

Is Your Health Plan Built for the Moments That Matter?

What Makes a Good Experience for Members.



I. Introduction

Most employers believe they offer employees a positive health plan experience. After all, there's an app. There are wellness programs. Maybe even a gym in the building or a step challenge every January. On the surface, the experience looks comprehensive. But research shows employees value more than digital tools when it matters most.

A 2025 consumer experience report found that **60% of healthcare consumers prefer human representatives,¹ even as AI and digital tools play growing roles.** In other words, technology may support the experience, but it doesn't define it—especially when situations become complex, emotional or financially risky. Those are the moments that truly test a health plan experience:

when an employee hesitates to schedule a doctor's appointment because of fear of the bill, when a confusing explanation of benefits arrives weeks after care, when a spouse gets diagnosed with cancer and the member doesn't know who to call, or when a health issue suddenly becomes urgent, overwhelming or unaffordable.

Yet too often, when employees encounter such situations, they are left to navigate them alone—via phone trees, chatbots and disconnected intermediaries—with no clear ownership or resolution.

For many, the safest option feels like avoidance. And that behavior is widespread, even among insureds. In fact, a national survey commissioned by Imagine360 found that 38% of insured American adults delay or skip necessary medical care because of cost,² which underscores the fact that uncertainty and financial fear shape healthcare decision-making.

That gap—between what employers believe they are offering and what members can actually rely on when a health situation emerges—is the core experience challenge that human resources (HR) leaders face today. As healthcare costs rise and more of the financial burden shifts to employees, experience is no longer about engagement features or program breadth. It's about whether people feel confident in using their health plans when it matters.

That confidence depends on support that is both human and holistic. Employees want advocates who can help them navigate care decisions, gain provider

access and make smooth transitions throughout their health journeys. Employees also want protection from financial harm—in the form of support that steps in when bills don't make sense, coverage breaks down or cost transparency disappears. Health and financial well-being are not separate experiences for employees; they are deeply interconnected.

Consumer expectations are rising faster than insurer service delivery

While **51%** of consumers now want their health plan to act as a “partner in care,” this expectation gap persists because most payer investments remain financially oriented.

- [Medical cost trend: Behind the numbers 2026 - PwC](#)

How satisfied are members with their current, traditional health plan carriers?

Member satisfaction and trust

44%

of U.S. health plan members say they are dissatisfied with their commercial health coverage.³

Trust, clarity and communication are key differentiators for high-performing plans, whereas underutilized digital tools and confusion around coverage correlate with lower member satisfaction.⁴

Confusion and problems

58%

say they've had problems in using their health insurance in the past year, with 4 in 10 reporting they skipped or delayed care due to cost concerns.⁵

About half of insured adults find at least one key aspect of how their insurance works difficult to understand, which reinforces the gap between having coverage and being able to use it confidently.⁶

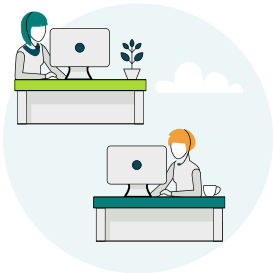
This is where many well-intentioned health plan experience strategies fall short. Digital tools and wellness programs can be useful, but they don't ease fears of unpredictable medical costs or support the trade-offs people make when care feels unaffordable. When health or affordability is on the line, employees overwhelmingly want a person to help them—someone who understands their situation, knows the system and actively advocates on their behalf.

The health plan experience should center around the moments that matter most to employees. By examining these moments when employees navigate care and cost, we explore a more meaningful definition of experience: one grounded in affordability, advocacy, transparency and the difference that alternative health plans can make when flexibility and human-centered design are built into the model.

Human-centered support for a more personal experience

ACCESS TO CARE

Concierge member support and personalized navigation from a team who knows how to guide members to the right care



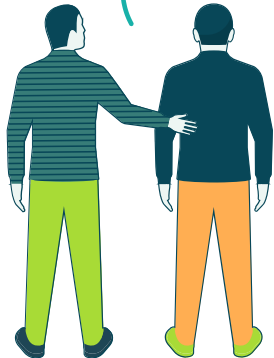
MEDICAL MANAGEMENT

Seamless care coordination and support for managing chronic conditions from licensed professionals.



MEMBER + SUCCESS ASSOCIATE

The Client & Member Success Associate serves as the member's partner in care, remaining by their side every step of the way



FINANCIAL SUPPORT

Helping members pay a fair amount for their care, from identifying potential issues in advance to ongoing out-of-pocket protection



“Experience begins before care—and affordability is the prerequisite. When people unexpectedly get a large bill that either isn't covered by insurance or is larger than they anticipated, they feel like the whole principle of insurance has been violated.”

— ANDREW CASE
Senior Director, Upland Advocacy

II. The moment of hesitation

When employees delay care because it feels financially risky

The first breakdown in the traditional health plan experience doesn't happen after a claim gets denied or a bill arrives. It happens much earlier: when a member pauses before seeking care at all. This is the moment of hesitation.

An employee notices a symptom, receives a referral or considers scheduling a doctor's appointment, but then stops—not because they don't value their health but because the plan feels risky to use.

The questions that surface in those moments are not clinical; they're financial: *Can I afford this? Will this be covered? What happens if the bill is bigger than expected? Whom do I call to find out?*

For many employees, the hesitation is shaped by prior experiences with traditional health plans' high deductibles, confusing coverage and unexpected bills that arrive long after care has been delivered. Through the course of time, the health plan becomes something to manage cautiously rather than to rely on confidently. When cost exposure feels unpredictable, avoiding care can feel like the safest option.

What makes such moments especially troubling is that the issues usually go unnoticed by employers. HR leaders don't typically see the effects of hesitation directly. They see the hesitation's downstream impacts in the forms of employees' delaying procedures, struggling with health issues, taking short-term disability and withdrawing money from retirement accounts to cover medical expenses. By the time the realities surface, the damage to health, trust and engagement has already been done.

This is why affordability isn't a nice-to-have feature of the health plan experience. It's the prerequisite. Experience begins with confidence—and confidence starts with knowing that receiving care won't lead to debt or financial strain.

63 million Americans are caregivers for others with medical conditions, and about half report negative financial effects, including paused savings, debt or depletion of emergency funds, which illustrates how care burdens can erode financial security.⁷

When employees feel supported, not exposed

In a better experience, this moment of hesitation looks dramatically different. Employees understand their options. If they don't, they know where to turn for help before costs escalate. They feel supported, not exposed. The decision to seek care is driven by health needs—not fear of what might come next.

EMPLOYEE HESITATION MANIFESTS AS:



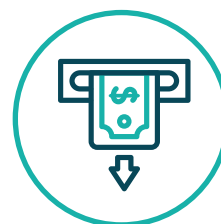
DELAYED CARE



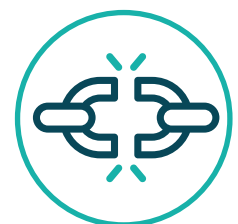
ABSENCES



SHORT-TERM
DISABILITY



401(K)
WITHDRAWALS



DISENGAGEMENT

III. The moment of panic

When an employee needs help but can't get it

Panic typically starts as frustration. It starts with an explanation of benefits that doesn't explain very much. A bill that's higher than expected. A denial that references plan language the employee doesn't remember having seen before. In that moment, the employee isn't thinking about wellness incentives.

They're thinking: *What do I do now?* And just as urgently: *Who can actually help me?*

What happens next is painfully predictable—and familiar. The employee opens the health plan app, hoping for clarity. Instead, what's there is only partial information, generic definitions or a chatbot offering scripted responses that don't match the situation. The phone number on the back of the ID card leads to a phone tree, then a long hold, then an agent who can explain what the plan says but not help change the outcome.

This is when frustration turns into panic as plan members try to understand whether the care is affordable, whether a bill is accurate or whether delaying treatment is the only option. But the structure of most traditional health plans is not designed for moments like this. It's designed to administer benefits and a mostly self-serve model

that consigns the burden of navigating care onto the member.

Members are expected to interpret coverage rules, manage billing errors and weigh financial trade-offs, often while dealing with illness, recovery or caregiving. The emotional toll is real: Fear of debt,

embarrassment about asking for help and helplessness when no one takes ownership of the problem.

True experience is not about how efficiently an employee can use an app when things go smoothly. It's about what happens when the employee needs help in navigating the complexities of the healthcare system. But what should happen in this moment looks very different.

The employee should have access to a single,

human point of contact—someone trained to take ownership of the issue from start to finish. Someone who can review a bill, explain what's happening in plain language, coordinate with providers and who stays involved until there's a resolution. Someone who understands not just coverage mechanics, but the real financial and emotional stakes involved. Someone trained to be empathetic.

Although health plan members increasingly rely on mobile apps and websites to manage their health plan benefits, research finds that the quality of those digital channels lags behind expectations for ease of navigation and clarity—especially around coverage details—which reinforces the reason that personalized support is still essential for resolving issues.⁸

“When someone accesses a call center, they're usually already frustrated or scared. The call center's job isn't just to answer a question; it's also to slow the moment down, understand what the caller is dealing with and stay with the caller until the issue is actually resolved.”

– BRIAN ATKINSON

Chief Operating Officer, Imagine360

When employees get help from real people who care

In best-in-class alternative health plan models like the one offered by Imagine360, that kind of support comes from advocates trained in healthcare navigation, billing and care transitions, and they often have backgrounds in social work, nursing or patient advocacy. Advocate teams are equipped to recognize when an issue is administrative, when it's clinical and when it's financial—and to then respond accordingly. They escalate when needed. They follow up. They advocate until resolution.

Support like this is especially critical during transitions of care such as after a hospitalization, during a new diagnosis or when multiple providers are involved. Nurses and clinical advocates play key roles by helping employees understand next steps, coordinate care and avoid downstream issues that often lead to more confusion and more cost.

When employees can't resolve issues during moments of panic, the fallout shows up everywhere in missed care, financial stress, disengagement and, eventually, attrition. When employees are surrounded by trained advocates who step in at the right moment, the experience shifts from being a feeling of abandonment to one of support.

Traditional health plan carriers' call center experience versus alternative health plans' call center experience

Experience area	Traditional health plan benchmarks 2023-26	Advocate led and alternative health plan based on Imagine360 model and data
Average speed to answer (ASA)⁹	<ul style="list-style-type: none"> • Average industry hold time is roughly 4.4 minutes for members • Longer waits during peak periods (open enrollment, January resets) • Provider lines frequently deprioritized 	<ul style="list-style-type: none"> • Average speed to answer is 27 seconds for members and providers • Call lines opened before go live and open enrollment • Fast response treated as core experience metric
Call handle time¹⁰	<ul style="list-style-type: none"> • Agents manage and are held accountable to strict handle-time targets • Pressure to move calls quickly • Complex issues often requiring callbacks 	<ul style="list-style-type: none"> • No time limits on calls • Advocates stay on the line as long as needed • Focus is on outcome, not call duration
First-call resolution (FCR)¹⁰	<ul style="list-style-type: none"> • Industry estimates 50-60% for healthcare first-contact resolution • Multiple transfers common for billing, denials, navigation 	<ul style="list-style-type: none"> • 78% first-call resolution • Designed for end to end ownership • Advocates coordinate internally rather than having the member contact various specialists
Staffing model	<ul style="list-style-type: none"> • Generalist customer service reps • Script driven, policy focused training • Limited authority to intervene • Commonly utilizes offshore resources 	<ul style="list-style-type: none"> • One number to call for real human support • Onshore advocates hired and trained for empathy and problem solving • Many with backgrounds in social work, healthcare navigation or clinical settings • Trained to intervene, not just explain • Warm hand-offs to external support as required
Billing and financial issues	<ul style="list-style-type: none"> • Agents provide explanations of benefits but rarely intervene on the member's behalf • Member is responsible for follow up with providers 	<ul style="list-style-type: none"> • Line by line bill review • Direct outreach to providers and billing offices • Help in accessing financial assistance, charity care or employer resources
Continuity of care support	<ul style="list-style-type: none"> • Limited clinical involvement unless high cost trigger is met • Nurses used selectively for managing cost risk 	<ul style="list-style-type: none"> • Registered nurses and nurses engaged proactively • Strong support during transitions of care such as during cancer treatment and hospitalizations • Clinical guidance integrated with advocacy

IV. The moment of financial fear

When an employee is dealing with a bill that won't go away

For many employees, the most emotionally draining part of the healthcare experience doesn't happen at the doctor's office. It happens when a bill arrives that doesn't make sense—and doesn't go away.

The bill may reference services the employee doesn't recognize, amounts that don't align with what the employee was told or adjustments that feel arbitrary and unexplained. Often, the bill arrives after care is already complete, leaving the perception of no opportunity to change decisions or control costs. What follows is anxiety: *Is this right? Do I owe this? What happens if I don't pay?*

This moment carries a unique kind of fear. Medical bills feel risky in a way few other expenses do. Medical bills threaten credit scores, savings and financial stability. Employees feel powerless, and they worry about collections, long-term debt and the possibility that one health issue could spiral into lasting financial harm.

Employees distracted by unresolved medical bills report higher stress, reduced focus and emotional exhaustion. Some disengage quietly. Others avoid future care altogether not because they're healthy but because they can't afford another unknown outcome. Through time, trust erodes—not just trust in the health plan but also trust in the employer.

This is where financial well-being becomes inseparable from employee experience. A health plan that leaves people to deal with confusing bills, opaque processes and unclear responsibility causes added stress. And that stress shows up in lost productivity, less engagement and an employer's inability to retain talent.

Medical bills are leading sources of financial anxiety¹³

41% of adults with healthcare debt report it has negatively affected their mental health by producing stress and anxiety.

More than half say medical debt has made it harder to pay for basic living expenses, which compounds stress levels through the course of care.

Lifting the emotional toll

The good news? This experience can look fundamentally different. The best health plan models, often seen within newer alternative health plans, are creating a better experience with a focus on human-led support. For starters, employees are not expected to decipher medical billing on their own. They have access to trained advocates who review bills line by line, explain what's valid and intervene when something isn't. Advocates coordinate directly with providers and billing offices, negotiate when appropriate and stay involved until an issue is *resolved*—not just *explained*.

When medical costs cause broader financial strain, advocates also help connect employees to additional resources, such as employer-sponsored programs, hospital financial assistance programs and short-term relief options, which serves to ensure that support extends beyond the bill itself.

Critically, advocacy support is proactive and human. Employees don't have to know the right terminologies or escalate repeatedly to get help. Modern alternative plans offer a single point of contact, continuity across interactions and a clear sense that someone is on their side. Financial advocacy doesn't just reduce costs; it restores confidence.

When employees know that confusing bills will be handled—fairly and transparently—the emotional load lifts. Fear gives way to trust. Healthcare becomes something employees can engage with rather than brace themselves against. And the employee's experience with the health plan—and by default with the employer—shifts from a source of stress to a source of support.

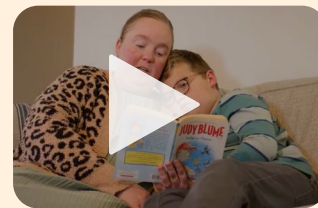
VIII. Conclusion:

Experience is how employees feel in the moments that matter

The employee moments explored—hesitation, panic and financial fear—share an underlying cause. They reflect how most traditional health plans are structured to administer benefits but less equipped to support people when complexity and risk increase. In those moments, employees are usually left to manage uncertainty, cost exposure and emotional stress on their own.

Some alternative health plans, especially those that recognize affordability as a pre-requisite to a good experience, work differently for members. Their value is not limited to cost containment but extends to greater flexibility in the ways support gets delivered around the employee. Without rigid service constraints, that means plan members get the advocacy and support they want—from a real human who cares. This is what allows the health plan experience to be shaped by real employee needs rather than by predefined service boundaries that many traditional health plan carriers establish.

[See the chart on page 6]



Listen to a member describe their experience

"This is what insurance is supposed to be. I had a team of people that backed me, backed my family, cared and supported my family, and we prospered and excelled because of it."

"Medical management with any of the traditional health plan carriers is a box-checking exercise. Members going through health crises lack visibility into whether they're choosing the right provider for their condition.

The way it should work? The second there is a diagnosis, a case manager should become engaged. Our Member Experience team is always available to call, but the case manager provides continuity by being at the member's side throughout the entire care journey.

It's a personalized model that surrounds the member with compassion and empathy."

— DAN MYERS

Vice President of Client Experience, Imagine360

Support is also applied more holistically. Financial advocacy may include bill review, provider coordination and assistance with income-based or employer-sponsored programs. Clinical advocates support employees during transitions of care when confusion and risk are often at their highest levels. Together the elements shape a more consistent experience—one that emphasizes clarity, follow-through and reliability.

Ultimately, a health plan's experience is defined by how it performs in moments of employee stress. Plans that can apply the right support at the right time reduce members' financial uncertainties, reinforce trust and free employees to focus on their health and their jobs. For employers, that experience strengthens the overall value of the benefit and the relationship with employees.

Now that is what *really* matters. Ask yourself, is your health plan built for the moments that matter?

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About Imagine360

Imagine360 is a leading healthcare solutions provider that helps self-funded employers take control of their healthcare costs while delivering better experiences for members. With more than 18 years of expertise in reference based pricing (RBP) and health plan administration, Imagine360 develops fully integrated solutions that combine deep industry knowledge, data-driven strategies and concierge-level support for employers.

The company partners with employers, brokers and consultants to design and manage customized health plans that lower costs, increase transparency and improve outcomes – without compromising quality or access.

Backed by dedicated advocacy, legal protection and proven results, Imagine360 is reimagining what smarter healthcare can look like for organizations and their employees.

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