SEVEN EMPLOYEE BENEFITS ISSUES EMPLOYERS CANNOT IGNORE IN 2026

A practical briefing for employers trying to control costs, reduce risk and build a health plan employees can actually use.

The benefits market is moving faster than most annual renewal processes. Medical inflation, expensive therapies, new fiduciary lawsuits and a growing compliance workload are forcing employers to look beyond premium increases. The real question is whether the plan is being actively managed - with reliable data, accountable vendors and a documented decision-making process.

$18,500+
Projected average cost per employee in 2026 [1]

9%
Median trend before plan changes [2]

11-12%
Forecast pharmacy cost increase [2]

Inside this issue

Seven priorities that deserve attention before the next renewal.

The common thread: better process, better data and better accountability.

Selected data sources: Mercer and Business Group on Health. Full source list appears on page 3.

TOPIC 1

1 Health Care Cost and Employee Affordability [1][2]

Health benefit costs are expected to rise faster than wages and general inflation again in 2026. Mercer projects average employer plan cost above $18,500 per employee, while Business Group on Health reports a median 9% trend before plan changes.

Employers should separate unit-cost inflation from utilization, identify the conditions driving claims and measure affordability for lower-paid employees. A renewal summary alone will not show whether the plan is purchasing care efficiently.

What employers should do: Request a 24-month medical and pharmacy cost-driver analysis, including high-cost claims, utilization, unit-cost changes, employee out-of-pocket exposure and vendor fees.

TOPIC 2

2 Pharmacy, GLP-1s and Specialty Drugs [2][3]

Pharmacy represented nearly 24% of total health spending among employers surveyed by Business Group on Health, with an 11% to 12% increase forecast heading into 2026.

GLP-1 medications, specialty drugs, biosimilars, infusion therapies and cell-and-gene treatments require category-specific strategies. Employers need to understand net cost after rebates, clinical criteria, site of care, formulary decisions and the incentives built into the PBM contract.

What employers should do: Review the PBM contract, rebate definitions, spread pricing, audit rights and specialty channels. Adopt a written GLP-1 policy covering eligibility, continuation criteria and measurement.

TOPIC 3

3 ERISA Fiduciary Governance and Litigation [4]

Health-plan fiduciary litigation is moving from theory to active risk. Recent lawsuits allege that employers failed to prudently monitor PBM pricing, fees and contract terms. Court outcomes have been mixed, but at least one major 2026 case moved beyond the dismissal stage.

The practical lesson is that plan sponsors should be able to show how decisions were made, what information was reviewed, how compensation was evaluated and how vendors were monitored.

What employers should do: Assign responsible fiduciaries, hold documented meetings, benchmark fees and pricing, review conflicts, evaluate alternatives and retain the supporting analysis.

TOPIC 4

4 Catastrophic Claims, Stop-Loss and Funding Risk

Cancer, neonatal care, complex chronic conditions, specialty medications and emerging gene therapies can reshape an entire renewal. For self-funded and level-funded employers, the stop-loss contract is as important as the rate.

Contract basis, lasers, exclusions, aggregating specific deductibles, run-in and run-out provisions, terminal liability, disclosure rules and policy mirroring can materially change the protection an employer believes it purchased.

What employers should do: Start early, model claim scenarios and compare contract language - not just premium. Document lasers, exclusions and limitations before accepting renewal terms.

Employers should be able to explain where plan dollars go, why vendors were selected and how performance is monitored.

TOPIC 5

5 High-Value Care and Vendor Accountability [2]

Employers are questioning whether every health and well-being vendor produces measurable value. Business Group on Health found 41% of surveyed employers were changing PBMs or running an RFP, and 51% were doing the same for other vendors.

High-value strategies can include advanced primary care, centers of excellence, site-of-care management and navigation. More programs are not a strategy; employers need clear objectives, useful reporting and accountability.

What employers should do: Inventory every vendor, identify overlap, define success metrics and require performance guarantees. Remove programs that cannot demonstrate value.

TOPIC 6

6 Mental Health Access and Parity [5]

Federal agencies announced they will not enforce the new portions of the 2024 MHPAEA final rule while litigation and regulatory reconsideration continue. That pause does not eliminate existing parity requirements or the CAA comparative-analysis obligations.

Employers should still evaluate network access, prior authorization, reimbursement, provider availability and nonquantitative treatment limitations.

What employers should do: Confirm an updated NQTL comparative analysis exists, test real-world access and require carriers or administrators to document how parity obligations are being met.

TOPIC 7

7 Compliance, Transparency and Data Ownership [6][7][8]

Compliance is a year-round operational responsibility. Employers should track RxDC reporting, Gag Clause attestations, PCORI fees, ACA reporting, notices, Section 125 testing and plan-document obligations. For 2026, the PCORI filing deadline is July 31 for applicable 2025 plan years, and the annual Gag Clause attestation is due by December 31. Data access also matters: a plan sponsor cannot effectively oversee a plan it cannot analyze.

What employers should do: Maintain one compliance calendar and evidence folder. Confirm responsibilities in writing and preserve filing confirmations, calculations, testing, contracts and source data.

A Practical 90-Day Action Plan

1. Obtain 24 months of medical, pharmacy and stop-loss data.
2. Review contracts, compensation, rebates, guarantees and audit rights.
3. Refresh the fiduciary committee and document decisions.
4. Model 2027 cost and funding scenarios before renewal.
5. Confirm 2026 filings and proof of completion.

ABOUT CORRY HULL

Corry is Vice President of Employee Benefits Consulting at BHC Insurance, a Health Rebate Certified Advisor, Certified Self-Funding Specialist and Registered Employee Benefits Consultant.

HealthReformGuy shares practical insight for employers building more transparent, affordable and high-performing health plans.

SOURCES [1] Mercer [2] Business Group on Health [3] Mercer GLP-1 [4] Jones Day [5] U.S. DOL [6-7] CMS [8] IRS