Alliant

2027 Global Health Review

Sustainable Strategies for Resilient Value



Compiled by:
Alliant Global Benefits Practice

Foreword

Dear Valued Global Benefits Community,

We are pleased to present the **sixth** edition of our Global Health Review, guided this year by our theme: Resilient Value.

Solving the full equation

Benefits leaders are under pressure to manage rising costs, improve outcomes, and sustain programs in an increasingly complex world. Yet one part of the equation is often neglected. Cost sustainability and employee sustainability are often viewed separately, when they must be understood together.

Cost Sustainability + Employee Sustainability = Resilient Value

Cost sustainability is not simply about reducing spend. It is about allocating resources more efficiently, understanding what is driving cost, targeting investment where it matters most, and creating programs that can endure.

Employee sustainability is about helping people remain healthy, capable, informed, and resilient over time. Employees are not simply recipients of benefits. They are active participants in their own well-being, and they need the right tools, access, and support to help themselves.

Resilient Value emerges when both sides of the equation are considered together. A benefits strategy cannot be truly sustainable if it protects the budget but weakens access, trust, health outcomes, or the employee experience. Nor can it succeed if it supports employees in ways that are financially unsustainable for the organization.

Creating value locally

For multinational employers, this balance must be achieved locally, reflecting each market's healthcare system, workforce risks, regulatory environment, access gaps, and employee expectations.

This year's review explores how organizations are creating Resilient Value through:

- Health equity
- Chronic condition management
- Healthy longevity
- Prevention
- Caregiving support
- Alternative financing
- Responsible AI
- Strategic benefits optimization

Our goal is to help benefit leaders create more value from existing investment – not by offering less, but by investing with greater precision and purpose.

The future of benefits depends on solving the full equation. When organizations sustain programs and help employees sustain themselves, benefits become a source of resilience, performance, and long-term value.

Sincerely,

Philippe de Dreuzy



Philippe de Dreuzy

EVP, Global Practice Leader, Alliant

Philippe has more than 30 years of experience in high-tech, telecoms, and global employee benefits. Philippe has an extensive international background with additional M&A experience, having lived and worked in multiple countries in Europe, North America, and South America. Philippe received his MBA from Georgetown University's McDonough School of Business, Washington D.C., and his B.S. from the University of Paris. He is fluent in French, Spanish, and Brazilian Portuguese.

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The Benefits Balancing Act: Spend Less, Benefit More



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Anushree has over 15 years of experience in the insurance and benefits industry, with expertise in employee benefits, commercial insurance, and risk solutions. At Alliant, she supports multinational clients with global benefits strategy, renewals, implementations, and market benchmarking. Her professional experience across APAC and the Middle East brings a valuable international perspective to her work.

The Benefits Balancing Act

Employers face a difficult balancing act: contain rising health costs while keeping benefits affordable, useful, and competitive. Employers say rising uncertainty in healthcare costs is pushing them to rethink how they manage spending while improving employee health outcomes. This is based on Business Group on Health's 2027 Employer Healthcare Strategy Survey[1]. A sustainable benefits strategy starts with understanding the drivers of spending and directing resources toward care and support that employees

"Spend less" usually means slowing the rate of increase.

[1] Business Group on Health, "Cost Volatility Forces Employers To Reassess Healthcare Strategy, Business Group on Health Survey Reveals," 25 August 2026; survey fielded June 2026.

can actually use. In a high-inflation environment, “spend less” may mean slowing the rate of increase in spending, rather than reducing the absolute budget.

The Future of Benefits Is Connected, Personalized, and Sustainable

Rising healthcare costs and evolving workforce expectations are making employee benefits one of the most complex and consequential strategic decisions organizations face. At the same time, increasing top-down pressure to control costs is challenging employers to maintain affordability while remaining competitive.

Business resilience does not come from hoping this complexity will disappear, but from designing for it deliberately. Benefits will continue to serve as a foundational pillar, supporting employees and organizations through periods of change, uncertainty, and hardship.

Against a backdrop of competing priorities, the message from employers is clear: organizations want affordability, measurable value, meaningful employee engagement, and long-term sustainability. The challenge and opportunity are to design benefit strategies that balance all four.

Defining Value, Understanding Cost Drivers, and Reducing Fragmentation

In a sustained high-cost environment, employers are redefining what value means in employee benefits. The objective is no longer simply to offer a broad portfolio of programs, but to ensure benefits are affordable, relevant, and easy for employees to access and use. This requires balancing financial discipline with an employee experience that supports health, security, and productivity. Increasingly, benefits are being evaluated not only by what they cost, but by the outcomes and value they deliver for both employees and the organization.

Healthcare remains one of the greatest challenges to achieving that balance. Medical inflation, increased utilization, specialty medications, chronic conditions, provider consolidation, and delayed care are all contributing to rising costs. Before determining where to reduce or redirect investment, employers need greater visibility into what is driving their spend. Sustainable optimization starts with understanding where costs are occurring, which populations and conditions are driving trends, and whether existing programs are meaningfully improving outcomes, access, and affordability.

That same discipline should extend beyond the core medical plan to the broader benefits ecosystem. Many benefit strategies have evolved over time through layers of vendors, point solutions, and

programs introduced to address specific workforce needs. While each may have been added for a valid reason, the result can be fragmentation, overlapping services, a more complicated employee experience, and unnecessary cost, with organizations sometimes paying multiple vendors to address the same underlying need.

A more deliberate approach evaluates how these programs work together: where they complement one another, where they duplicate services, and where solutions should be targeted to specific populations versus standardized across the broader workforce. Simplification does not mean providing less support. It means making benefits easier to navigate and directing investment toward the programs and interventions that deliver the clearest value.

Making Benefits Usable and Understandable

The challenge is not simply offering more benefits, but ensuring employees can understand, access, and afford the benefits already available to them. Complexity creates its own cost. McKinsey's analysis of the US market describes large employers working with ten or more organizations in a health ecosystem. Its findings support closer attention to how partners work together, although they do not establish a universal savings figure from consolidation[2]. When employees struggle to identify the right resource or understand how to access support, they may disengage, delay care, or fail to use valuable programs altogether. As a result, employers are moving away from a traditional "menu of options" toward a more guided experience that helps employees navigate their benefits and make informed decisions at the moments that matter most. Simplified plan design, clear communication, and effective navigation can improve the employee experience while increasing the value of existing benefits investments.

Fewer menus, more guidance at the moments that matter.

Creating that experience becomes even more important as workforce needs continue to diversify. As many as five generations may now be represented in the workplace, with employees viewing benefits from different personal, financial, and career perspectives. Priorities may shift throughout an employee's journey, from mental health, family building, and caregiving support to flexibility, financial wellbeing, and long-term health security.

Meeting these diverse needs does not necessarily require adding more programs. Instead, employers have an opportunity to design benefits that are flexible enough to remain relevant across different life stages while making it easier for employees to find and use the support that matters to them. The

[2] McKinsey & Company, "Transforming employer health benefits: Large employers' activist role," 26 June 2025, section on a more complicated ecosystem. US large-employer context.

goal is to create a benefits experience that recognizes individual needs without creating an increasingly complex and unsustainable collection of disconnected programs.

Measuring Outcomes and Building Accountability

Effective benefits strategy begins with clearly defined outcomes. Employers should first determine what they are trying to achieve, whether that is greater affordability, improved access, stronger workforce resilience, better health outcomes, or greater equity. These priorities should be informed by workforce demographics, utilization patterns, employee feedback, and cost data. From there, organizations can establish meaningful measures of success and regularly assess whether their benefits are delivering the intended value. McKinsey Health Institute's report recommends establishing a baseline, piloting interventions, and tracking three to five metrics. This is a practical discipline for benefits governance: define the problem and the measure of success before signing the next contract. Its wider economic analysis should not be interpreted as a promised return for an individual benefits program[3].

Set the baseline and the measure before the next contract.

Measurement alone, however, is not enough. Strong governance and vendor accountability are essential to turning insights into action. Employers need a consistent process for reviewing performance, identifying gaps, holding partners accountable, and adjusting their strategy as business and workforce needs evolve. This creates a benefits model that is not only measurable, but also responsive to change.

That ability to adapt will become increasingly important. Complexity is unlikely to disappear as rising costs, evolving regulations, changing workforce demographics, and shifting employee expectations continue to influence benefits strategy. The most resilient organizations will not necessarily be those that offer the most benefits or the richest programs. They will be those with clear priorities, flexible designs, strong governance, accountable partners, and the ability to evolve as conditions change.

Ultimately, benefits decisions are business decisions. They influence talent attraction and retention, financial performance, workforce resilience, and the overall employee value proposition. Rather than viewing benefits solely as an expense to control, employers have an opportunity to use them as a strategic investment in their workforce.

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[3] Barbara Jeffery et al., McKinsey Health Institute, "Thriving workplaces: How employers can improve productivity and change lives," 16 January 2025, guidance on baselines, pilots, and measurement.

The most effective strategies balance cost, compliance, access, equity, and employee experience, while recognizing that these priorities do not exist independently. When thoughtfully designed and continuously evaluated, benefits can support employees through changing needs while strengthening the organization's ability to perform, compete, and remain resilient over the long term.

Utilizing Technology to Make Better Decisions

Technology and AI have the potential to reshape how employers design, deliver, and manage benefits. Their greatest value, however, will not come from replacing human judgment or relationships. It will come from connecting benefits strategy more effectively to everyday employee needs and giving employers better information to make decisions.

For employees, technology can create a simpler and more personalized benefits experience. Rather than expecting employees to navigate multiple vendors, portals, and programs on their own, digital tools can help guide them toward the most relevant resources based on their needs and life circumstances. AI can simplify complex plan information, answer routine questions, support benefit comparisons, and help employees act at important moments such as starting a family, managing a health condition, caring for a loved one, or preparing for retirement. More targeted and timely communication can also increase awareness and engagement with valuable programs that may otherwise remain underutilized.

For employers, the opportunity extends beyond navigation. Advanced analytics can bring together cost, claims, utilization, demographic, and program performance data to create a more complete view of the benefits ecosystem. This can help organizations understand what is driving cost, identify emerging workforce needs, uncover gaps or duplication across vendors, and determine which programs are delivering meaningful value. Over time, predictive capabilities may allow employers to move from reviewing what has already happened to anticipating where costs and workforce needs are likely to emerge, creating an opportunity for earlier and more targeted intervention.

Use AI to connect vendors, data, and employees in one view.

Technology can also strengthen the operating model behind benefits. AI can support activities such as reviewing plan documents, comparing benefit provisions, monitoring regulatory developments, identifying inconsistencies across programs, and automating routine administrative workflows. For global organizations in particular, this can create greater consistency across markets while allowing benefits teams to spend less time gathering and reconciling information and more time on strategy, governance, and employee needs.

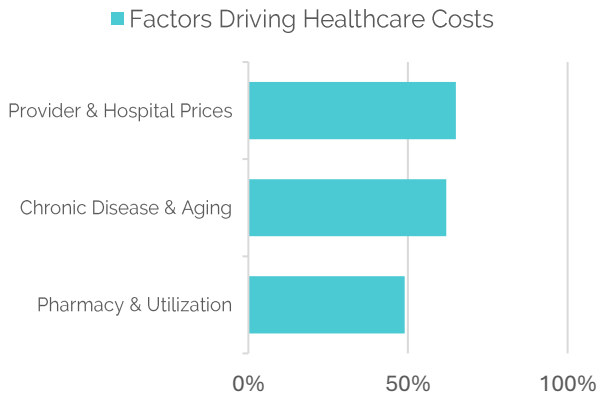
The longer-term opportunity is to create a more connected benefits ecosystem. Instead of operating as a collection of separate plans and vendors, technology can serve as the connective layer between employees, employers, brokers, insurers, and benefit providers. Better integration can make the experience easier for employees while giving employers greater visibility into how programs interact, where investment is generating value, and where the benefits portfolio should evolve.

Technology alone, however, will not create a successful benefits strategy. As AI becomes more embedded in health, financial, and workforce decisions, trust and responsible governance will become increasingly important. Employers will need clear standards for protecting personal and health information, evaluating bias, maintaining transparency, validating the quality of recommendations, and preserving human oversight for decisions that materially affect employees.

The strategic opportunity is therefore not simply to introduce more technology, but to use it deliberately to create a benefits model that is more connected, personalized, measurable, and responsive. Organizations that combine technology with strong governance and human judgment will be better positioned to manage costs, improve the employee experience, and adapt their benefits strategy as workforce needs continue to evolve.

What Are Employers Doing?

Alliant surveyed over 60 broker partners worldwide on what is driving healthcare costs: Provider or Hospital Prices (65%), Chronic Disease or aging (62%), and Pharmacy & Utilization (49%). These percentages describe themes mentioned in responses, not the share of claims spending attributable to each driver. They suggest that employers should separate price, service use, treatment mix, and population health when diagnosing their own cost increases.



That diagnosis should shape local action. Provider price pressure calls for scrutiny of network contracts and care settings. Higher utilization requires investigation into whether employees are receiving necessary care, duplicating services, or struggling to find the right provider. A common global framework can guide these reviews while local teams account for public coverage, financing arrangements, and available care.

The strongest recurring clinical themes in Alliant's survey are cardiovascular disease or hypertension (84%), and cancer and diabetes, metabolic conditions, or obesity (83%). These are coded mentions of

medical cost drivers, not disease prevalence or a ranking of total spending. They support a focused review of chronic-condition care rather than a separate purchase for every diagnosis.

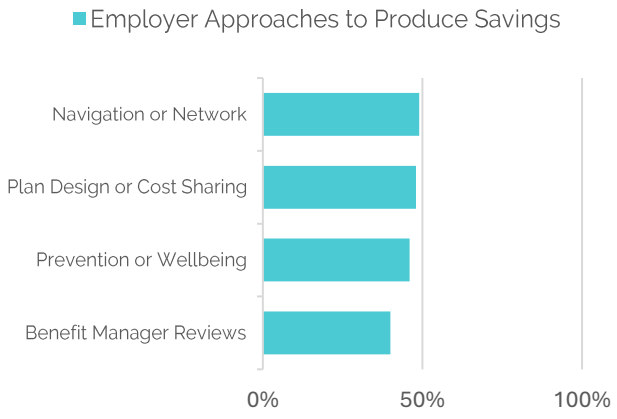
For employers, the next step is to examine the complete care pathway: access to appropriate screening and primary care, timely diagnosis, specialist referral, treatment support, and return to work. Claims can identify spending concentrations; absence data and employee feedback can reveal difficulties that claims alone will miss. Local clinical advice should determine appropriate services, and individual health information should remain with authorized care and administration partners.

A program's health value and its financial return should be evaluated separately. Earlier diagnosis may increase near-term spending, while improving access or outcomes. A credible business case should state the expected time horizon, the employees it aims to reach, and the evidence needed to judge results. Better outcomes should not be presented as guaranteed immediate savings.

Employers are pursuing responses such as:

- navigation or network actions (49%),
- plan design or cost sharing (48%),
- prevention or wellbeing (46%)
- vendor, claims, or pharmacy benefit manager reviews (40%).

These are reported approaches, not evidence that any one approach produces savings. A practical review should map each vendor's purpose, eligible population, fees, services, and referral arrangements. Where services overlap, ask whether employees gain a distinct clinical or access benefit. Low utilization alone is insufficient reason to remove coverage: it may reflect a rare but important need, poor communication, or barriers to access.



Ultimately, employers can use benefits as a strategic investment, balancing cost and compliance with access, equity, and employee experience to support workforce and organizational resilience. By directing resources toward support that employees can access and use, employers can strengthen workforce health while building an organization better prepared to adapt.

Global Chronic Conditions & Workforce Health



Taya Brown

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Taya has more than 20 years of experience in the benefits industry, including leading global benefits & total rewards initiatives for multinational organizations. At Alliant, she partners with clients & global teams to develop & manage benefits strategies that support their workforce & business needs.



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Kay has more than 6 years of experience with global benefits consulting. At Alliant, she has built deep relationships with our broker partners around the globe. Kay also focuses on key health & wellbeing initiatives within the Alliant practice – acting as the primary liaison with & expert regarding global family-forming solutions & as the main project manager for this Health Review each year.

Chronic Conditions and their Financial Impact

Chronic conditions raise medical costs and disrupt employees' ability to work. Multinational employers often lack a clear, comparable picture of which conditions are behind each challenge across different countries. Alliant surveyed our Asinta broker partners in over 60 countries to understand employer sentiments and priorities for managing chronic health conditions in the workplace. Multinational employers need both a claims view and a workforce view to target support[4].

The financial impact is broader than the claims history.

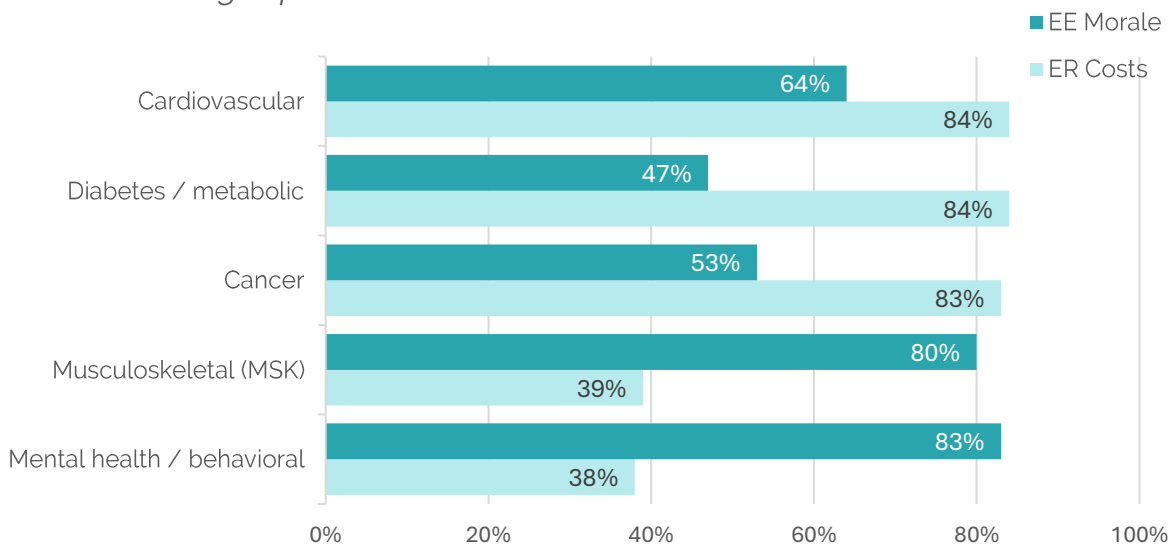
[4] Alliant / ASINTA Global Health Review (2027)

What conditions are impacting employers?

Medical costs and workforce impact diverge

The feedback in most countries was clear: there is a gap between what drives medical spending and what disrupts employees' work and their productivity. Cardiovascular disease, diabetes and other metabolic conditions, and cancer were each identified as medical-cost drivers in more than 80% of the countries included. Mental health and musculoskeletal (MSK) conditions were cited more often for absence, disability, and lost productivity. Claims alone therefore miss much of the workforce impact.

Conditions driving impact



Alliant's Asinta broker partners in over 60 countries participated in the survey to confirm which health conditions are driving medical costs ("ER Cost") and workforce productivity losses ("EE Morale"). The chart summarizes the number of countries within the survey that identified each condition as a key contributing factor.

How is the impact emerging?

Top health conditions

Average global medical trend has exceeded 10% for more than five years. Chronic-condition claims and advances in treatment contribute alongside other economic factors. Disability claims related to chronic disease and burnout add to renewal pressure and productivity losses.

Aging workforce

Our Asinta partners rated the aging-workforce challenge as moderate to very significant, especially in physically demanding roles, markets with aging populations and workforces with skilled labor shortages or long tenure. Longer working lives connect chronic disease with disability, MSK needs, cancer and mental-health support, caregiving, and retention.

Value, access, and employee experience

Access barriers vary by local health system. Employees may face out-of-pocket costs, long waits, provider shortages, coverage or network limits, distance, and language barriers. Transportation, caregiving, work schedules, health literacy, digital access, stigma, and financial stress can add friction. Delayed care can add to claims pressure and worsen employee experience. Since COVID, overloaded public systems have also pushed some employees toward private care.

Solutions becomes stronger when considered together rather than as separate benefit, HR, or finance issues.

Benefit evolution and family support

Chronic-condition support also intersects with caregiving, family health, financial stress, and the wider employee experience.

Use and spending are growing for mental-health services, virtual care, navigation, preventive screening, MSK and cancer support, caregiver support, and financial wellness. Expected growth areas include metabolic and obesity care, behavioral health, digital MSK, pharmacy management and AI-enabled navigation.

From medical cost to workforce value

When access barriers delay treatment, medical costs may rise and employees may face more disruption at work and at home. Navigation, prevention, and condition management may improve employee experience and work capacity alongside any claims savings.

How are employers responding?

Employers are managing four linked pressures: direct medical costs, workforce costs, affordability and access, and financing risk. They favor targeted programs with clear measures of access, health, or workforce outcomes; the value of broad initiatives can be harder to assess.

Programs in use

Aging workforce

For aging workforces, employers are considering prevention, condition management, MSK, cancer and mental-health care, navigation, telemedicine, caregiver support, financial wellness, flexible work, phased retirement, and return-to-work resources.

Value, access, and employee experience

Care navigation, virtual care, transportation and language support, community referrals, flexible leave, behavioral-health services, and financial-wellness resources can ease access barriers.

Family benefits can also respond to changing needs through parental and caregiver leave, fertility and family-building support, dependent coverage, backup care, lactation support and return-to-work flexibility.

Risk Financing

Employers report or consider self-funding, level funding, medical-risk captives, stop-loss, multinational pooling, focused networks, pharmacy strategies, value-based contracts, employee cost sharing and vendor guarantees. No single financing model works globally, and financing alone does not improve health. Its value depends on access, condition management, pharmacy performance and vendor accountability.

AI

The use of advanced clinical AI is still limited. Carriers are exploring AI mainly for benefits navigation, triage, member support, claims and risk analytics, fraud or waste detection, and vendor monitoring; advanced clinical uses remain limited. Adoption depends on privacy, security, accuracy, integration, bias controls, clinical accountability, employee trust, and local data rules. Employers can start with navigation, then test whether analytics improve outreach, care management, vendor performance, avoidable high-cost events and employee outcomes.

What this means for employers

No single program addresses the full global burden. Cardiovascular disease, diabetes, and cancer call for prevention, screening, timely diagnosis, treatment continuity, pharmacy management and high-cost claims support. Mental health and MSK require access to care, behavioral support, workplace design, absence management and return-to-work resources.

A portfolio of locally relevant interventions should reflect regulation, provider capacity, affordability, and employee needs.

To manage claims costs, employers are reviewing vendors, contributions, plan design and networks, sometimes delaying new programs. To limit workforce disruption, they are considering navigation, virtual care, behavioral health, prevention, pharmacy coaching, and condition support. Alliant has not seen clients terminate benefits entirely.

Impact Categories & Their Consequences

	Direct medical cost	Workforce cost	Affordability & access
Driving conditions	**Cardiovascular Metabolic conditions Cancer**	**MSK Mental health**	**Mental health**
Driving factors	• Inflation • Provider pricing • Diagnostics • High-cost claimants / treatments	• Economic pressures • AI uncertainty • Insufficient WFH set-ups	• Out-of-pocket costs • Wait times • Provider shortages
Business consequence	Budgetary pressure	Lost productivity & engagement	Delayed care with additional cost

Solutions by Impact Category

	Direct medical cost	Workforce cost	Affordability & access
Policy solutions			
Behavioral health support		✓	✓
Navigation & communication	✓		✓
Screening & prevention	✓	✓	
Condition management	✓		
Network changes	✓		
Ergonomics & physio cover		✓	
Flexible work & RTW policies		✓	
Caregiver support & leave		✓	✓
Risk financing solutions			
Pooling & captives	✓		
Self-funding	✓		
Level funding	✓	✓	
Stop loss & pharmacy strategies	✓	✓	
WFH allowances	✓		

Alliant's Asinta broker partners in over 60 countries participated in the survey to confirm key drivers, consequences, and solutions tied to the top health conditions identified. The table summarizes how chronic-condition pressures shape employer medical costs, workforce productivity, employee affordability, and risk financing.

Where do multinational employers go from here?

A practical workforce-health value scorecard

Employers should assess programs against medical costs and workforce outcomes. A common scorecard can track claims and pharmacy spend, avoidable high-cost events, clinical outcomes, prevention and condition-management use, care delays, out-of-pocket costs, provider access, participation, employee feedback, absence, disability, and productivity. Reviewing results over one to three years can clarify the value of vendors, financing, and digital tools. Benefits, HR, finance, procurement, risk, regional leaders and employees should agree on shared measures while allowing local teams to tailor programs.

The model should consider costs and productivity impact together.

Priorities for multinational employers

Multinational employers could consider a more integrated approach to chronic conditions connecting health strategy, workforce outcomes, and affordability, rather than managing each independently.

Prioritize by cost and workforce impact: cardiovascular disease, diabetes and cancer lead medical-cost mentions; mental health and MSK have the greatest reported effect on absence, disability, and productivity. Allocate resources across both groups.

Strengthen prevention and early intervention: assess screening, primary care, condition-specific support, pharmacy coaching, navigation, and behavioral health. Check whether employees can get timely care before conditions become more complex or costly.

Set global principles and adapt locally: reflect statutory coverage, private-care capacity, regulation, provider access, language, geography and affordability in each market's approach.

Connect financing to health outcomes: assess captives, pooling, stop-loss and self-funding alongside condition management, pharmacy, navigation, and vendor results. These arrangements may also improve visibility into claims experience.

Help employees use available support: communicate consistently about condition management, pharmacy, behavioral health and other benefits. Use participation and outcomes to guide which programs to implement, expand or promote.

Use AI selectively with clear governance: start with navigation, triage, member support and analytics. Set requirements for privacy, security, accuracy, bias, integration, accountability, employee trust and local compliance before expanding clinical uses.

Use the four pillars for decision-making:

Pillar	What the evidence shows	What to do
01 Cost and access	Medical trend and chronic disease increase cost; affordability, wait times, and provider capacity worsen access.	→ **Track claims, access, employee cost burden, and workforce outcomes together.**
02 Global consistency and local relevance	Health systems, regulation, coverage, and provider networks differ materially between countries.	→ **Set global principles but allow local operating choices.**
03 Financing and health improvement	Captives, pooling, stop-loss, and self-funding can improve risk visibility, but financing alone does not improve health.	→ **Tie funding decisions to condition strategies and compare to tracked cost / access data to ensure outcomes.**
04 AI promise and trust	AI may improve navigation, analytics, and operations, but the security of sensitive health data is required.	→ **Scale use cases only when privacy & accuracy are defined.**

The "Do Nothing" Cost Curve: Quantifying the Price of Inaction



Brittney Goodgame

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Brittney has over 15 years of experience in the employee benefits industry as a clinical leader and data scientist. She acts as a clinical and population health consultant, specializing in improving employee health outcomes and cost containment strategies.

The Hidden Baseline: Do Nothing as the Default Strategy

Across the globe, employers and health plan sponsors face mounting financial pressure as rising prescription drug and treatment costs, coupled with growing prevalence of chronic disease, continue to drive healthcare costs higher. Recent OECD (Organisation for Economic Co-operation and Development) data show that health spending remains a substantial share of national economies, while the effects of high-cost treatments continue to grow[5,6]. In this environment, inaction is not a neutral choice. Failing to intervene early as clinical risk progresses can lead to greater utilization and compounding costs over time. Yet, many organizations focus their cost-management efforts on controlling immediate spending through strategies such as increased cost sharing, network optimization, and benefit design adjustments. While these approaches can affect near-term spending, they often manage the cost of care without addressing the underlying factors driving healthcare utilization and long-term spending. As healthcare costs continue to rise, organizations can look beyond traditional cost containment measures and consider how earlier, more proactive interventions may help influence future costs while supporting employee health and solving access to care.

[5] OECD. (2025). Health at a glance 2025: OECD indicators. OECD Publishing. https://doi.org/10.1787/8f9e3f98-en
[6] Cunningham, M. (2026, September 4). Employer and worker health plan costs expected to jump in 2027. CBS News. https://www.cbsnews.com/news/employer-health-care-costs-increase-2027/

Understanding the Cost Curve of Inaction

Healthcare cost management remains largely reactive, with meaningful intervention only occurring after a high-cost event or jump in utilization has already taken place. Traditional measures of plan performance and utilization provide valuable insight into historical utilization and spending but offer limited visibility into costs that might have been prevented through earlier action. The global burden of chronic diseases continues to rise, with prevalence projected to increase steadily in the coming decades[7]. The financial implications of maintaining the status quo in the face of rising occurrence are rarely evaluated with the same scrutiny as the costs of implementing a new intervention or program. Organizations may understand the cost of proactive strategies yet have far less insight into the financial consequences of inaction. This creates a blind spot in healthcare strategy: doing nothing is often treated as a neutral baseline, even though it carries its own risks and costs.

Higher-risk diabetes and CKD patients had 2–3 times the costs.

Many chronic and progressive health conditions follow a recognizable pattern in which clinical complexity and healthcare costs increase as the condition advances. In earlier stages, risks may be managed through relatively low-cost interventions, while disease progression results in higher utilization, more complex treatment needs, and potentially costly acute events or hospitalizations. The cost curve associated with this escalation is rarely linear, with plan costs often increasing substantially in later stages of disease. For example, a recent study found that people with type 2 diabetes and chronic kidney disease who were identified as being at higher risk for progression had two to three times the utilization and costs of patients at lower risk for progression[8]. For employers and health plan sponsors, recognizing these patterns can help identify where earlier support and intervention may improve outcomes and reduce future care needs. Organizations should also account for indirect costs associated with worsening health, including absenteeism, medical leave, and disability, to better understand the condition's full impact on the workforce.

Assessing this risk requires organizations to look beyond historical spending and consider how healthcare costs may evolve with and without targeted intervention. While traditional claims analysis provides valuable insight into what has already occurred, predictive modeling offers an opportunity to estimate what might happen with or without intervention. By combining claims-based progression analysis and cohort-level modeling, organizations can identify populations at greater risk for costly

[7] UN News. (2023, May 19). Chronic diseases taking "immense and increasing toll on lives," warns WHO. https://news.un.org/en/story/2023/05/1136832

[8] Tangri, N., Singh, R., Betts, K. A., Du, Y., Gao, S., Katta, A., Farag, Y. M. K., Fatoba, S. T., Liu, H., Chen, J., Ferguson, T., Whitlock, R., Leon, S. J., & Singh, A. K. (2025). Risk of progression and costs of care for patients with type 2 diabetes and chronic kidney disease. Diabetes Therapy, 16(11), 2257–2264. https://doi.org/10.1007/s13300-025-01787-8

disease progression and evaluate the potential impact of targeted interventions. Scenario modeling can then compare projected outcomes and costs under the current program against those associated with proactive management. This approach shifts the focus from simply measuring healthcare spending to estimating the potentially avoidable costs, providing employers and health plan sponsors with a more informed basis for evaluating investments in prevention and disease management.

Why Early Intervention Drives Disproportionate Value

The timing of intervention plays a critical role in both clinical outcomes and financial impact. Addressing health risks earlier in their progression often requires fewer intensive resources, creates opportunities to reach a broader population, and may prevent more costly complications downstream. Conversely, delayed intervention can narrow the range of effective treatment options, increase the complexity of care, and require significantly greater investment to achieve comparable outcomes. While the financial benefits of prevention vary by condition and intervention, the greatest opportunity to influence long-term costs often exists before progression occurs. Yet healthcare spending remains heavily concentrated on our already high-cost ailments, as opposed to proactive investments in future risk mitigation. In 2022, the top 5% of people in the U.S. accounted for nearly half of total healthcare spending[9]. This highlights a fundamental disconnect between where resources are spent and where proactive investment may deliver value.

The greatest opportunity to influence cost comes before progression.

Financial implications of delayed intervention can be illustrated across several common and costly health conditions. In diabetes, inadequate or delayed management of the disease early on can contribute to disease progression, increasing the likelihood of cardiovascular complications, kidney disease, and hospitalization. One study showed a one-year delay in appropriate care for diabetics was associated with over $7.3 billion in additional costs within the U.S. and a measurable loss of life years, with longer delays associated with even greater economic burden[10]. Musculoskeletal conditions present another clear opportunity, as unmanaged pain may lead to repeated imaging, specialist consultations, and surgical intervention, whereas early access to physical therapy and conservative treatment was associated with less imaging, emergency visits, and specialist care, resulting in

[9] Hernandez-Viver, A., & Mitchell, E. M. (2025). Concentration of healthcare expenditures and selected characteristics of people with high expenses, United States civilian noninstitutionalized population, 2018–2022 (Statistical Brief No. 560; AHRQ Publication No. 25-0017-3-EF). Agency for Healthcare Research and Quality. https://meps.ahrq.gov/data_files/publications/st560/stat560.shtml

[10] Ali, S. N., Dang-Tan, T., Valentine, W. J., & Hansen, B. B. (2020). Evaluation of the clinical and economic burden of poor glycemic control associated with therapeutic inertia in patients with type 2 diabetes in the United States. Advances in Therapy, 37(2), 869–882. https://doi.org/10.1007/s12325-019-01199-8

significantly lower treatment costs[11]. Together, these examples show why interventions should be evaluated against both employee health outcomes and total cost of care.

Why Organizations Struggle to Act

Despite the potential benefits of early intervention, organizational structures and financial priorities can make proactive investment difficult. Annual budget cycles often emphasize immediate cost reductions, while the financial benefits of prevention and disease management may take several years to materialize. Because clinical, financial, and human resources leaders are accountable for different outcomes, organizations should tailor the evidence and business case to each group while aligning investment decisions around shared long-term measures. Analytical limitations present additional challenges, as organizations may lack the data or modeling needed to identify progression risk, estimate avoidable or influenceable costs, or demonstrate the value of interventions that prevent events from occurring. As a result, decisions frequently rely on historical spending and short-term performance measures, leaving longer-term opportunities for risk and cost reduction underrepresented in strategic planning.

Budgets reward quick cuts.

Prevention can pay back over years.

Moving beyond traditional cost containment requires a more forward-looking approach to healthcare strategy, one that considers not only current expenditures but also the risks likely to drive future spending. Organizations can strengthen decision-making by incorporating predictive analytics, prioritizing investments based on clinical and financial risk, and aligning performance measures with longer-term health outcomes. By directing resources toward populations and conditions where intervention has the greatest potential impact, employers and health systems can make more informed investment decisions while balancing near-term financial goals with long-term sustainability.

Implications for Global Health Systems and Employers

The cost of inaction has implications across healthcare systems, regardless of geography, funding structure, or coverage model. Whether costs are the responsibility of governments, insurers, employers, or individuals, unmanaged healthcare risks can contribute to greater healthcare utilization,

[11] Marrache, M., Prasad, N., Margalit, A., Nayar, S. K., Best, M. J., Fritz, J. M., & Skolasky, R. L. (2022). Initial presentation for acute low back pain: Is early physical therapy associated with healthcare utilization and spending? A retrospective review of a national database. BMC Health Services Research, 22, Article 851. https://doi.org/10.1186/s12913-022-08255-0

more complex treatment needs, and increased costs over time. For employers and health plan sponsors, it presents an opportunity to expand workforce health strategies beyond managing utilization and negotiating unit costs to include targeted efforts that reduce clinical risk and influence future demand for care. In healthcare, doing nothing is still a decision and it may be the most expensive one an organization makes.

Although the financial incentives and mechanisms for intervention differ across markets, the underlying principle remains consistent: sustainable healthcare financing requires attention to both the cost of care delivered today and the risks that may drive costs tomorrow. Those that quantify and act on the cost of inaction will be best positioned to deliver resilient value in an increasingly high-cost world.

Benefits Blind Spot



Luisa Sepulveda

Consultant, Health & Productivity, Alliant

Luisa has more than 8 years of experience in well-being and clinical consulting. She specializes in helping organizations design data-driven wellness initiatives that align with organizational goals, support a healthier workforce, and help manage healthcare costs. Her work also focuses on identifying and addressing various barriers to care, facilitating equitable access to resources that help individuals and organizations achieve better health outcomes.



Brittney Goodgame

VP, Lead Consultant, Clinical Informatics, Alliant

Brittney has over 15 years of experience in the employee benefits industry as a clinical leader and data scientist. She acts as a clinical and population health consultant, specializing in improving employee health outcomes and cost containment strategies.

Why Employer-Sponsored Health Insurance Alone Can't Solve Health Inequities

Executive Summary

- Employer-sponsored healthcare coverage does not guarantee practical access to care. Across markets, respondents identified barriers such as affordability, provider shortages, wait times, geography, health literacy, and time constraints even where public, private, or employer-sponsored coverage was available.
- The point of friction varies by market. In Mexico, deductible costs, and lost income from taking time away for appointments were highlighted, while Canadian respondents emphasized physician shortages, regional access differences, language and cultural barriers, and benefits literacy.

- **Employer responses often extend beyond insurance design.** Reported practices included flexible work, telehealth, navigation, transportation support, financial education, caregiver support, and targeted communications, suggesting that practical access barriers may require workplace or navigation solutions in addition to benefit changes.
- **A uniform global solution is unlikely to work across markets.** The responses indicate that employer strategies need to reflect local healthcare systems, workforce needs, and the barriers that employers can realistically influence rather than applying identical interventions everywhere.

Beyond Healthcare: Why Investment Alone Doesn't Determine Health Outcomes

The distance between two populations may be measured in miles or kilometers, but the gap in health outcomes can be measured in years of life. across the globe, where people are born, grow, live, work, and age — and their access to resources and opportunities — shape avoidable differences in health. Conditions such as housing, education, employment, and access to healthcare can materially influence health and longevity[12].

This relationship is illustrated in the OECD's Health at a Glance 2025. Nine OECD countries — including Korea, Spain, Italy, Israel, Portugal, Chile, Greece, Japan, and Slovenia — report lower-than-average health spending while achieving higher-than-average life expectancy. At the same time, high spending does not guarantee stronger population health outcomes. Norway and the United States both devote substantial resources to healthcare, yet life expectancy is approximately 83.1 years in Norway and 78.4 years in the United States. These comparisons do not establish that spending itself determines longevity; rather, they reinforce that health outcomes reflect a broader set of healthcare and non-healthcare factors[13].

U.S. life expectancy trails Norway's by nearly five years.

The same principle is relevant at the workforce level. In this article, healthcare coverage refers broadly to the public, private, or mixed mechanisms through which individuals receive care, while employer-sponsored coverage refers specifically to health insurance and benefits provided or facilitated by employers. Access refers to whether covered care or benefits are practically available to employees; utilization refers to whether healthcare services or employer-sponsored benefits are used; and outcomes refer to the health, benefit, or workforce results that follow.

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[12] World Health Organization. (2025a). World report on social determinants of health equity. Geneva: World Health Organization. ISBN 978-92-4-010758-8. Chapter 1, Page 4.

[13] OECD. (2025). Health at a Glance 2025: OECD Indicators. OECD Publishing, Paris. https://doi.org/10.1787/8f9e3f98-en. Page 26, Figure 1.7. Figure 1 for Norway and United States life expectancy.

Providing employer-sponsored health coverage or other health and well-being benefits does not necessarily mean employees can practically access, use, or benefit from those resources. The conditions surrounding an employee — from affordability and transportation to health literacy, caregiving responsibilities, provider availability, and cultural norms — can create barriers between the availability of employer-sponsored benefits, employees' ability to access and use them, and the health outcomes those benefits are intended to support. These consequences extend beyond the individual as employers and healthcare systems bear the downstream costs through increased healthcare utilization, absenteeism, and reduced productivity. For global employers, the challenge is understanding where that pathway breaks down and, just as importantly, which barriers they are positioned to influence.

The Uneven Landscape of Health and Well-being: Understanding Social Risk

The reality is that an individual's sense of health and well-being is shaped long before they ever enter a healthcare facility. Employment can serve as an important buffer, providing income, financial stability, and many times access to employer-sponsored health insurance or other health benefits. However, with rising inflation, employees are facing increased financial strain, obligating them to make difficult tradeoffs among necessities like food, housing, transportation, and healthcare, and these pressures vary substantially across geographies based on wages, social protections, and healthcare infrastructure. In 2025, an estimated 2.69 billion people — roughly one-third of the global population — were unable to afford a healthy diet, with substantial variation across regions and income groups[14].

Financial constraints can influence everyday health behaviors and consumption decisions while contributing to a reinforcing cycle of financial and health inequity. Employees may defer preventive care or ongoing management of chronic conditions because of cost, transportation, an inability to take time away from work, or competing household expenses. Delayed care can increase the risk of more complex and costly health needs, while worsening health can affect an individual's ability to work and earn income. further intensifying financial vulnerability.[13,15]

Social and cultural environments introduce another dimension of risk. Social connection and community support can vary across cultures, influencing where employees turn for support and how they experience health and well-being. According to the World Health Organization's report of the

[14] FAO, IFAD, UNICEF, WFP, & WHO. (2026). The State of Food Security and Nutrition in the World 2026: Understanding and addressing the high cost of a healthy diet. Rome. https://doi.org/10.4060/cd8306en

[15] Vrtikapa, K., Hoque Urmy, F., & Hoque, F. (2025). Social Determinants of Health: The Impact of This Overlooked Vital Sign. Brown Hospital Medicine.

WHO Commission on Social Connection, one in six people worldwide is estimated to experience loneliness, and the WHO reports associations between loneliness or social isolation and higher risks of cardiovascular disease, stroke, diabetes, cognitive decline, depression, anxiety, and premature death[16]. Workplace expectations and cultural norms may also influence whether employees recognize, disclose, or seek support for stress, loneliness, or burnout.

Employer-sponsored benefits and programs may provide a degree of protection, but their impact depends on whether employees can practically access, understand, and use them. For example, an employee may have preventive care covered under a public or employer-sponsored health plan but delay using that care because of out-of-pocket costs, transportation challenges, an inability to take time away from work, or competing household expenses. Identifying and measuring the socioeconomic conditions that influence access — and determining where employers can realistically mitigate their effects — is critical to developing a meaningful and sustainable strategy for improving health outcomes. For employers, the opportunity is not to solve every social or economic challenge affecting their workforce, but to identify where those conditions create barriers to care — and where targeted benefit design, workplace practices, or targeted support can realistically reduce their impact.

Benefits only work if employees can afford, reach, and use them.

From Global Trends to Localized Strategy

To better understand how these barriers manifest across markets, Alliant gathered qualitative input from June to October 2026 from local market specialists across 90 countries in the Americas, EMEA, and Asia-Pacific regions. Respondents were asked about perceived healthcare utilization, perceived importance of SDOH, perceived barriers to care, and targeted employer responses within their markets. The findings from 66 countries reflect local expert observations rather than employee-level prevalence estimates and should be interpreted as directional insights rather than representative market statistics. Responses were not complete for every market or question, and missing responses were treated as unavailable information rather than evidence that a barrier or employer practice was absent.

Across the regional exhibits, the key question is not simply whether healthcare coverage exists, but where the pathway from coverage to better health outcomes begins to break down. Coverage must translate into practical access to care; access must enable appropriate utilization; and utilization must

[16] World Health Organization. (2025a). World report on social determinants of health equity. Geneva: World Health Organization. ISBN 978-92-4-010758-8. Chapter 1, Page 4.

ultimately contribute to better health outcomes. Social, economic, cultural, and structural conditions can create friction at any point along that pathway.

The market responses illustrate how those points of friction vary. In some markets, respondents emphasized affordability or cost-sharing; in others, provider shortages, wait times, geography, health literacy, or difficulty navigating care were more prominent. Private insurance and employer-sponsored health benefits can improve provider choice, speed of access, and access to services not fully available through public systems, but they do not eliminate every practical barrier to care.

Taken together, these findings suggest that global consistency in benefits strategy should not be confused with uniformity. The same intervention may solve an access problem in one market and have limited relevance in another. Effective strategy therefore begins by identifying where the barrier occurs — whether in benefit availability and awareness, practical access to care, healthcare navigation, healthcare utilization, or the broader healthcare environment — and whether the employer has a realistic mechanism to influence it.

Americas

The Americas illustrate how different barriers can interrupt the pathway from broad healthcare coverage to care. In Mexico, respondents identified deductibles as a barrier to use of private or employer-sponsored healthcare, along with lost income from taking time away for appointments and limited specialist availability outside major cities. Reported targeted employer responses included transportation and food vouchers, flexible work, telemedicine, childcare support, and financial education. In Canada, respondents highlighted physician shortages, rural and regional access differences, language and cultural barriers, and limited benefits literacy, with employer's targeted responses including virtual care, financial education, flexible work, transportation assistance, and food and nutrition programs. These examples show that the barrier may sit not in whether an employer-sponsored benefit exists, but in whether employees can afford, navigate, reach, or take time to use it.

EMEA

Across EMEA, the diversity of healthcare systems produces an equally diverse set of access challenges. Employer-sponsored health benefits and private insurance coverage frequently improve access to specialists, diagnostics, and faster treatment, yet waiting times, provider shortages, affordability, transportation, mental health stigma, health literacy, and urban-rural disparities remain common. For example, Poland and Spain continue to report long waits for care and provider scarcity. In several African markets, employers reported more targeted responses, including transportation assistance, referral navigation, support for medicine access, telemedicine, screening clinics, and evacuation assistance. Several local respondents also observed that larger multinational employers were more likely to offer targeted programs or more formalized approaches to SDOH-related barriers

than smaller or locally headquartered organizations. Because the survey was not designed as a representative employer comparison, this should be interpreted as a recurring market observation rather than a quantified regional finding.

APAC

Responses across APAC illustrate how similar access barriers can persist within very different healthcare and benefit environments. In Australia, respondents noted increasing use of mental health, allied health, and preventive services while also identifying regional provider availability, caregiving responsibilities, health literacy, and stigma as barriers. In India, mental health stigma and health literacy emerged as concerns, while respondents in Thailand highlighted affordability, time constraints, language barriers, and provider availability outside major cities. These examples reinforce that healthcare utilization alone does not provide a complete picture of access, and it does not necessarily mean that practical access barriers have been eliminated.

Solutions to Points of Friction

Barrier	Benefit & Vendor Management	Comms & Education	EAPs & Telehealth	Family-Friendly Policies	Meal & Transport Support	Savings Program
Affordability and Cost Sharing	1	2			1	1
Provider Availability, Wait Times, and Geographic Differences	2	1	1		1	
Health and Benefits Literacy and Navigation		4				
Time, Work, and Caregiving Constraints			1	4		
Language, Culture, and Stigma		3	2			
Transportation and Infrastructure Constraints	1	2	1		2	

Alliant's Asinta broker partners in 64 countries participated in the survey to confirm solutions for various types of barriers typical in each country. The table does not cover all 64 countries. Instead, a representative sample of countries is chosen. The maximum number of responses per solution is 6. Darker cells indicate more survey countries indicated this solution is used.

Designing for Access and Not Just Coverage

Employers have made significant investments in health, wellbeing, and financial protection benefits, yet many continue to face rising healthcare costs, growing mental health concerns, and persistent workforce challenges. The findings reinforce an important distinction for global employers: private insurance and employer-sponsored health benefits can improve access by expanding provider choice, reducing wait times, or covering services not fully available through public systems, but they do not remove the broader social and structural conditions that determine whether care is affordable, available, and practical to use. Social, economic, cultural, and structural conditions can create barriers between having health insurance or access to employer-sponsored benefits and being able to practically use available healthcare services.

For global employers, the opportunity is not to solve every social determinant of health. It is to identify where the pathway from coverage to access, utilization, and outcomes breaks down, determine which barriers the organization can realistically influence, and focus resources accordingly. The survey findings suggest that this can be approached through three steps: diagnose local barriers, design targeted interventions, and measure impact.

1. **Diagnose local barriers.** Use claims, healthcare and benefit utilization, employee surveys, absence and disability data, workforce demographics, geographic data, and local market intelligence to identify where the pathway from coverage to care may be breaking down. Employers should assess whether barriers are related to affordability, provider availability, benefit design, navigation, health literacy, language or cultural factors, time constraints, caregiving responsibilities, or other local conditions. Establishing a baseline can also help identify which populations or geographies may be experiencing disproportionate barriers. The survey illustrates why this diagnosis needs to be market specific. Respondents in Mexico identified deductible costs, lost income associated with taking time away for appointments, and limited specialist availability outside major cities, while respondents in Canada highlighted physician shortages, regional access differences, language and cultural barriers, and limited benefits literacy.
2. **Apply an SDOH lens to design targeted interventions.** Use identified barriers to inform benefit, vendor, and workplace decisions. Employers can evaluate affordability, accessibility, cultural and language capabilities, health literacy, network adequacy, eligibility, prescription drug coverage, and local relevance when assessing existing programs or new solutions. Importantly, not every barrier requires — or can be solved through — an employer-sponsored intervention. Investments should be prioritized where employee needs intersect with areas the organization can realistically influence. In some cases, this may mean redesigning a benefit or improving affordability; in others, it may mean helping employees navigate

structural barriers through telehealth, navigation and advocacy, decision-support tools, transportation or meal support. Where needs fall outside the traditional scope of benefits, employers can also consider workplace practices — such as flexible scheduling or paid time away — or partnerships with community organizations, public programs, health systems, and other local resources.

The survey provides examples of this distinction. Respondents in Mexico reported transportation and food support, flexible work, telemedicine, childcare, and financial education, while several African markets reported transportation assistance, referral navigation, medicine access, telemedicine, screening clinics, and evacuation assistance.

3. **Measure impact on access and workforce outcomes.** Create a measurement strategy to evaluate whether interventions are improving access, engagement, and workforce outcomes over time. Relevant metrics may include preventive care uptake, appointment completion, healthcare utilization by geography, benefit utilization, absence and disability claims, and medication adherence. Cross-border measurement should account for applicable privacy and data-protection requirements, as well as the risk of drawing conclusions from small employee populations.

Affordability Is Among the Most Frequently Cited Barriers

Affordability deserves particular attention because it was among the most frequently cited barriers in the market responses, including in markets with broad publicly financed or statutory healthcare coverage. Employers should evaluate the full cost of accessing care from the employee's perspective—not only out-of-pocket insurance-related expenses such as premiums, deductibles, and coinsurance, but also indirect costs such as transportation, lost time from work, and caregiving.

Provider Capacity and Geography Shape Access

Provider capacity and geography require a similar lens. Employees in rural areas or care deserts may face fewer specialists, longer travel distances, longer waits, and weaker provider networks. Digital solutions can help in some markets but may have limited value where connectivity or provider infrastructure is inadequate. These challenges are particularly important for employers with geographically dispersed workforces as they need to consider that a benefit may not have the same impact across their entire population. Understanding where employees live and what care is available locally can therefore be as important as understanding what the benefit plan technically covers to identify where provider or network gaps may be affecting employees' ability to practically use available healthcare services and employer-sponsored resources.

Moving from Fragmented Programs to Embedding SDOH into a Broader Framework

One of the clearest themes in the market responses is that employers may already be addressing SDOH-related barriers without using SDOH terminology. Flexible work, financial well-being, caregiver support, mental health resources, health education, telehealth, and transportation assistance frequently appear as workforce or well-being initiatives rather than as components of a formal SDOH strategy. The opportunity, therefore, may be less about creating an entirely new category of benefits and more about connecting existing efforts under a clearer framework, ownership structure, and measurement strategy.

Several markets reported targeted interventions addressing practical barriers, including transportation assistance, meal or nutrition support, flexible work, telemedicine, and navigation. Examples were reported in markets including Canada, Mexico, Egypt, France, Bosnia and Herzegovina, and parts of Africa. These examples are important because they address practical barriers that can determine whether an employee is able to obtain care at all. However, these approaches remain the exception rather than the norm.

Many employers already address SDOH without the label.

Several local respondents observed that larger multinational or global-headquartered employers were more likely to offer targeted programs addressing SDOH-related needs, while smaller or locally headquartered organizations more often focused on core coverage, cost management, or general well-being. These observations are directional and do not represent a quantified comparison across employer types. However, this does not mean smaller employers cannot act; it means that the strategy needs to be proportionate, focused, and realistic for the resources available.

For all employers, the appropriate response depends on where the barrier sits and how much influence the organization has over it. Some barriers can be addressed directly through benefit design, such as cost-sharing, provider networks, eligibility rules, or vendor capabilities. Others may be mitigated through workplace practices that enable and empower employees to leverage available resources, including flex time, caregiver support, health education, or culturally appropriate communication. Structural barriers—such as provider shortages, public-system wait times, or weak infrastructure—may sit largely outside the employer's control, but navigation, telehealth, transportation support, advocacy, and local partnerships can help employees work more effectively within those constraints.

For decades, employers have invested heavily in health benefits with the expectation that health insurance and employer-sponsored benefits will translate into practical access to care, appropriate healthcare utilization, and ultimately better health outcomes. Yet the market responses show that the barriers between those steps vary significantly by geography. Employer-sponsored health insurance and benefits alone cannot overcome every circumstance in which employees live, work, care for their families, and manage their health—but employers can identify where those circumstances diminish the value of existing programs and intervene where they have a realistic ability to make a difference.

The opportunity is not simply to provide more benefits, but to use locally grounded intelligence to understand where employee need and employer influence intersect. By diagnosing local barriers, designing targeted responses, and measuring whether existing benefits improve access and value, Alliant can help employers build global strategies that are more relevant, effective, and sustainable.

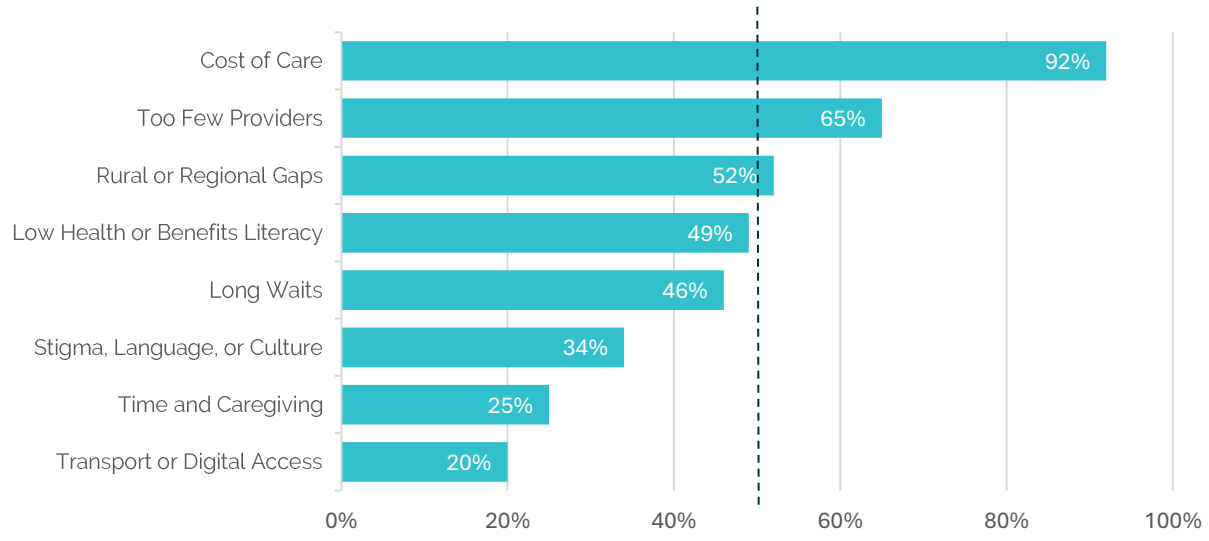
Detailed Survey Findings

Exhibit note: Findings reflect qualitative input from local market specialists and are intended as directional market observations. Healthcare utilization and SDOH indicators reflect respondent perceptions rather than standardized quantitative measures. Employer practices represent examples reported by respondents and should not be interpreted as market-wide prevalence.

** Define an aging workforce as a significant business issue*

Barriers to Care

Summary of Results



Detailed Results

Country	Cost	Too Few Providers	Rural Gaps	Health Literacy	Long Waits	Stigma & Culture	Time & Care	Transport & Digital
Americas								
Brazil*				*not available*				
Canada	✓	✓	✓	✓	✓	✓		
Colombia				*not available*				
Costa Rica	✓							✓
El Salvador	✓							
Mexico	✓	✓	✓	✓	✓			✓
Panama*	✓	✓	✓	✓	✓	✓	✓	
United States	✓			✓	✓			✓
APAC								
Australia*	✓	✓	✓	✓	✓	✓	✓	
China*	✓							
Hong Kong*	✓	✓			✓			

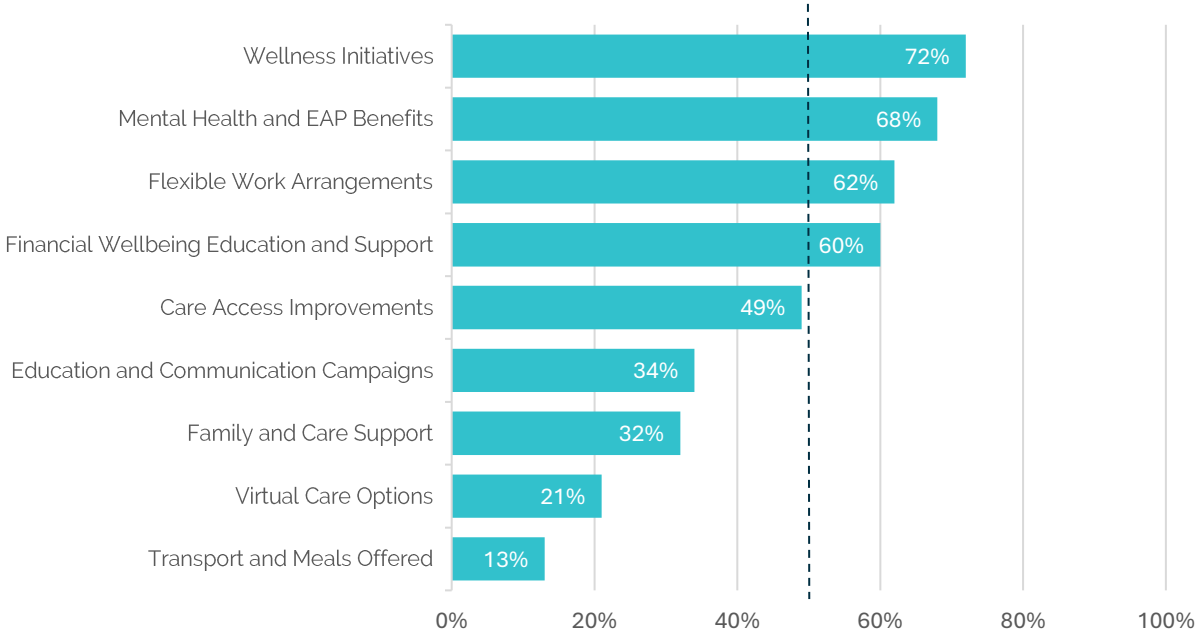
Country	Cost	Too Few Providers	Rural Gaps	Health Literacy	Long Waits	Stigma & Culture	Time & Care	Transport & Digital
APAC								
India	✓		✓	✓		✓		
Indonesia	✓	✓	✓	✓	✓	✓	✓	✓
Japan*					✓	✓		
Philippines	✓							
Singapore*	✓				✓			
South Korea*	✓					✓	✓	
Taiwan*	✓			✓		✓	✓	
Thailand*	✓	✓	✓	✓		✓	✓	
EMEA								
Pan-Africa*	✓	✓	✓	✓		✓	✓	✓
Albania*	✓						✓	
Armenia*	✓	✓	✓	✓	✓			
Austria*	✓	✓			✓			
Azerbaijan*	✓	✓	✓					✓
Bahrain*	✓	✓				✓		
Bosnia & Herzegovina*	✓	✓	✓	✓	✓	✓		
Bulgaria*	✓	✓	✓	✓				
Croatia*	✓	✓	✓	✓	✓	✓		
Cyprus*		✓		✓			✓	
Czech Republic	✓	✓		✓	✓	✓	✓	✓
Egypt	✓	✓	✓	✓				✓
Estonia*	✓		✓		✓			
Finland*	✓	✓	✓	✓	✓			
France	✓		✓	✓	✓	✓		✓
Georgia	✓	✓	✓	✓		✓		

Germany*		✓	✓		✓			
Greece*	✓	✓			✓			
Hungary*	✓		✓		✓			
Ireland	✓	✓						
Italy					✓		✓	✓
Jordan	✓	✓	✓					
Kazakhstan	✓	✓						✓
Kuwait	✓	✓		✓				
Latvia*	✓	✓			✓			
Lebanon*	✓	✓						
Lithuania*	✓		✓		✓	✓		
Macedonia*	✓	✓	✓			✓	✓	✓
Moldova	✓							
Montenegro	✓							
Netherlands*	✓	✓		✓	✓	✓	✓	
Norway*				*not available*				

Country	Cost	Too Few Providers	Rural Gaps	Health Literacy	Long Waits	Stigma & Culture	Time & Care	Transport & Digital
EMEA								
Oman	✓	✓	✓	✓				
Poland	✓	✓	✓	✓	✓	✓	✓	
Portugal	✓		✓	✓	✓			
Qatar	✓	✓		✓				
Romania*	✓	✓	✓	✓				
Saudi Arabia	✓		✓	✓				
Serbia*	✓		✓					
Slovakia*	✓	✓						
Slovenia*	✓	✓	✓		✓	✓	✓	
Spain*	✓	✓		✓	✓		✓	✓
Sweden		✓						
Switzerland*	✓				✓	✓		
Turkey*	✓	✓	✓		✓			
Ukraine*	✓	✓	✓					
United Arab Emirates	✓	✓	✓	✓				
United Kingdom	✓			✓				
Uzbekistan	✓	✓	✓	✓				

Solutions to Address Barriers

Summary of Results



Detailed Results

Country	Wellness	Mental Health	Flexible Work	Financial Wellbeing	Care Access	Education & Comms	Family & Care	Virtual Care	Transport & Meals
Americas									
Brazil*	✓	✓						✓	
Canada			✓	✓		✓		✓	✓
Colombia	✓				✓	✓			
Costa Rica					*not available*				
El Salvador	✓	✓			✓	✓		✓	
Mexico		✓	✓	✓	✓	✓	✓	✓	✓
Panama*					*not available*				
United States	✓	✓	✓	✓			✓		
APAC									
Australia*		✓	✓	✓		✓		✓	
China*		✓					✓		
Hong Kong*					*not available*				
India		✓	✓	✓	✓	✓			
Indonesia	✓	✓	✓		✓	✓			✓
Japan*		✓	✓	✓					
Philippines					*not available*				
Singapore*					*not available*				
South Korea*		✓	✓	✓			✓		
Taiwan*					*not available*				
Thailand*	✓	✓	✓	✓		✓	✓	✓	
EMEA									
Pan-Africa*	✓	✓	✓	✓	✓	✓		✓	✓
Albania*	✓		✓	✓	✓				
Armenia*	✓		✓		✓	✓			
Austria*		✓			✓		✓		
Azerbaijan*			✓		✓				
Bahrain*	✓	✓		✓					
Bosnia & Herzegovina*	✓	✓	✓	✓	✓				✓
Bulgaria*			✓		✓				
Croatia*	✓	✓	✓	✓	✓	✓	✓	✓	
Cyprus*					*not available*				
Czech Republic	✓	✓	✓	✓	✓	✓			
Egypt		✓		✓					✓
Estonia*	✓		✓		✓				
Finland*	✓	✓	✓	✓			✓		
France		✓	✓	✓	✓	✓	✓		✓
Georgia	✓		✓		✓				
Germany*	✓				✓				
Greece*	✓								
Hungary*	✓				✓		✓		

Country	Wellness	Mental Health	Flexible Work	Financial Wellbeing	Care Access	Education & Comms	Family & Care	Virtual Care	Transport & Meals
EMEA									
Ireland	✓	✓		✓					
Italy			✓	✓			✓		
Jordan	✓	✓		✓					
Kazakhstan	✓			✓	✓			✓	
Kuwait	✓	✓		✓					
Latvia*	✓	✓	✓		✓		✓		
Lebanon*	✓	✓		✓					
Lithuania*	✓	✓	✓			✓			
Macedonia*	✓	✓	✓				✓		
Moldova					*not available*				
Montenegro					*not available*				
Netherlands*	✓	✓	✓	✓	✓	✓	✓		
Norway*					*not available*				
Oman	✓	✓		✓					
Poland	✓	✓	✓	✓	✓	✓	✓		
Portugal	✓	✓	✓		✓				
Qatar	✓	✓		✓					
Romania*					*not available*				
Saudi Arabia	✓	✓		✓					
Serbia*					*not available*				
Slovakia*					*not available*				
Slovenia*	✓		✓	✓					
Spain*		✓	✓	✓		✓	✓	✓	
Sweden					*not available*				
Switzerland*			✓	✓					
Turkey*	✓	✓	✓	✓	✓			✓	
Ukraine*					*not available*				
United Arab Emirates	✓	✓		✓			✓		
United Kingdom	✓								
Uzbekistan	✓				✓	✓			

Resilient Value in Practice

From Thought Leadership to a Working Solution

The four articles in this review make the case for Resilient Value. Alliant's global practice is built to take the next step: turn that insight into a solution clients can implement and measure.

The **Alliant Mega Pool** is one example. Private equity portfolios often buy benefits company by company and country by country, with no portfolio view of cost, risk, or insurer performance. We applied the Resilient Value framework to that problem and designed a portfolio-level pooling structure that works on both sides of the equation.

How the Mega Pool delivers Resilient Value

Resilient Value Lever	How the Mega Pool Delivers	What the Portfolio Gains
COST **Buying power**	Combines insured premium across portfolio companies and countries	**Stronger pricing and renewal leverage**
COST **Shared upside**	Links local policies to a portfolio pooling account through reinsurance	**Potential annual pooling payment; designed to absorb adverse experience within the pool**
EMPLOYEE **Coverage and service**	Opens access to leading insurer capacity	**Smaller companies can gain stronger coverage and service than they could obtain alone**
EMPLOYEE **Continuity**	Keeps local plans, administration, and regulatory requirements in place	**Employees keep the local plans they know**
GOVERNANCE **Portfolio control room**	One view above all local programs	**Visibility into premium, renewals, and emerging risk, plus a repeatable M&A framework**

How Alliant Built It

Diagnose: Map premium, insurers, renewal dates, and claims data across the portfolio.

Design: Start with life, accident, and disability benefits, then add medical plans selectively.

Deliver: Coordinate local brokers and insurers through Alliant's existing global model, with no new administration function for the sponsor.

Govern: Set rules for eligibility, acquisitions, exits, and local decisions, and report at the portfolio level.



The Mega Pool Opportunity



Dennis Tokarsky

VP, Consultant, Global Benefits, Alliant

Dennis Tokarsky is a Vice President in Alliant's Global Benefits practice with more than 20 years of experience in multinational employee benefits consulting. He specializes in global benefits strategy, multinational pooling and captive solutions, benchmarking, and global program governance. Dennis works with multinational employers to optimize benefits programs, improve financial performance, and coordinate benefits strategies across international markets.



Michael Snyder

Consultant, Global Benefits, Alliant

Mike has over seven years of experience in global employee benefits. Along with helping clients manage and align their global benefits programs through strategic guidance, Mike also specializes in multinational pooling and global risk financing solutions.

Turning Fragmented Benefits Spend into Portfolio Value

This article is for private equity firms, portfolio company executives, finance and HR leaders, and advisors responsible for managing employee benefits across a global portfolio. It explains how global pooling, including a potential portfolio-wide structure sometimes referred to as a "mega pool," can bring portfolio-level thinking to global employee benefits and improve scale, insurer access, risk management, employee value, and governance.

Employee benefits are rarely at the center of a private equity firm's value-creation plan. They are usually delegated to portfolio company management, with decisions made locally and revisited at renewal. That approach is understandable. Benefits are local, regulated, and operationally complex. It can also hide a material portfolio opportunity.

Across multiple companies and countries, employee benefits represent a recurring pool of insured premium. Viewed separately, each company may have limited negotiating power. Viewed together, the portfolio may have enough scale to improve insurer access, strengthen financial results, and create a more consistent management framework.

A business case for one private equity firm with a substantial international portfolio showed potential annual financial participation of roughly USD 1 million under a risk-focused structure and approximately USD 1.5 million under a broader risk-led structure.

The precise result will vary by portfolio. The strategic point is more important: a cost managed locally may also create value at the portfolio level.

A different financial view of benefits

Global pooling provides a mechanism.

In a conventional local arrangement, each insurer evaluates the business it covers in a particular country. The insurer collects premiums, pays claims, and retains the financial result under the terms of the policy.

Pooling adds another financial layer. Eligible insurance programs are evaluated together. The local plans remain in place, but they are linked to the global pool through reinsurance. This creates a financial connection between the local policies and the portfolio-level pooling account without replacing local coverage or administration.

Local plans stay intact. The portfolio shares in favorable

If the combined results are favorable, the portfolio receives an annual pooling payment (dividends). If experience is unfavorable, the sponsor is not expected to receive a direct bill for the deficit. The reinsurance and loss-protection structures are designed to absorb adverse experience within the pool rather than pass it directly back to the private equity firm.

The sponsor can therefore participate in favorable results without taking on the full downside risk of direct underwriting. The exact protections and accounting treatment depend on how the arrangement is structured, but the intended economic model is participation in the underwriting profit without direct responsibility for the loss. Without pooling, this underwriting profit would stay with local insurers.

In a private equity setting, this can become a portfolio specific to global arrangements: a mega pool. The participating companies are connected through common ownership or sponsorship. They do not become one employer, and they do not need to adopt identical benefits.

Local plans, local administration, employee experience, and local regulatory requirements can remain intact.

The portfolio control room

The strategic value of a mega pool extends beyond the potential financial payment. It creates a control room above the local programs.

The private equity sponsor and its global benefits advisor can see where premium is concentrated, which renewals are approaching, where risk is emerging, and where smaller portfolio companies may lack leverage with local insurers. The portfolio gains a clearer view of cost, risk, insurer performance, and opportunity. That view can support several forms of value.

A larger combined opportunity may improve pricing discussions and renewal leverage. It may also help a smaller portfolio company access stronger insurer capacity than it could obtain independently. A company with limited local competition, or one that chooses a less-established provider mainly because of price, may be able to approach leading insurer capacity through the broader portfolio relationship.

The potential benefit is not limited to price. It may include stronger coverage, better service, more consistent claims handling, and greater confidence in the insurer relationship. Local underwriting, regulation, plan design, and insurer appetite will still matter, but the company is no longer negotiating only from the strength of its own premium.

The one portfolio view shows risks no single company can see.

The portfolio view can also improve risk management. It may identify concentrations of disability risk, recurring claims issues, inconsistent service, or opportunities for prevention and wellbeing investment. These patterns are difficult to see when every company and country is reviewed separately.

The same structure can support M&A. Newly acquired companies often arrive with different brokers, insurers, plan designs, renewal dates, and data standards. A repeatable portfolio framework can make due diligence, onboarding, and renewal planning more consistent without removing local decision-making.

A practical operating model

A mega pool does not require the private equity sponsor to build a new benefits administration function.

The coordination can be provided through an existing broker-agnostic global benefits management model. A global benefits consultant can identify eligible programs, organize the required data, coordinate local brokers and insurers, manage renewal timing, and oversee portfolio-level reporting.

This gives the sponsor access to a broader financial and governance opportunity without adding another operational burden to the investment team or requiring portfolio companies to manage a new global process independently. In many situations, the work can be incorporated into an existing global benefits coordination mandate rather than requiring a separate implementation or administration fee.

The model still requires clear governance. The sponsor and its advisor must establish which companies and benefits are eligible, what information is required, how acquisitions and exits are handled, and which decisions remain local.

But the sponsor does not need to operate every plan or direct every country-level transaction.

Where should the opportunity begin?

The private equity sponsor does not need to include every portfolio company into a pool. Participation can be selective, based on financial and strategic fit, eligibility, data readiness, local plan structure, and implementation timing. The objective is not to select only the best-performing risks. A well-designed pool should also benefit from diversification. The goal is to begin with the companies and benefits that create the strongest practical business case, then expand the structure as additional plans become suitable.

The largest possible pool is not necessarily the best first pool. A risk-led approach may be more practical. Life, accident, and disability benefits are often insured across multiple countries and may provide a clearer starting point for demonstrating the value of aggregation.

Existing local placements that fit the structure can provide a lower-disruption entry point. Additional risk benefits can be reviewed as they reach renewal.

Start with risk benefits.

Add medical selectively.

Medical benefits should be considered selectively. They can add scale, but they also bring higher claims frequency, greater local variation, and potentially more volatility. Each plan should be assessed based on claims experience, plan design, insurer terms, local requirements, and its expected contribution to the overall arrangement.

The objective is not to include every company or every benefit immediately. It is to build a structure that is financially meaningful, operationally manageable, and aligned with the portfolio's investment model.

The strategic takeaway

Private equity firms already use portfolio-level thinking to manage procurement, technology, operations, and risk. Employee benefits are often still treated as a collection of local operating expenses.

A mega pool offers a way to bring them into the portfolio's field of view. It can create greater buying power, improve access to insurer capacity, support employee value, strengthen risk visibility, and generate potential participation in favorable financial results, all while preserving local plans and relying on an existing global coordination model.

The opportunity is not to turn employee benefits into a revenue line. It is to maximize the return on the portfolio's existing benefits spend. That means more than a potential pooling payment. It means stronger purchasing power, better insurer access, improved risk visibility, protected downside, and greater employee value. The value is not in making benefits global. It is in making their portfolio value visible.

About Medical Trend

The following information provided in this survey is meant to support organizations in understanding the expected "baseline" increase to medical premiums. Our analysis covers 88 countries.

What is Medical Trend?

Medical trend is the predicted change in health plans' per capita claims costs. Factors that influence medical trend include:

- Price inflation
- Leveraging effect of fixed deductibles and copays
- Cost shifting from the uninsured to private payers
- Increased utilization
- Use of more expensive drugs and treatments or technological advancements
- Government-mandated benefits

Medical Trend Process

To forecast the change in per capita costs for medical services in each surveyed country, Alliant asked our Asinta broker partners to connect with key insurers in the market to determine what trend figure will be applied by their underwriting teams. This is referred to as the "insurer-rated trend". Our broker partners also reviewed their book of business and shared the anticipated increase in medical premiums in 2027. This is referred to as the "broker-rated trend".

The intent of this approach is to provide full transparency to employers with two data-points that would impact their renewal rate. We also aim to provide employers with a line of sight into what the baseline factor is for rate negotiations with carriers. This factor will be applied along with a client's claims utilization/experience to generate the medical premium. There are instances where the broker trend is higher and more appropriate for analysis.

Medical Trend by Country

2027 Medical Trend by Country

Americas

Country	Insurer-Rated Trend	Broker-Rated Trend
Brazil	13.8%	13.8%
Canada	11.5%	12.3%
Chile	5.0%	5.0%
Colombia	8.7%	8.7%
Costa Rica	15.0%	18.4%
Dominican Republic	19.0%	19.0%
Mexico	14.5%	14.0%
Panama	6.5%	6.5%
United States	9.0%	8.4%

APAC

Country	Insurer-Rated Trend	Broker-Rated Trend
Australia	5.5%	6.0%
China	7.0%	9.0%
Hong Kong	6.5%	10.5%
India	14.0%	15.0%
Indonesia	17.5%	16.5%

Country	Insurer-Rated Trend	Broker-Rated Trend
Japan	2.0%	2.0%
New Zealand	15.0%	15.0%
Philippines	18.0%	18.0%
Singapore	13.0%	14.0%
South Korea	22.5%	22.5%
Taiwan	12.0%	13.0%
Thailand	10.0%	15.0%

EMEA

Country	Insurer-Rated Trend	Broker-Rated Trend
Albania	10.0%	12.0%
Armenia	15.0%	13.0%
Austria	6.0%	8.0%
Azerbaijan	10.0%	12.0%
Bahrain	10.5%	12.5%
Belgium	8.0%	8.0%
Benin	11.0%	11.4%
Bosnia & Herzegovina	7.0%	5.0%
Bulgaria	10.0%	13.0%
Burkina Faso	12.5%	13.0%
Burundi	20.5%	21.5%
Cameroon	12.0%	12.5%
Central African Republic	14.5%	15.0%
Chad	12.5%	13.0%
Congo	11.5%	12.0%
Croatia	9.0%	10.0%
Cyprus	8.5%	8.5%
Czech Republic	5.0%	6.0%
Denmark	3.0%	3.0%
Egypt	24.5%	25.5%

Country	Insurer-Rated Trend	Broker-Rated Trend
Equatorial Guinea	10.5%	11.0%
Estonia	9.0%	10.0%
Finland	8.0%	8.0%
France	7.0%	8.0%
Gabon	9.5%	10.0%
Georgia	10.0%	10.0%
Germany	3.0%	7.0%
Greece	8.0%	8.0%
Guinea	9.5%	10.0%
Hungary	12.0%	9.0%
Ireland	14.0%	14.0%
Italy	3.0%	5.0%
Ivory Coast	15.0%	15.5%
Jordan	16.0%	18.5%
Kazakhstan	15.0%	15.0%
Kosovo	9.0%	9.0%
Kuwait	10.5%	12.5%
Latvia	9.0%	10.0%
Lithuania	5.0%	7.5%
Macedonia	9.0%	10.0%
Madagascar	10.5%	11.0%
Mali	16.5%	17.5%
Mauritania	9.5%	10.0%
Moldova	10.0%	10.0%
Montenegro	8.0%	10.0%
Netherlands	8.0%	8.0%
Niger	17.5%	18.5%
Norway	7.0%	10.0%
Poland	12.0%	13.0%
Portugal	9.0%	7.3%
Qatar	10.5%	12.5%
Romania	15.0%	13.0%

Country	Insurer-Rated Trend	Broker-Rated Trend
Saudi Arabia	10.5%	12.0%
Senegal	8.0%	8.5%
Serbia	9.0%	11.0%
Slovakia	8.0%	9.0%
Slovenia	8.0%	6.0%
South Africa	12.5%	13.0%
Spain	9.0%	10.5%
Sweden	4.5%	4.0%
Switzerland	3.5%	3.7%
Togo	10.5%	11.0%
Turkey	48.0%	50.0%
Ukraine	18.0%	15.0%
United Arab Emirates	11.5%	16.0%
United Kingdom	16.0%	18.0%
Uzbekistan	10.0%	10.0%

Meet the Alliant Team



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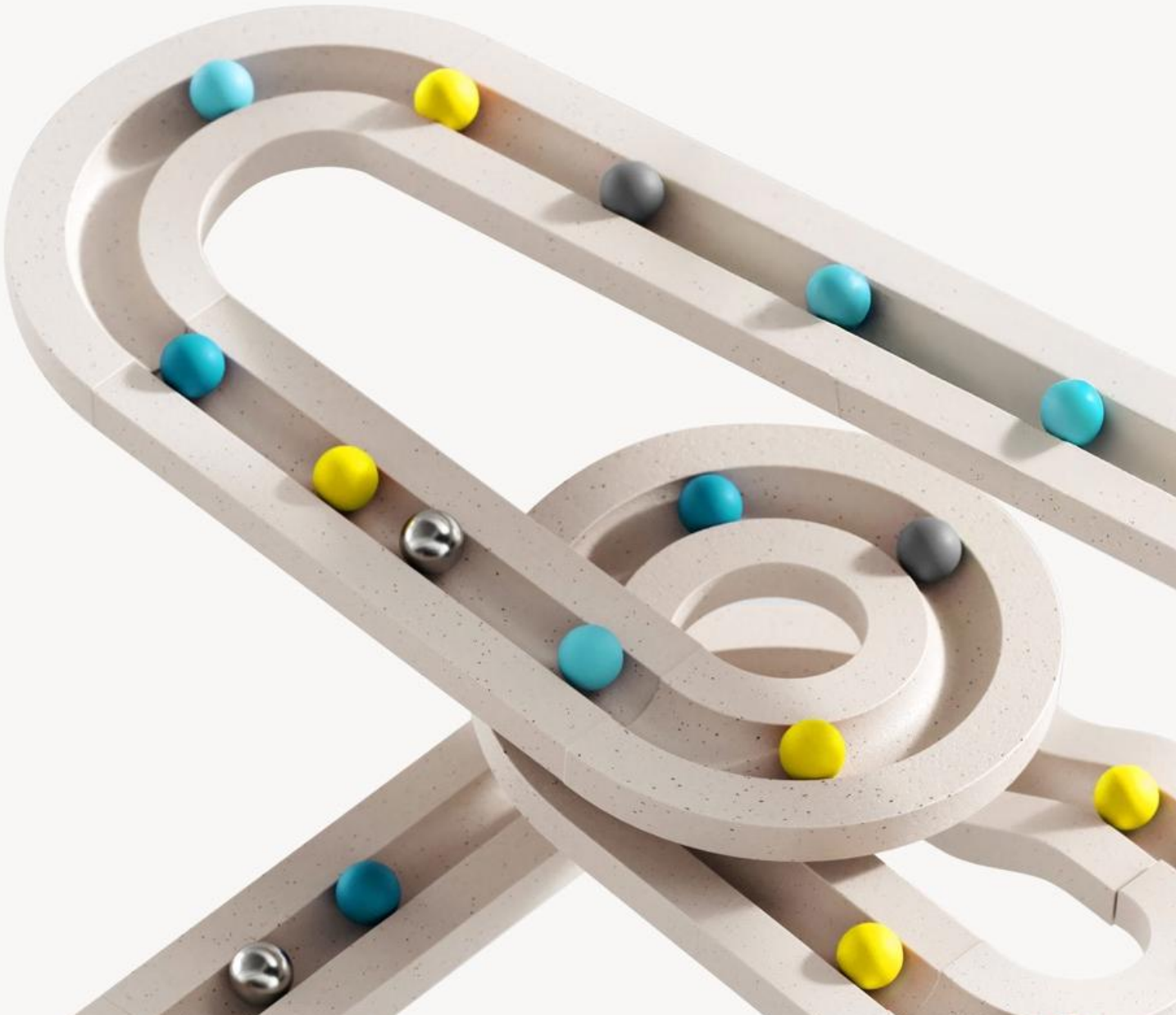
About Asinta

Alliant is a proud partner of the Asinta Network.

Asinta's network includes partner firms whose like-mindedness creates a natural, supportive, and responsive system that gets both the everyday and the spectacular accomplished.

The Asinta network, including its affiliates, operates in over 100 countries, with a proven track record of servicing Alliant clients. The brokers are rigorously vetted to ensure their local teams have English language proficiency and are a cultural match for U.S.-based multinationals.

Visit asinta.com for more.



Is Creative Agility important to you? It should be.

At Alliant, we celebrate the collective intelligence of our people. We are constantly learning and growing with the industry, enabling us to challenge the status quo on how we deliver our products, services, and experiences to our partners. We call this mindset creative agility. It means that we are not only striving to find solutions today, but we're already looking ahead to solve tomorrow's challenges.

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