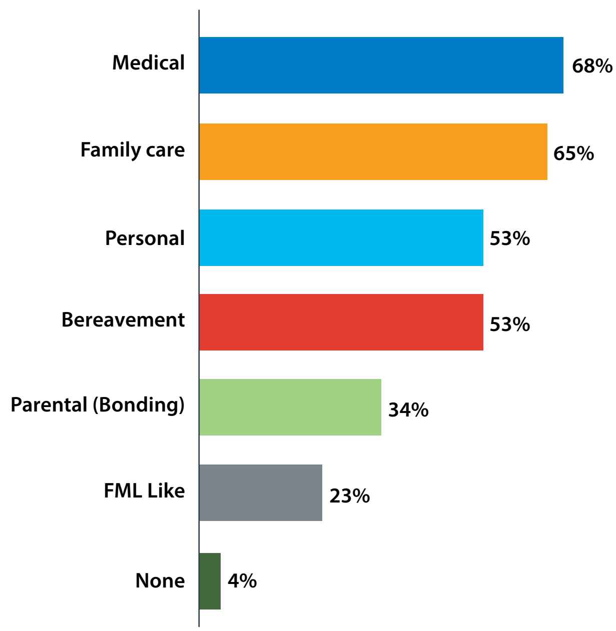
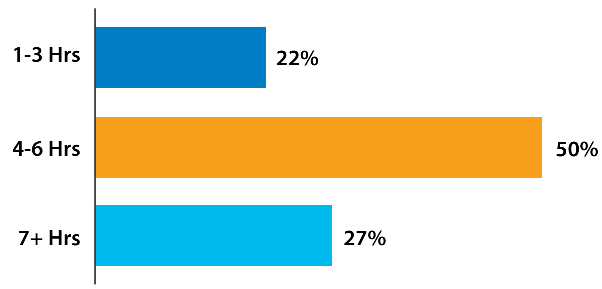


Figure 2:
Hours Spent on Leave Admin per Leave*



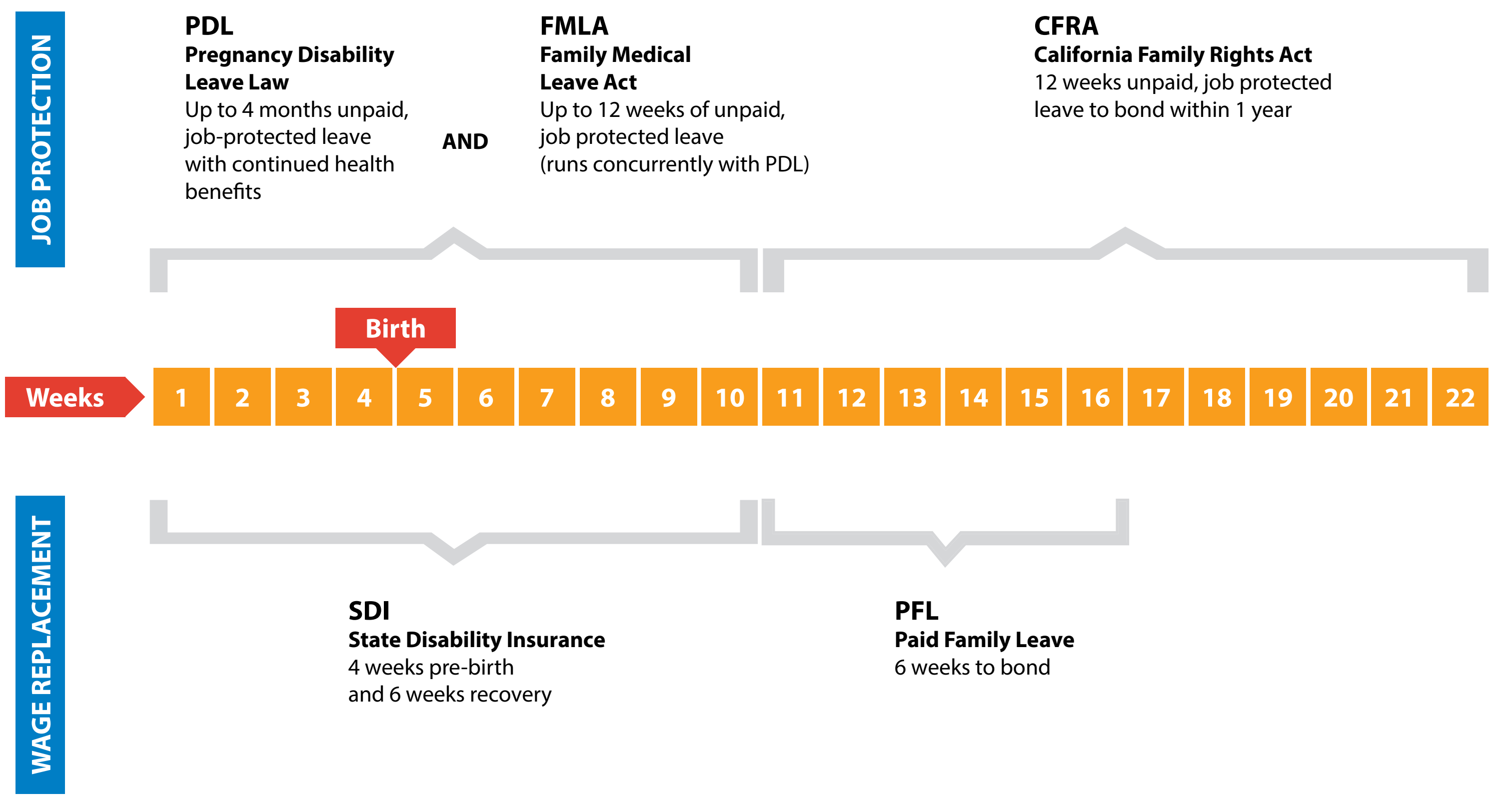
Note: With the right leave solution in place, the graphic would show 71% of respondents spending just one to three hours per leave request, a stark contrast to the current reality where 71% are spending more than four hours on each leave.

Impact to Employers

Unpaid leaves, like the FMLA, are by default the employer's responsibility to administer. To remain compliant, employers must follow rules and regulations that cover many aspects of the administration process. As these regulations can vary from law to law, keeping up with these regulations can be complex, time consuming and operationally difficult to manage consistently.

*Due to rounding conventions, data may not add to 100%. For more details about the data, see Page 46 or contact marketing@nfp.com.

Figure 3:
Family Leave in California*

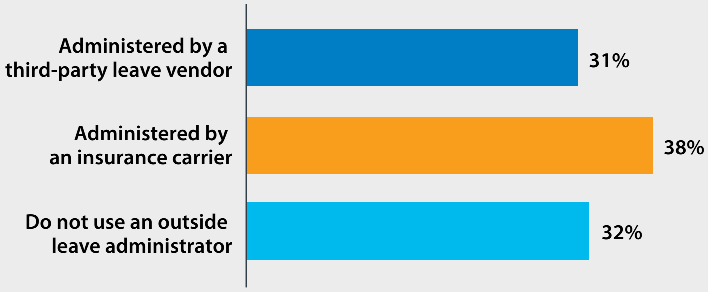


This is especially true when multiple laws overlap for the same leave request. Considering that more organizations are becoming more distributed with employees working in numerous states, it is essential for employers to understand and navigate the complexities of overlapping state and federal leave laws. For example, an employee in California taking leave for their pregnancy would likely have at least five applicable leave plans from the federal and state laws alone before taking into consideration the company's own internal plan.

In these instances, the employer would need to know and consistently administer each plan according to the plan's regulations. This means they would need to know and apply the eligibility requirements specific to each plan, calculate the leave entitlement specified by each plan, ensure the notifications required by each plan are sent appropriately and more.

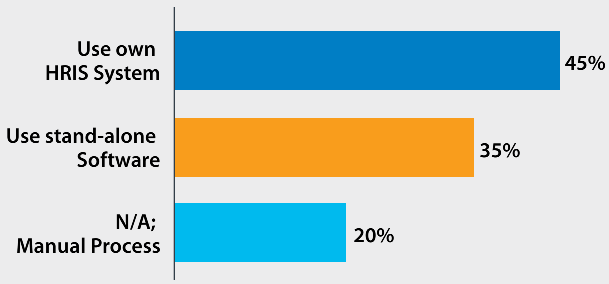
*"Know Your Rights: Paid Leave in California," aclusocal.org.

Figure 4:
Leave Management Partners



Note: 30%+ of those surveyed are still navigating leave administration processes without support.

Figure 5:
Leave Admin Software Leveraged



Leave Management Solutions

To aid employers with administration, there are generally two types of leave management solutions — bring in technology to support internal resources or outsource the administration.

- **Outsourced Administration:** With this option, the administrative burden is shifted to a company that manages leave requests on the employer's behalf. While vendors take on the administration process for the employer, the employer is still responsible for some processes that relate to an employee's leave such as managing paid time off, collecting healthcare premiums or managing return-to-work processes.

There are two types of vendors that typically handle the administration processes for employers — third-party administrators or insurance companies.

- **Third-Party Administrators (TPAs):** The services provided by TPAs are often referred to as "white glove" or "high touch," as leave resources are often heavily involved in each leave request. With leave being the primary or only service provided, TPAs offer additional customizations and attention to nuance which can add value for paternalistic employers or those with complex policies or employee populations.

- **Insurance Companies:** Leave administration services are typically available through any insurance company that provides group disability products. Leave services are paired with disability products like short-term disability. With the administration of these complementary products, insurance companies can provide integrated administration where leave requests and disability claims are managed in tandem.

Outsourcing the leave administration is typically preferred by companies that prefer shifting the administration processes outside of their HR staff, enabling resources to focus on other responsibilities.

- **Internal Administration:** When managing leaves internally, software solutions can be leveraged to support internal teams. The software vendor manages the solution to ensure leave laws are updated, rules are consistently applied, and notifications are sent at the correct time and with the proper content.

These solutions systematically apply the plans based on the employee's request and determine eligibility based on the plan's rules. The tools also commonly embed workflows and tasks for resources to follow to ensure certification processes, calculations and tracking are performed consistently. With these solutions, the team can focus on the employee and other HR-related functions while leveraging a consistent and compliant process that is developed and maintained by industry experts.

Internal administration and software solutions are particularly attractive to employers that want to continue to manage the leave process but need to optimize their processes. This prioritization is often based on company culture or the complexity of company policies and pay.

Evaluating the Right Solution

When considering a leave vendor, there are three important steps to take for all employer types and vendors being considered.

Define and Document Goals and Priorities

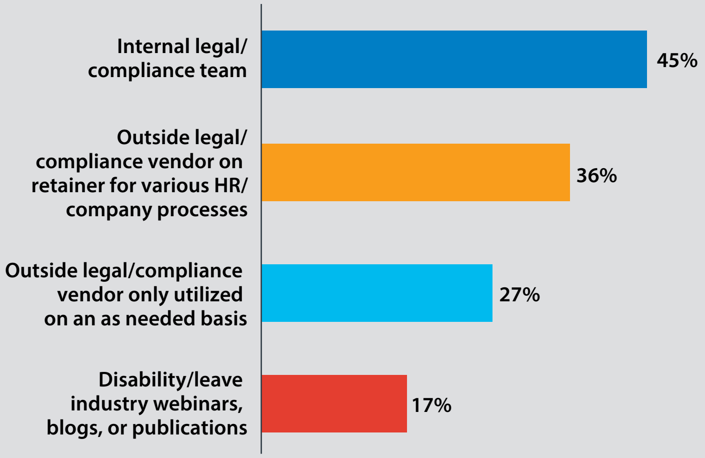
Defining the goals and priorities around the company's leave administration process provides a starting point and a foundation for considering the vendor solutions in the market.

When considering solutions, it's important to ask questions to understand the underlying reasons for the review. Are there challenges in staying compliant with various leave laws? Are there concerns about costs? Are there service-related issues that need to be addressed?

Furthermore, the employee experience should be taken into account. It's crucial to understand how the vendor's solution prioritizes and enhances the employee experience throughout the leave process.

Lastly, consider whether there are additional products or key features that need to be included in the outsourced solution. These may include seamless integration of leave data with HRIS/payroll systems, administration of company-paid leave policies, assistance with tracking and managing accommodations, and other relevant functionalities that streamline leave management and support your organization's specific needs.

Figure 6:
Employers Means of Staying Informed of Leave Changes/Compliance



Note: If a vendor is being utilized for administration, don't forget to lean on their compliance teams for tracking legal changes and education.

NFP data shows employers generally rank price and compliance as most important, with integration capabilities, bundling availability and employee experience as secondary concerns.

Define the Vendor Type

Knowing the company's goals and priorities and considering the organization's budget and resources, is the objective to optimize internal administration and remove compliance and/or consistency risk? Or is the desire to remove this process from the HR team's ever-growing list of responsibilities?

If outsourcing is the goal, consider the type of administrator that would be right for the organization — stand-alone leave vendor or integrated with a disability carrier. Since leave requests and disability claims (short-term disability or state-mandated) run together, having multiple vendors can have pros and cons to the overall experience for both employer and the employees.

Include Key Resources

From the initial discussions around leave management solutions to the final vendor selection process, don't forget to include key internal subject matter experts from the organization. These resources are often administering or assisting in processes and have direct insight on what's working, where the gaps are and how employees are impacted during the process. This is valuable insight that needs to be shared so the focus stays on goals and priorities in discussions with potential vendors. All too often, these resources can be overlooked, leading to the implementation of a solution that later causes friction as it doesn't work well with the company's process or culture.

Mitigating Risk — Compliance and Consistency

When evaluating potential risk within an organization, leave administration processes should not be overlooked. Discussed previously were the complexities of leave laws as well as the time employers spend administering these laws. As if this were not complex enough, employers also must navigate the intricacies of accommodations laws, such as the Americans with Disabilities Act, the Pregnant Workers Fairness Act and others, as they continue to evolve and pose additional challenges for employers.

Ultimately, administering leave requests in-house without any assistance opens the door to costly fines and fees for mismanagement, employee lawsuits, potential audits/oversight by government agencies and attorney fees. Lots and lots of attorney fees. The best way to win a lawsuit is to avoid it altogether by ensuring a compliant and consistent process is in place.

Whether the preference is to administer leave requests internally or outsource the administration to a vendor, the complexity of leave laws, the burden on employers and the potential cost of mismanagement warrants a look (or a second look) at leave solutions in the market.

For a deeper dive into leave management, check out the 2025 NFP US Leave Management and HR Trend Report.

About the Experts

Kim Bell

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.

E. Heidi Cottle

Heidi is senior vice president, Cost Containment Strategies, collaborating with offices to develop strategies driven by data analytics, medical/clinical risk management programs and service/vendor assessments. With 30+ years of experience in the health and welfare market, Heidi has specialized insights on medical/Rx cost containment and emerging trends in traditional and non-traditional strategies. Heidi was also a finalist for the 2019 World Health Congress "Innovator of the Year" award, a reflection of her engagement in digital transformation efforts designed to enhance the client experience. Heidi holds over 30 health and welfare licenses, credentials and certifications in the US and its territories to support a holistic view of the market.

Nelly Rose

As vice president of Clinical Pharmacy, Nelly supports NFP's Rx Solutions with clinical insights and new initiatives while also providing strategic analysis for drug trends and utilization. She works directly with members to support and educate on clinical programs and drug interventions. Nelly received her Doctor of Pharmacy degree from St. Louis College of Pharmacy.

Nick Conway

Nick is president of Rx Solutions, where he guides a team working across private equity, coalitions, small carved-in groups, consultants and pharmacists. Throughout his career, Nick has prioritized patient needs, community health and industry advancement to impact prescription medication accessibility and affordability nationwide.

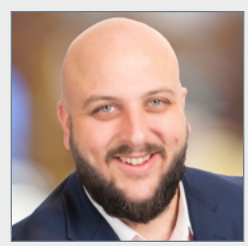
Deb Smolensky

Deb is senior vice president, Vitality and Wellbeing Solutions practice leader and #1 best-selling author of *Brain On!* In addition, Deb serves as a subject matter expert for the insurtech, fintech and digital health verticals of NFP Ventures. She consults with a variety of clients, including numerous Fortune 500 companies, to develop programs and practices that empower employees and leaders to lead healthy, productive lifestyles through innovative and highly engaging solutions. Deb holds a bachelor's degree in accounting from Illinois State University as well as a multitude of certifications and designations in organizational health and productivity.

Joel Pierce

As leave management practice leader for Totalis Benefits, Joel supports clients with identifying and implementing leave management solutions. He works directly with human resource and benefits teams to identify and create efficiencies in the leave process that also produce an improved user experience for employees. His 15+ years in implementation and client configuration provide a unique administrative and systems perspective, providing insight on vendor processes and functionality.

Nate Schoedel



Nate is senior vice president of Totalis Benefits, which is a general agent that focuses on optimizing employer's ancillary benefit offerings from cost containment and employee experience and by building competitive plan designs. He works with broker partners and clients to streamline and enhance benefit offerings to ensure employers stay competitive in their benefit offering within their industry vertical. Nate has over 15 years of experience specifically in group disability and life insurance, as well as experience in dental, vision and voluntary benefit offerings. Nate holds a bachelor's degree in business administration from Robert Morris University in Pittsburgh, PA.

About the Data

The 2025 NFP US Benefits Trend Report draws on data from NFP's 2024 Benefits Trends Employer Survey and Benefits Trends Employee Survey, which were conducted in October 2024 in partnership with Empatix, a strategy, insights and activation firm.

The employer survey of 515 benefits decision-makers was conducted online. Respondents represented a mix of organizations across the US, ranging in size from <100 employees to 5,000+. To qualify for the survey, respondents had to have decision-making responsibility for their organization's benefits offerings.

The employee survey included a mix of 1,011 employees from various company sizes across the US. To qualify for the survey, respondents had to receive insurance through their employer and have primary or shared health insurance decision-making responsibility.

Supplementary data was included from NFP's 2024 Rx Satisfaction Survey. Any other sources are as referenced throughout. Due to rounding conventions, data may not add to 100%. For full information on the methodology for each NFP survey, contact marketing@nfp.com.

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NFP, an Aon company, is an organization of consultative advisors and problem solvers helping companies and individuals address their most significant risk, workforce, wealth management and retirement challenges. With colleagues across the US, Puerto Rico, Canada, UK and Ireland, we serve a diversity of clients, industries and communities.

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