Taking a strategic, end-to-end approach to cost management is critical for employers looking to reduce health care spend without compromising quality.

Managing cost trend while delivering quality benefits

United Healthcare®

Proof is greater than promises

A third-party study found that UnitedHealthcare delivered a

≈10% average lower total cost of care than others in the market[4]

View the findings →

Employer medical costs are initially projected to rise 8.5% in 2026, matching the increase seen in 2025 and continuing a 4-year upward trend from 5.5% in 2022.[1] These increases may be driven by a number of factors, including regulatory changes, an aging population and a rise in chronic conditions.[2]

Employers may also see cost increases due to the growing use of expensive specialty drugs and fluctuation of claims and utilization patterns within their employee population – such as more frequent catastrophic claims and increased behavioral health utilization.

While significant and much-needed efforts are underway at the industry level to address these cost challenges, it's important for employers to understand what's behind rising health care costs. This knowledge may enable them to make more informed decisions and better manage expenses.

Yet, navigating this landscape can be difficult. Employers often find themselves balancing financial responsibilities to the business with a commitment to offering quality, affordable benefits to their employees. As a result, many are hesitant to shift health care costs to employees – though rising expenses are prompting some to reconsider. In fact, a recent survey found that more than 50% of employers plan to raise deductibles or annual out-of-pocket limits for employees.[3]

"Employer sentiment over the past several years has been more protective of employees when it comes to rising care costs. But recently that seems to be shifting as employers look for greater cost-control tactics," explains Katy Curry-Lorusso, vice president of health care economics for UnitedHealthcare Employer & Individual. "Knowing that passing costs on to employees may cause abrasion, we work with our clients to help them explore other options."

Designing a benefits plan that protects an employer's bottom line while still providing employees with access to quality care and coverage may feel like walking a tightrope. But for employers looking to avoid the talent backlash that may come from increasing employee health care contributions, finding that balance may be worth the effort.

This also means considering strategic cost management approaches that go beyond network discounts. An employer's health spend is often complex and determined by a combination of unit cost – the fixed cost of visiting a certain provider or facility based on negotiated network discounts – and utilization – the variable costs based on how a member engages with the health system.

Investing in strategies that aim to address both unit cost and utilization offers greater potential to reduce health care expenditures for both organizations and their employees. These strategies include:

- **Choosing health plans and networks designed to help make quality care more affordable and accessible**
- **Adding clinical and care management programs to enable better health outcomes and lower costs**
- **Working with a carrier committed to delivering upfront value and maximizing health care dollars**

Choosing health plans and networks designed to help make quality care more affordable and accessible

48%

of surveyed CFOs said that there should be an emphasis on networks that prioritize higher-value providers to better manage costs[5]

When it comes to choosing group health plans and provider networks, 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 that their employees get the most out of their benefits—while remaining engaged along the way.

Plan designs 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.

It may also be critical to consider a plan's network access, as well as any digital tools and capabilities that are included.

Plans built with broad networks, for instance, are popular among employers because they offer flexibility and preserve employee choice—but they may come at a higher cost. Plus, increased choice may prompt employees to make sub-optimal care decisions. Tiering those plans may help encourage employees to choose higher-value providers, while retaining their ability to choose. These tiered plans are designed to help employees pay less in copayments and coinsurance, as well as empower them to make more informed decisions about their care.

Ensuring those plans are backed with digital tools and capabilities can help employees navigate their care options. For instance, a provider search experience that prioritizes results based on the provider's ability to deliver quality care, whether they are in network and how convenient and personally suitable they are for the employee based on the employee's preferences may help drive more informed and cost-effective care decisions.

Focused networks that offer access to a smaller subset of providers and health care facilities may limit the choices employees have but can help lower costs. This can include plans and networks that encourage or even require employees to establish a relationship with a primary care provider (PCP) to help ensure members are referred to care that is medically necessary, appropriate and cost-effective.

Other examples of these focused networks are those that are built based on contracts with value-based Accountable Care Organizations (ACOs), in which providers and health systems agree to be paid based on the quality of care they deliver rather than the volume of services they perform, or Centers of Excellence (COEs), which are networks of clinically superior, cost-effective health care centers designed to support specific complex conditions. Both ACOs and COEs aim to deliver better health outcomes and lower costs.

"With today's financial pressures, employers are finding themselves having to find a balance that works in a high-cost trend environment — keeping costs in check for themselves and employees without sacrificing the quality of their plan or network."

Katy Curry-Lorusso

Vice President of Health Care Economics
UnitedHealthcare Employer & Individual

Discover how the right network strategy can make a big difference when it comes to quality care and lower costs →

Adding clinical and care management programs to enable better health outcomes and lower costs

129M

Americans are managing a chronic disease[7]

29%

of an employer's total health care spend is attributed to chronic conditions[8]

"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. It's going to take a concerted effort across the health care system, government, carriers, employers and individuals to work on this problem together."

Dr. Rhonda Randall
Chief Medical Officer
UnitedHealthcare Employer & Individual

Nearly 64% of surveyed chief financial officers (CFOs) indicated that placing a "strong" or "very strong" emphasis on clinical management is key to managing costs over the next 3 years.[6] This approach may be less abrasive than other cost management levers, such as increasing employee cost-sharing or limiting provider choice.

"A key strategy for reducing costs is to invest in clinical and care management programs because those can help an employee understand what the most appropriate site of care is for their needs," says Curry-Lorusso.

This is especially important when employees or their family members are managing complex or chronic conditions.

The prevalence of complex and chronic conditions — and the costs that accompany them — makes clinical and care management programs essential. These programs are designed to identify members with clinical needs and provide support to help them access the right care at the right time. In fact, two-thirds of surveyed employers indicated that improving care management for high-cost conditions was one of the top 3 areas where they're seeking the most support over the next 5 years.[5]

Clinical and care management programs have the potential to make a significant difference in health outcomes and cost reduction — for employees, their families and employers — especially as the workforce ages and chronic conditions become more prevalent.

In addition to these broader programs, it should be noted that obesity is an underlying risk factor for several chronic conditions, such as diabetes, heart conditions and cancer. This is partly why GLP-1s have risen in popularity.

But while GLP-1s have the potential to help members lose weight and may reduce the risk of developing related chronic conditions,[9] these medications are extremely expensive for employers to cover. That's why it's important for employers to carefully evaluate coverage and consider how other care or lifestyle-modification programs can help without the price tag that comes with GLP-1s.

For instance, encouraging employees to establish relationships with PCPs may help manage costs and reduce waste. PCPs can address health concerns during office visits, prescribe medications for behavioral health concerns and other common issues, as well as help employees navigate their overall health and wellness through annual checkups.

"While GLP-1s may be effective, employers can help control costs by encouraging employees to engage in other programs, like those that help employees adopt better lifestyle habits through nutrition counseling and also leveraging their PCP for regular wellness checks and certain cancer screenings," says Jim Winkler, chief strategy officer for Business Group on Health.

Learn more about the conditions driving costs for employers and the strategies that can help manage them →

Rated as "most thorough"

Surveyed providers and carriers found UnitedHealthcare Payment Integrity solutions to be the "most thorough" in the industry[11]

$6.8B

in employer savings generated from UnitedHealthcare Payment Integrity solutions, impacting 49.6M claims and 17.2M members[12]

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

It's no secret that there are opportunities to streamline health care and reduce unnecessary spending. In fact, a study published by The Journal of the American Medical Association (JAMA) found that about 25% of all health care spending was identified as wasteful or unnecessary due to ineffective care delivery or coordination, pricing failures, administrative complexity or fraud and abuse.[10]

Eliminating some of this waste may not only reduce overall health care costs but – perhaps more importantly – also help ensure that employees are receiving quality care and paying the appropriate amount, and not a dollar more.

Because employers have a fiduciary responsibility to their employees, working with a carrier that prioritizes these efforts is critical. This includes ensuring a carrier has a thorough claims review process, with checks in place across the entire lifecycle of a medical claim – from pre-claim to post-payment. At the same time, it's important that these processes don't delay care for plan participants.

While most of the time these processes don't cause delays, when they do, it's often because claims are submitted with missing or incorrect information – or not submitted in a timely manner. Carriers that are taking steps to streamline and simplify those administrative processes for providers can help prevent these issues.

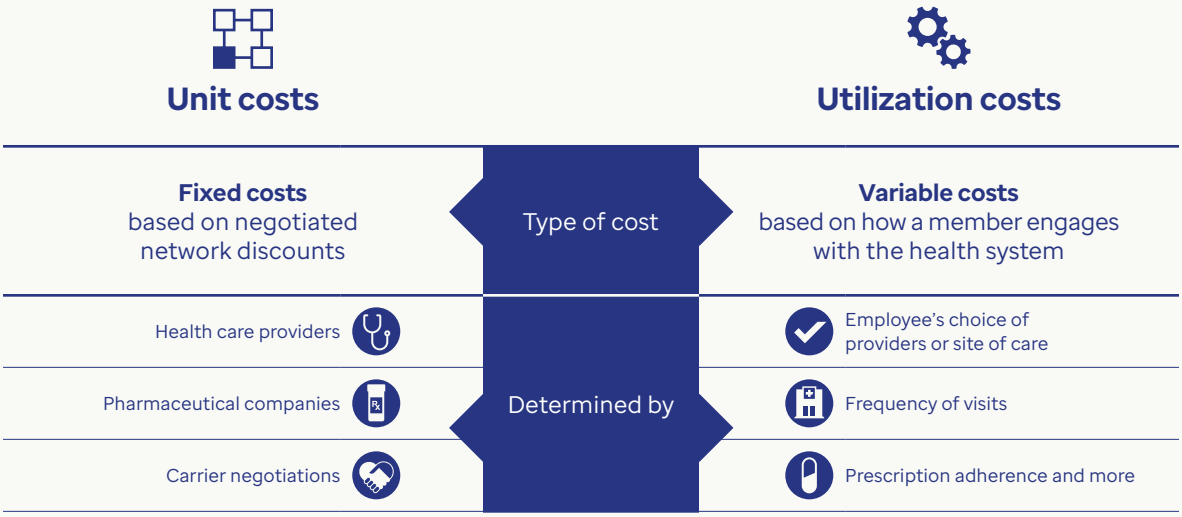
This can include reducing prior authorizations where they aren't necessary or creating greater interoperability between providers and carriers – such as embedding member health plan information into provider workflows to support more informed clinical decision-making. Additionally, employers can work with their carrier, broker or consultant to help educate employees about how their health care decisions impact both their health and their wallets.

All of these efforts are designed to help maximize every health care dollar – ensuring each dollar spent is necessary, appropriate and accurate. Beyond the cost savings this may generate, employers, employees and their family members may feel more satisfied, confident and trusting of their carrier, their plan and the health system overall.

Find out how managing costs also means reducing wasteful spending and ensuring claims are paid correctly →

At a glance: The factors that determine health care costs

Health care costs are determined by a combination of unit costs and utilization costs.



Ultimately, utilization plays a critical role in determining the final cost for both employees and employers

Learn how UnitedHealthcare is working for more affordable care >

United Healthcare®

[1] No let up in sight. Medical cost trend set to grow at 8.5%. Is your playbook ready? PwC, July 16, 2025. Available:https://www.pwc.com/us/en/industries/health-industries/library/behind-the-numbers.html.

[2] Cox, C. et al. Health Care Costs and Affordability. Kaiser Family Foundation, May 28, 2024. Available: https://www.kff.org/health-policy-101-health-care-costs-and-affordability/?entry=table-of-contents-introduction.

[3] Luhby, T. Here's why you might be spending more on health care next year. CNN, July 16, 2025. Available: https://www.cnn.com/2025/07/16/economy/health-care-costs-employees-2026.

[4] Wakely Consulting Group: By looking at risk-adjusted allowed claims per member per month (PMPM) in 2021, Wakely was able to perform a holistic comparison of UnitedHealthcare's ability to drive cost savings for members and determined it outperformed the market by approximately 10%—even though UnitedHealthcare is not the leader in discounts in many of these markets. Site of care redirection, inpatient management and preventive care utilization are key savings drivers.

[5] Advisory Board 2023 Employer Innovation Survey.

[6] Survey on Health & Benefit Strategies for 2025 Report. Mercer, 2024. Available: https://www.mercer.com/en-us/insights/total-rewards/employee-benefits-strategy/health-and-benefit-strategies-report/.

[7] Chronic disease prevalence in the U.S.: Sociodemographic and geographic variations by ZIP code tabulation area. Centers for Disease Control and Prevention, Feb. 24, 2024. Available: https://www.cdc.gov/pcd/issues/2024/23_0267.htm.

[8] UnitedHealthcare Employer & Individual book-of-business data, Dec. 2023. Excludes Alaska, Hawaii, Puerto Rico and the U.S. Virgin Islands.

[9] Bell, A. Drugs like Ozempic cut death risk 30% for people with obesity and type 2 diabetes: JAMA study. BenefitsPRO, July 16, 2025. Available: https://www.benefitspro.com/2025/07/16/drugs-like-ozempic-cut-death-risk-30-for-people-with-obesity-and-type-2-diabetes-jama-study.

[10] Waste in the US Health Care System: Estimated Costs and Potential for Savings. JAMA, Oct. 7, 2019. Available: https://jamanetwork.com/journals/jama/article-abstract/2752664. Accessed: July. 23. 2025.

[11] Study summary: Independent study of different carriers' payment integrity programs. ZS Associates, Q4 2022. Available: https://www.uhc.com/content/dam/uhcdotcom/en/BrokersAndConsultants/tri1-2023-cost-zs-case-study-lr.pdf.

[12] UnitedHealthcare 2024 medical claims data.

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.

Insurance coverage provided by or through UnitedHealthcare Insurance Company or its affiliates. Administrative services provided by United HealthCare Services, Inc. or their affiliates.