Healthcare: Cost Containment and Price Transparency Compliance

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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

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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 em-ployer greater participation in cost containment.

Figure 1:
Documentation Process of Selection and Due Diligence

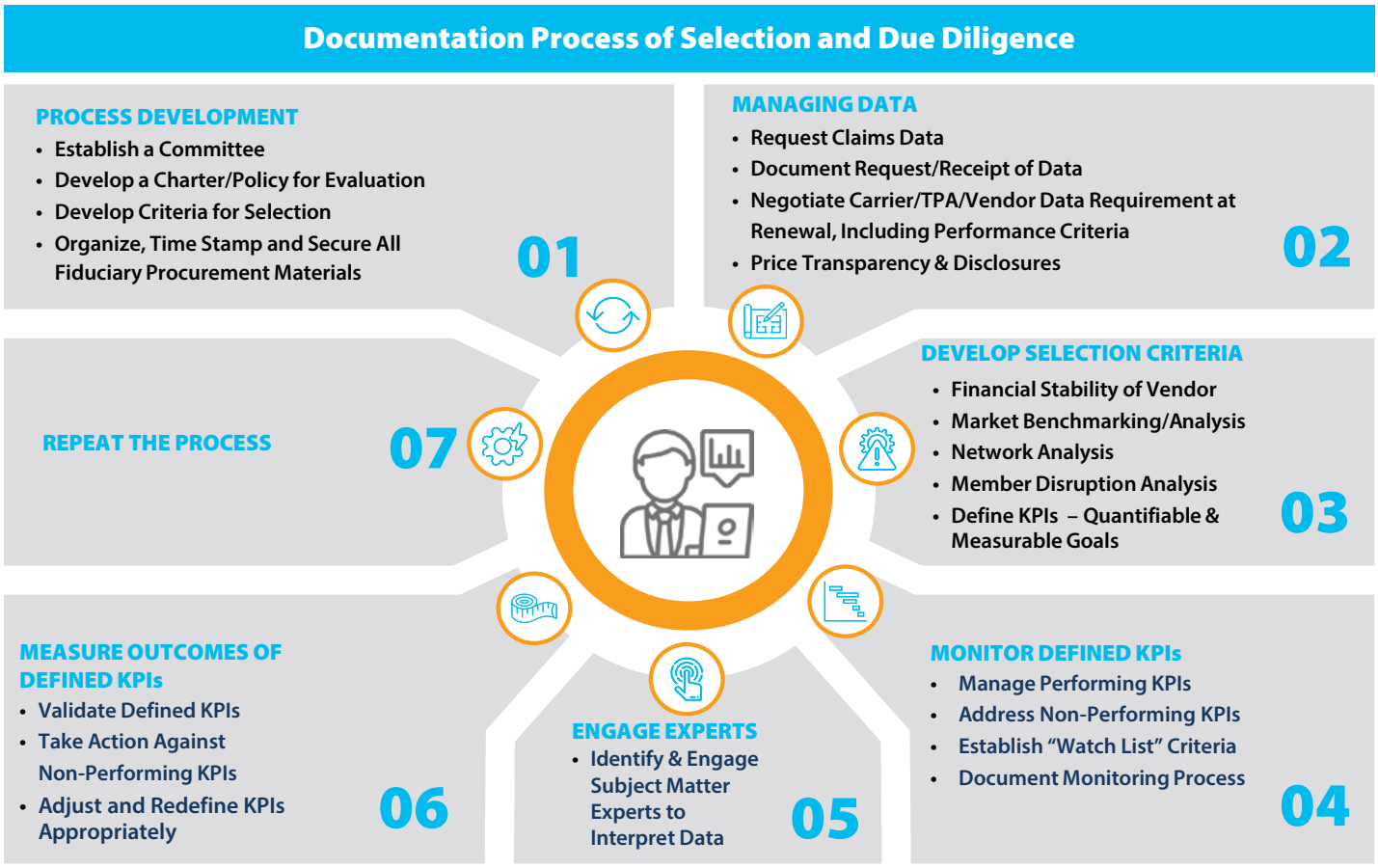


Figure 2:
Plans for Medical/Rx Renewal

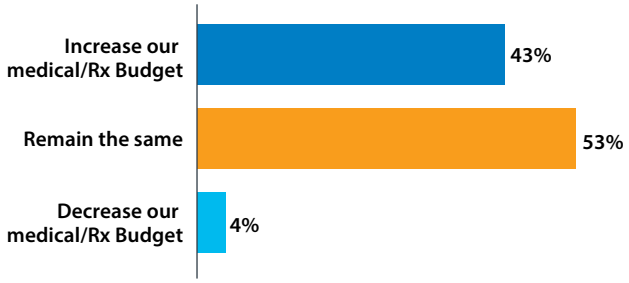
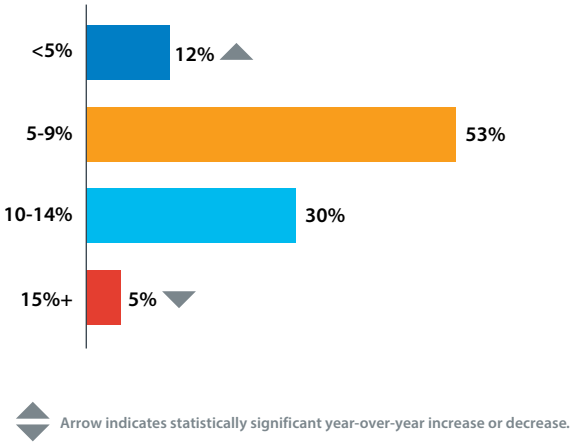


Figure 3:
Percentage Increase Planned
(Among those planning to increase medical/Rx budget)



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

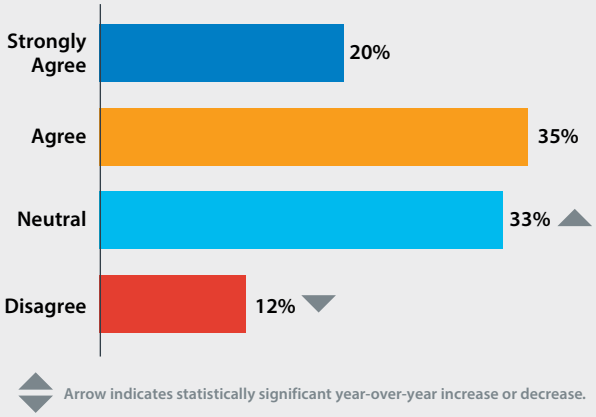


Figure 5:

Considerations for Offsetting Costs

(Among those planning to keep costs the same)

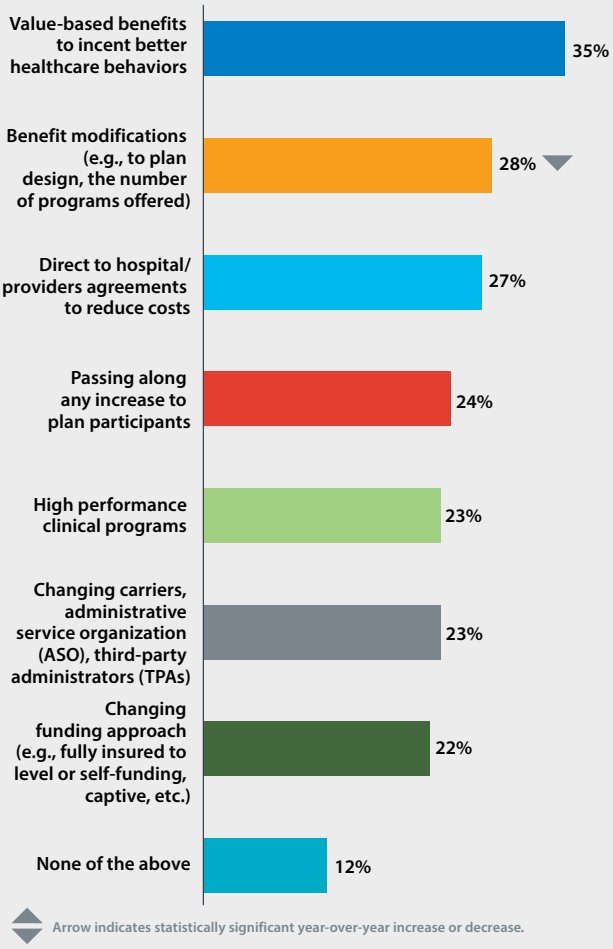


Figure 5 shows that employers are also choosing innovative solutions like value-based benefits and direct-to-hospital/provider agreements to reduce costs versus modifying employee benefits. Many of these coalitions are pioneering direct-to-employer arrangements with major health systems, demonstrating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

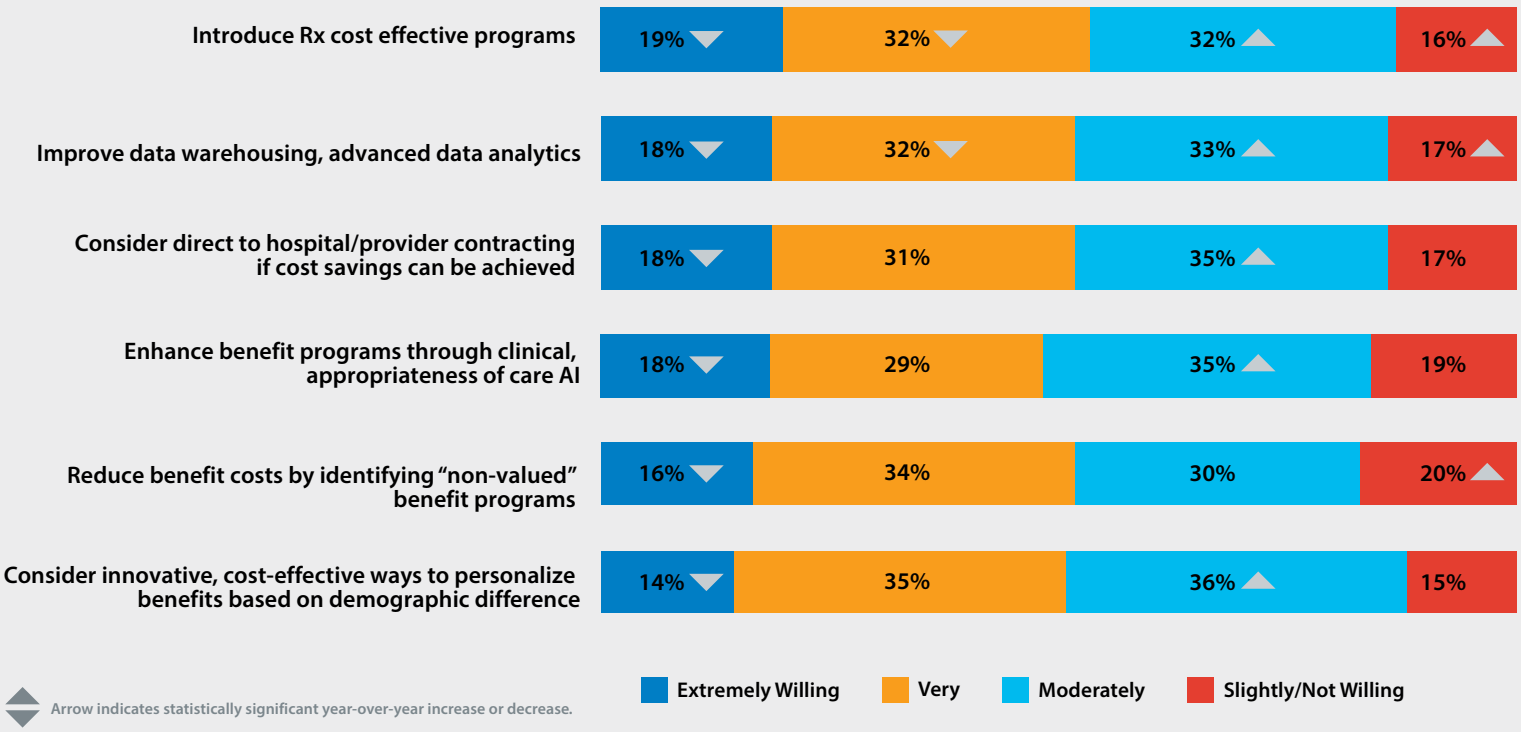
For self-funded plans, direct-to-employer limited scope hospital bundles represent another strategic approach to cost containment. These arrangements establish fixed pricing for defined episodes of care while maintaining quality through integrated metrics. The success of these programs depends heavily 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 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.

Figure 6:
Likelihood to Consider Cost Containment Mechanisms*



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 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.

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


ART ALTERNATIVES
FLEXIBLE STAINLESS STEEL

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.

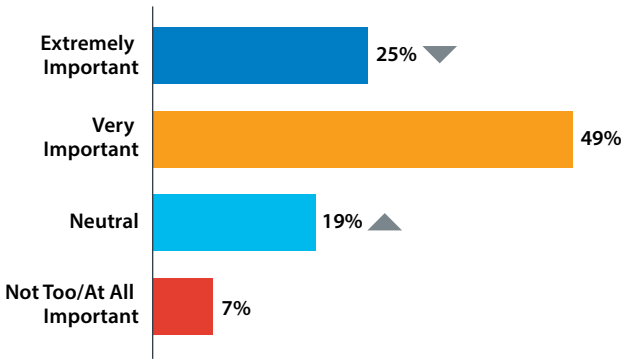
Plan sponsors can now monitor these innovative solutions in a new way. These modern platforms integrate quality measures with procedural cost data, analyze clinical appropriateness and benchmark against Medicare rates. This comprehensive approach enables organizations to make better informed decisions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

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.

Figure 7:
Importance of Having Access to Data Analytics



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

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.

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.

About NFP

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.

Our global capabilities, specialized expertise and customized solutions span property and casualty insurance, benefits, wealth management and retirement plan advisory. Together, we put people first, prioritize partnerships and continuously advance a culture we're proud of.

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