



Health care costs continue to rise. Employers seek affordability strategies that will help them manage costs while keeping employees healthy.

Managing cost trend while delivering quality benefits



↑9%

projected increase in
medical cost trend for 2027¹



↑11.5%

projected increase in
pharmacy cost trend for 2027²

Contributing to...

\$9T

U.S. health spend
projection for 2035¹

The affordability challenge facing employers today has reached a new level of urgency. Medical costs are projected to rise 9% in 2027¹ – the highest increase in 17 years – while pharmacy costs are expected to climb 11.5%, fueled by specialty medications, GLP-1 therapies and other emerging treatments.²

As costs continue to outpace inflation and wage growth, employers are increasingly looking beyond traditional cost-control measures. They want to understand not only what actions they can take to manage trend, but also what their brokers, consultants and carriers are doing to address affordability at the system level.

With U.S. annual health care spending projected to approach \$9T by 2035 if current trends persist, the conversation is shifting from incremental savings to meaningful cost management strategies.¹ The organizations that are best positioned for the future are those willing to reconsider long-held assumptions, embrace new approaches and pursue affordability without sacrificing the quality of their benefits.

Keys to striking this balance include:

- Working with a carrier committed to delivering upfront value and maximizing health care dollars
- Choosing a plan and network strategy built to help make quality care more affordable and accessible
- Investing in targeted programs and solutions designed to drive engagement, improve health outcomes and lower costs

What are the driving forces behind health care costs?



Forces pushing costs up

- ▲ Complex health needs
- ▲ Behavioral health utilization
- ▲ Specialty and GLP-1 medications
- ▲ Fraud, waste and abuse
- ▲ Coding intensity
- ▲ Aging workforce and metabolic risk
- ▲ High-cost claims
- ▲ Provider reimbursements
- ▲ Growing condition prevalence among younger populations



Forces pushing costs down

- ▼ Affordability initiatives
- ▼ Total cost of care approach
- ▼ Real-time admission notifications
- ▼ Biosimilars
- ▼ Centers of Excellence (COEs)
- ▼ Integrated benefits
- ▼ Whole-person care management

Working with a carrier committed to delivering upfront value and maximizing health care dollars

A third-party study found that UnitedHealthcare delivered a more than

 **11%**

lower total cost of care compared to national benchmarks³

[View the findings →](#)

 **≈\$5B**

in savings generated for self-funded clients by UnitedHealthcare Payment Integrity solutions in 2025⁴

 **\$22.4B**

in additional health care spending generated by the No Surprises Act during its first 4 years⁵

Many employers feel the tension between offering quality benefits at the lowest possible costs to their employees while protecting their own bottom lines. It can be a balancing act, but working with a carrier that is driving greater affordability at every step of the health care journey can be critical. It's often the behind-the-scenes efforts that are delivering the greatest value to employers and their employees.

This can include initiatives a carrier may lead to create greater efficiencies by streamlining processes and reducing administrative burden, often through the use of AI. When used responsibly, AI has the potential to remove friction from the care journey, help employees get to the right care more efficiently and cut wasteful or unnecessary spending.

At the same time, AI's growing role in clinical documentation and coding has introduced new cost-management challenges. Providers are increasingly using AI-powered tools to capture diagnoses and recommend billing codes, which can improve efficiency and documentation accuracy. However, in some cases these systems may suggest higher-acuity diagnoses or higher-level billing codes than the care delivered ultimately supports, resulting in incremental increases in health care spending over time.

Dr. Rhonda Randall, chief medical officer for UnitedHealthcare Employer & Individual, further explains, "While utilization and high-cost claims are up, much of today's rising health care costs are due to increases in unit costs."

That makes network negotiations, robust payment integrity and claims management capabilities more important than ever. Through comprehensive pre-payment and post-payment reviews, advanced analytics and

ongoing claims monitoring, carriers can help ensure that rates are fair from the start, identify billing inaccuracies, validate that services are coded appropriately and ensure health care dollars are spent accurately and responsibly.

Health care affordability is influenced by more than utilization and medical inflation alone. In some cases, well-intentioned policies can produce unintended consequences that contribute to higher costs. The No Surprises Act (NSA) is one example that is taking center stage. While the law has successfully protected people from millions of surprise medical bills, the arbitration process created to resolve payment disputes has generated significant administrative complexity and cost pressures, including independent dispute resolution (IDR) volume exceeding expectations and escalating reimbursement outcomes. These challenges have been driven, in part, by concentrated activity among a small number of NSA IDR dispute mills and private equity-backed participants.

Addressing these challenges requires carriers and other stakeholders, including employers, to actively advocate for policy reform efforts and innovative strategies that can preserve patient protections but also limit unnecessary cost escalation.

Ultimately, the goal is to select a carrier that employers and their employees and families can feel confident about the efforts they are taking to help ensure each dollar spent is necessary, appropriate and accurate.



Choosing a plan design and network strategy built to help make quality care more affordable and accessible

“Managing trend is no longer really a viable path. Employers may need to take a closer look at their existing plans and be prepared to make bold moves, if necessary, to accomplish the task ahead.”

Jim Winkler

Chief Strategy Officer
Business Group on Health

When it comes to choosing between group health plans and network options, it's important for employers to understand the nuances within their workforces. Understanding and selecting the right medical plan and network design for their unique employee population can help employers ensure their workforce gets the most out of their benefits—while remaining engaged along the way.

Plans that are becoming increasingly attractive to employers and employees are those built to offer greater simplicity, affordability and transparency. For example, copay-only plans without deductibles or coinsurance can help reduce some of the guesswork or confusion employees may have around health care costs. Additionally, employees may perceive more immediate value from their health plan since they don't have to meet a deductible.

Layering in tiering and focused networks, Accountable Care Organizations (ACOs) and Centers of Excellence (COEs) can help navigate participants toward providers that consistently deliver quality, cost-efficient or even specialized care. These models are designed to improve outcomes and reduce unnecessary variation in care.

For the many organizations that continue to offer broad network access, helping employees navigate the healthcare system effectively can be just as important as network design itself. By providing visibility into provider quality, site of care alternatives and estimated costs, employees can feel empowered to make more informed decisions that balance quality, convenience and affordability. In many cases, simply helping employees identify a lower-cost, clinically appropriate site of care, provider-administered prescription drug or higher-value provider can generate meaningful savings without requiring employers to limit choice or network access.

Many high deductible health plans (HDHPs) also offer a health savings account (HSA), which can be attractive to employees who want the ability to budget for eligible medical expenses, or who see an HSA as a valuable investment option. The trade-off is that these HDHPs are not always optimal for lower-income workers or those with higher health needs, so many employers may find that empowering employees with different plan options – and providing adequate education around their differences – can allow them to choose the best fit for themselves and their families.

Funding strategy can also be a powerful affordability lever, influencing how much predictability, flexibility, transparency and control an employer has over health care costs. Fully insured, level funded and self-funded arrangements each offer different trade-offs, making it important for employers to evaluate funding options through the lens of their workforce, risk tolerance, cash flow and need for data visibility.

The trend toward greater employer ownership of health care spending continues to accelerate. In 2025, 67% of covered workers were enrolled in self-funded plans, including 80% of those at firms with 200 or more employees,⁶ while 37% of businesses with 3-199 employees offered a level funded plan in 2025⁷ compared to just 7% in 2019.⁸

Ultimately, affordability is not solely about reducing benefits or shifting costs. It is about creating an environment where employers, employees and providers are aligned around delivering the right care, in the right setting, at the right cost. Future-ready benefits strategies will likely incorporate a wider range of network and funding arrangements designed to balance choice, access and cost management.



Investing in targeted programs and solutions designed to drive engagement, improve health outcomes and lower costs

26%

of an employer's total health care spend is attributed to chronic conditions⁹

10.9%

year-over-year increase in mental health per member per month (PMPM) costs⁹

\$10

average PMPM medical savings with integrated UnitedHealthcare Medical and Pharmacy benefits¹⁰

↓60%

lower health care costs are associated with higher health care activation scores as measured by the proprietary UnitedHealthcare Health Activation Index® (HAI®) tool¹¹

Once employers are working with a carrier that has proven affordability initiatives and an effective total cost of care approach, and have selected the right plan and network mix for their population and fiscal priorities, they can begin exploring opportunities to add targeted programs and solutions to their plans. These strategies can help address major cost drivers they are experiencing. For instance, investing in programs that manage complex or chronic conditions or integrating pharmacy and/or behavioral health benefits for a whole-person health approach can enable better cross-benefit management and lead to savings.

The prevalence of complex and chronic conditions – and the costs that accompany them – make clinical and care management programs essential.

Clinical and care management programs have the potential to make a significant difference in health outcomes and costs – for employees, their families and employers – especially as conditions are becoming increasingly prevalent among working-age adults.

“What we’re seeing is higher rates of diabetes, heart disease, cancer and joint-related conditions that are often related to physical inactivity and obesity, which underscores an issue with the American lifestyle,” says Dr. Randall. “It’s going to take a concerted effort across the health care system, government, carriers, employers and individuals to work on this problem together.”

Behavioral health utilization also continues to climb, making it an important contributor to overall health care cost trend. While greater utilization reflects positive progress in reducing stigma and improving access to care, it also creates new affordability challenges for employers. As a result, many organizations are moving beyond simply expanding behavioral health benefits and

focusing on how to connect employees with the right level of support. By combining broad access with a continuum of support and data-driven engagement strategies, employers may be able to improve behavioral health outcomes while helping moderate long-term cost growth.

Additionally, as pharmacy costs continue to accelerate, many employers are recognizing that managing medical and pharmacy benefits separately can create blind spots that make it harder to control spending effectively. Integrating pharmacy and medical benefits provides a more comprehensive view of a member's whole-person health needs, allowing for earlier identification of risks, more coordinated interventions, end-to-end support and better decision-making.

When data is connected across benefits, the insights around next-best actions become clearer. Employers can better understand the relationship between utilization and outcomes, identify opportunities to improve treatment adherence, reduce avoidable hospitalizations and more effectively and proactively address the drivers of future health care spend.

Additional ways employers can help employees become more engaged in their health and well-being, which is linked to better decision-making and lower costs, include encouraging the use of digital tools and promoting or even incenting healthier behaviors. Examples include establishing a relationship with a primary care provider (PCP) or offering rewards for preventive care.

Health care affordability is ultimately tied to health outcomes. When employees receive the right support, utilize preventive screenings to identify risks earlier, manage chronic conditions effectively and access care before issues escalate, both outcomes and costs may improve. Targeted programs and solutions may get and keep employees engaged in their health and well-being and help employers address today's most significant cost drivers.





Putting it all together

Health care affordability has become one of the most pressing challenges facing employers. But cost management does not have to mean choosing between financial discipline and employee support. By evaluating carrier performance, payment integrity practices, plan and network options, and targeted programs and solutions, employers can build a more intentional benefits strategy – one designed to help manage trend while preserving access to quality care.

**Learn how UnitedHealthcare is working
for more affordable care >**

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¹ Behind the numbers 2027: Medical cost trend is expected to hit 9%, highest in 17 years. PricewaterhouseCoopers, June 11, 2026. Available: <https://www.pwc.com/us/en/industries/health-industries/library/behind-the-numbers.html>. Accessed Sept. 7, 2026.

² What Are the Projected Health Plan Cost Trends for 2027? Segal, July 23, 2026. Available: <https://www.segalco.com/consulting-insights/2027-health-plan-cost-trend-survey/>. Accessed Sept. 7, 2026.

³ Milliman Analysis of Total Cost of Care Benchmarks, March 2026. Based on UnitedHealthcare allowed medical claims and enrollment data using 2022 service dates compared to Merative® MarketScan® industry benchmarks across 50 U.S. regions, adjusted for difference in health status, demographics, geographic mix and excess large claims. Actual results may vary. Full white paper available: <https://www.milliman.com/en/insight/total-cost-care-benchmarks-ppo-health-claim-costs>.

⁴ Based on UnitedHealthcare ASO commercial business 2025 claims reporting.

⁵ No Surprises Act arbitration costs employers \$22.4B, analysis finds. BenefitsPRO, Aug. 31, 2026. Available: <https://www.benefitspro.com/2026/08/31/no-surprises-act-arbitration-costs-employers-224b-analysis-finds/>. Accessed Sept. 1, 2026.

⁶ Self-Funded vs Level-Funded vs Fully-Insured Health Plans: How Small Employers Cut Premium Costs Without Taking on Catastrophic Claim Risk. Beancount.io, May 10, 2026. Available: <https://beancount.io/blog/2026/05/10/self-funded-vs-level-funded-vs-fully-insured-health-plans-small-employers-cut-premium-costs-catastrophic-claim-risk-guide>. Accessed Sept. 7, 2026.

⁷ 2025 Employer Health Benefits Survey. KFF, Oct 22, 2025. Available: <https://www.kff.org/health-costs/2025-employer-health-benefits-survey/>. Accessed Sept. 7, 2026.

⁸ 2019 Employer Health Benefits Survey. KFF, Sept. 25, 2019. Available: <https://www.kff.org/health-costs/2019-employer-health-benefits-survey/>. Accessed Aug. 25, 2026.

⁹ 2022 MHO Value Suite Study conducted by UnitedHealthcare Actuarial. Actual client savings will vary depending on client specific experience and attributes that include but are not limited to the client's risk and demographic profile, actual benefits implemented, and member engagement.

¹⁰ UnitedHealthcare 2026 Health Trends Report. UnitedHealthcare Employer & Individual self-funded and fully insured data based on claims incurred between Nov. 2024-Oct. 2025, paid through Jan. 2026. Available: <https://www.uhc.com/employer/news-strategies/annual-health-trends-report>.

¹¹ Lower adjusted costs, correlated with higher HAT® scores. Geographic and risk adjusted study, 2025 UnitedHealthcare commercial book of business.

Disease Management programs and services may vary on a location-by-location basis and are subject to change with written notice. UnitedHealthcare does not guarantee availability of programs in all service areas and provider participation may vary. Certain items may be excluded from coverage and other requirements or restrictions may apply. If you select a new provider or are assigned to a provider who does not participate in the Disease Management program, your participation in the program will be terminated. Self-Funded or Self-Insured Plans (ASO) covered persons may have an additional premium cost. Please check with your employer.

Certain preventive care items and services, including immunizations, are provided as specified by applicable law, including the Patient Protection and Affordable Care Act (ACA), with no cost-sharing to you. These services may be based on your age and other health factors. Other routine services may be covered under your plan, and some plans may require copayments, coinsurance or deductibles for these benefits. Always review your benefit plan documents to determine your specific coverage details.

Level Funded: Person must reside within the United States. An employee residing in Hawaii is not an Eligible Person. May not be available in all states.

The UnitedHealthcare plan with Health Savings Account (HSA) is a qualifying high deductible health plan (HDHP) that is designed to comply with IRS requirements so eligible enrollees may open a Health Savings Account (HSA) with a bank of their choice or through Optum Bank, Member FDIC. The HSA refers only and specifically to the Health Savings Account that is provided in conjunction with a particular bank, such as Optum Bank, and not to the associated HDHP.

The Centers of Excellence (COE) program providers and medical centers are independent contractors who render care and treatment to health plan members. The COE program does not provide direct health care services or practice medicine, and the COE providers and medical centers are solely responsible for medical judgments and related treatments. The COE program is not liable for any act or omission, including negligence, committed by any independent contracted health care professional or medical center.

Employee benefits including group health plan benefits may be taxable benefits unless they fit into specific exception categories. Please consult with your tax specialist to determine taxability of these offerings.

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Administrative services provided by United HealthCare Services, Inc. or their affiliates, and UnitedHealthcare Service LLC in NY. Stop-loss insurance is underwritten by UnitedHealthcare Insurance Company or their affiliates, including UnitedHealthcare Life Insurance Company in NJ, and UnitedHealthcare Insurance Company of New York in NY.