Employee Benefits Report

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Benefits Planning

The 2026 Mental Health Access Crunch: Employers Turn to Direct-to-Provider Networks

A System Under Pressure

Mental health access has become one of the most pressing benefits challenges of 2026. Employees seeking therapy or psychiatric care are facing wait times of six to twelve weeks in many regions. Demand for outpatient mental health services has climbed sharply, driven by higher stress levels, increased medical inflation, and expanded use of medications that require behavioral support. Traditional networks simply haven't kept up.

For employers, the consequences are showing up in claims data and workforce performance. Delayed care often leads to worsening conditions, higher medical costs, and increased disability leaves. HR teams are fielding more complaints from employees who cannot find in-network providers or who face long delays for follow-up care. In many organizations, mental health access has become a top driver of employee dissatisfaction—second only to rising out-of-pocket costs.

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This Just In ...

Federal regulators issued new guidance in late August 2026 on the use of artificial intelligence in HR and benefits administration. The Department of Labor and EEOC emphasized transparency, bias prevention, and employee privacy.

The guidance requires employers to disclose when AI tools are used in onboarding, benefits navigation, claims support, or employee communications. Employers must also conduct annual bias testing and maintain audit trails for automated decisions. Any adverse determination—such as denial of a benefit or eligibility issue—must include human review. Regulators added that employers must ensure "meaningful human oversight" and verify that automated systems "operate consistently with federal nondiscrimination standards." The agencies also warned that employers must be able to "demonstrate the basis for any automated recommendation" when questioned by investigators.

Why Networks Are Struggling

Carrier networks were built for a different era. Many still rely on narrow panels, low reimbursement rates, and outdated contracting models. Providers often leave networks because they can earn more privately or through digital platforms. Telehealth expanded access, but demand outpaced supply.

The result is a mismatch between employee needs and network capacity. Employers are left with rising claims and frustrated workers.

Direct-to-Provider Contracting Emerges

To address the access gap, more employers are contracting directly with mental health provider groups. These arrangements bypass traditional networks and guarantee appointment availability within a set timeframe. Some employers secure therapy appointments within five days and psychiatric care within ten.

Direct-to-provider networks typically blend virtual and in-person care, offer care coordination, and provide predictable pricing. Employers appreciate the stability. Employees appreciate the speed. For organizations with high mental-health utilization, these partnerships are becoming a cornerstone of workforce well-being strategies.

The ROI Case

Early adopters report meaningful improvements. One mid-sized manufacturer saw a double-digit reduction in mental-health-related disability claims within six months of launching a direct-provider partnership. Another employer reported fewer emergency room visits tied to unmanaged anxiety and depression.

Timely care prevents escalation. And when employees feel supported, retention improves. Employers also report fewer manager escalations and improved employee engagement scores—an often overlooked but important benefit.

What Employers Should Do Now

Benefits managers planning 2027 renewals should begin by auditing current access times and reviewing carrier reports. Understanding how long employees wait for care is the first step in determining whether a new strategy is needed.

Key steps include:

- **Assessing telehealth utilization** to determine whether virtual care is filling gaps or simply adding another layer of complexity.
- **Mapping regional access differences,** especially for multi-state employers with uneven provider availability.
- **Evaluating direct-provider models** for high-need populations or locations with persistent access complaints.

Direct contracting is not the only solution, but it is becoming a practical one—especially for employers with high mental-health utilization or persistent access complaints. Clear communication is essential. Employees need to know where to go, how to schedule, and what the benefit covers.

Mental health access is now a core workforce issue. Employers who address it proactively will be better positioned for 2027, when demand is expected to rise again.

This shift reflects growing concern that AI tools, while helpful, may unintentionally create compliance risks. Many employers adopted AI quickly during 2024–2026 without fully evaluating how these tools make decisions or how data is stored. The guidance also reminds employers that responsibility for outcomes cannot be delegated to vendors, even when systems are fully automated.

Benefits managers should review all AI-enabled tools before open enrollment. Vendors may need to update documentation, revise algorithms, or add human-review steps. Regulators have made it clear: AI oversight will be a major enforcement priority heading into 2027.

Pharmacy Carve-Outs Gain Ground as Employers Seek More Control Over Drug Costs

A Shift Toward Transparency

Pharmacy costs continue to rise in 2026, driven by specialty medications, GLP-1 utilization, and new gene-therapy treatments. Many employers are discovering that their medical carriers' pharmacy programs offer limited transparency and few levers for cost control. As a result, pharmacy carve-outs—where employers contract directly with a PBM—are gaining traction.

Carve-outs give employers more visibility into pricing, rebates, and utilization patterns. They also allow for customized formularies and tighter specialty-drug management. For employers facing unpredictable pharmacy trend, the appeal is clear: more control, more data, and more flexibility.

Why Employers Are Making the Move

Specialty drugs now account for more than half of total pharmacy costs for many employers. Traditional carrier contracts often bundle medical and pharmacy pricing, making it difficult to isolate the true cost drivers. Carve-outs separate the two, allowing employers to negotiate directly with PBMs and evaluate performance more precisely.

Employers that have made the switch report clearer reporting, better rebate structures, and more flexible plan design. Some also note improved alignment between pharmacy strategy and broader health-plan goals, especially when managing chronic conditions or high-cost claimants.

The Tradeoffs

Carve-outs are not a universal solution. They require stronger vendor management and can introduce administrative complexity. Some employers worry about member disruption, especially if formularies change or prior authorization rules tighten. Others are cautious about the learning curve involved in managing a standalone PBM relationship.

Still, carve-outs are becoming a central part of 2027 planning. Brokers play a key role in helping clients evaluate options, compare pricing models, and assess operational impacts. For employers with rising specialty-drug spend, carve-outs may offer the clearest path to regaining control.

Preparing for 2027

Benefits managers considering a carve-out should begin with a review of current pharmacy trend, specialty-drug utilization, and rebate performance. Understanding the baseline makes it easier to evaluate whether a carve-out will deliver meaningful savings. It also helps identify where current programs are falling short—whether in pricing, formulary management, or member experience.

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Key steps include:

- **Analyzing specialty-drug claims** to identify high-cost categories and recurring utilization patterns.
- **Reviewing rebate guarantees and pass-through arrangements** to determine whether current contracts are delivering full value.
- **Assessing member experience** to understand how access, prior authorization, and communication affect satisfaction and outcomes.

For many employers, pharmacy carve-outs are becoming a practical way to regain control over one of the fastest-growing components of healthcare spend. As 2027 planning accelerates, carve-outs offer a strategic opportunity to improve transparency, stabilize budgets, and build a more sustainable long-term pharmacy strategy.

Paid Leave 2.0: States Expand Mandates, Employers Race to Standardize Policies

A Growing Compliance Puzzle

Paid leave laws are expanding again in 2026. Several states have broadened eligibility, increased wage-replacement rates, and added new covered reasons for leave. Multi-state employers are struggling to keep policies consistent while staying compliant with a patchwork of rules. What used to be a once-a-year policy update has become a continuous cycle of monitoring, adjusting, and retraining.

The challenge is administrative as much as legal. Payroll systems, HRIS platforms, and benefits administration tools must all be updated to reflect new requirements. Managers need training. Employees need clear communication. And HR teams must coordinate leave with disability, PTO, and health benefits. For many employers, paid leave has become one of the most resource-intensive compliance areas—second only to health-plan regulation.

Why Employers Are Standardizing

To reduce complexity, many employers are adopting national paid-leave policies that exceed state minimums. This approach simplifies administration and reduces compliance risk. It also improves employee satisfaction, especially in competitive labor markets where paid leave is a key differentiator.

Standardization helps employers avoid confusion when employees move between states or work remotely. It also reduces the need for constant policy updates as new laws take effect. Employers that have adopted national policies report fewer employee questions, smoother payroll processing, and more predictable staffing coverage.

What's Changing in 2026

The most significant changes involve expanded eligibility for part-time workers, broader definitions of family, and new reporting requirements. States are also tightening documentation rules and increasing enforcement activity.

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Key updates include:

- **Expanded covered reasons,** including caregiving for non-traditional family members and mental-health-related leave.
- **Higher wage-replacement rates,** especially in states aligning with new cost-of-living benchmarks.

These changes affect staffing, scheduling, and benefits coordination—especially for employers with large hourly or hybrid workforces.

Preparing for 2027

Benefits managers should conduct a state-by-state review, update handbooks, coordinate with payroll vendors, and communicate changes clearly. The most successful employers are treating paid leave as a strategic benefit rather than a compliance burden.

Recommended steps include:

- **Mapping leave interactions** between PTO, disability, and state programs to prevent overpayments or gaps.
- **Auditing HRIS workflows** to ensure eligibility, accruals, and wage-replacement calculations are accurate across jurisdictions.

Paid leave is no longer a fringe benefit—it's a core part of workforce planning. Employers that invest in clear policies, strong systems, and proactive communication will be better positioned for 2027, when additional states are expected to introduce or expand paid-leave programs.

Digital Physical Therapy: A Practical Tool for Reducing MSK Claims

Musculoskeletal (MSK) conditions remain one of the top drivers of medical claims. Back pain, joint issues, and repetitive-motion injuries affect employees across industries. Traditional physical therapy works, but access varies widely and costs can escalate quickly.

Digital physical therapy platforms are changing the equation. These programs combine app-based exercises, remote coaching, and motion-tracking technology to deliver therapy at home. Employees can begin treatment quickly, often within days of reporting discomfort. Faster access means problems are addressed earlier, before they turn into more serious—and more expensive—conditions.

Employers are paying attention because digital PT offers faster access and lower costs. Completion rates tend to be higher than traditional PT, and employees appreciate the flexibility. One national employer reported a significant reduction in MSK claims after integrating digital PT as a first-line option. Others say digital PT has reduced unnecessary imaging and helped employees stay at work while managing pain more effectively.

How Employers Are Using Digital PT

Digital PT fits easily into plan design. Employers are incorporating it in several ways:

- **As a pre-authorization step before** in-person therapy to ensure early intervention.
- **As part of condition-management programs** for chronic back or joint pain.
- **As a voluntary benefit** for remote or hybrid workers who struggle to access traditional PT.

It also supports return-to-work programs by helping employees recover more quickly from injuries. Some employers report fewer workers' compensation claims tied to MSK issues after adding digital PT as an early-intervention tool.

For benefits managers, the key is reviewing MSK claims data. If MSK is a top cost driver, digital PT may be one of the simplest and most cost-effective solutions available for 2027 planning.