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VIRTUS MARKET INTELLIGENCE

Employee Benefits Market Update

A market perspective for Virtus clients and partners. Updated November 1, 2026.

2027 COST FIGURES / FROM SEPARATE STUDIES

8.2%

Expected 2027 health cost growth per employee, after changes [1]

9%

Projected 2027 group medical cost trend [3]

12%

Estimated 2026 drug cost increase [2]

1 in 2

Employees who say they often avoid care over cost [4]

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Research available through November 1, 2026. National forecasts are planning context; individual renewal results will vary.

01 / MARKET OVERVIEW

Health Costs Are Rising Faster in 2027

Health benefits will take a bigger share of the budget in 2027. Our advice is to understand the renewal before accepting it, give pharmacy its own review and weigh savings against what employees can afford.

What We Are Seeing at Virtus

Published forecasts do not tell the whole renewal story. We are seeing carriers use trend assumptions as high as 12-15% on fully insured contracts. Even plans with favorable claims experience are facing conservative pricing. Ask how much of your renewal reflects your plan's results and how much comes from the carrier's assumptions.

A small share of claimants continues to account for much of employers' spending, and million-dollar claims are no longer unusual in the plans we review. Ongoing specialty drug costs are a growing part of that picture. These are observations from our client work, separate from the national studies below.

What the Forecasts Tell Us

Business Group on Health's large-employer survey projects a median 9.2% increase in 2027 before plan changes and 8% after. Marsh's preliminary national survey (formerly Mercer) projects 8.2% per-employee cost growth after planned reductions and 11% without them, the largest increase since 2003, up from 6.7% in 2026. Many employees will see payroll deductions rise faster than the average. These studies cover different populations; they are not a range of renewal quotes. [1, 2]

PwC projects 9% group medical cost trend for 2027, driven by provider payment pressure, pharmacy and greater use and intensity of care. Trend measures changes in care costs, including prices and use. An employer's premium also depends on geography, claims, enrollment and funding. [3]

Pharmacy accounts for 25% of spending among employers in the Business Group on Health survey, with drug costs estimated to rise 12% in 2026. Half of respondents in MetLife's 2026 research said they often avoid medical care because of out-of-pocket costs. [2, 4]

Three Priorities for Your Next Benefits Meeting

Understand the renewal. Ask for the claims and pricing assumptions, then compare the total employer budget. A higher specific or aggregate stop-loss deductible changes retained claims risk. Reprice expected claims, stop-loss premiums and fees together; a lower stop-loss premium alone does not establish budget savings.

Review pharmacy separately. Understand how the PBM gets paid, including fees, drug markups and retained rebates. Ask whether that compensation is reasonable, and compare a disclosed admin-fee arrangement on total net cost. Review specialty drugs, GLP-1 coverage, clinical rules and access, too.

Check affordability and access. Compare deductions, deductibles and employer account funding together. Build the budget around your employees and claims, including what the business could owe in a bad year.

MARKET AT A GLANCE

Each Benefit at a Glance

> National forecasts show the direction. Your renewal depends on your contracts, claims and enrollment.

Benefit	Outlook	Planning reference	What to review
Medical	Rising	8.2% projected 2027 cost growth after changes [1]	Employer survey average; not a premium quote.
Pharmacy	Rising	12% estimated 2026 drug cost growth [2]	PBM fees, markups and rebates; net cost, specialty drugs and GLP-1s.
Stop-loss	Rising	12.7% average premium increase, latest survey [13]	Deductible level, lasers, gene therapy terms and renewal caps.
Dental	Plan specific	Confirm any rate guarantee	Network access, annual maximums and waiting periods.
Vision	Plan specific	Confirm any rate guarantee	Provider access, allowances and employee out-of-pocket cost.
Life / disability	Plan specific	Seek multi-year rate guarantees	Covered earnings, benefit caps and eligibility.
Behavioral health	Access matters	Evaluate actual availability	Appointment access, referrals and vendor overlap.
Voluntary benefits	Affordability sensitive	Evaluate total payroll cost	Participation, exclusions and fit with the core plan.

The medical, pharmacy and stop-loss figures come from different studies, periods and populations and should not be added together.

Comparing Funding Arrangements

We are seeing more willingness among smaller employers to consider self-funding. Interest is a reason to compare options carefully: fully insured, level-funded and self-funded arrangements leave the business with different obligations.

Compare premiums or claims funding, administration, stop-loss and other fees on the same basis. Test maximum contractual exposure, payment timing, reserves and the ability to absorb a bad year. For level funding, check surplus ownership, refund conditions, claims paid after termination and other exit terms.

A Practical Comparison

Suppose a higher specific or aggregate stop-loss deductible lowers the premium. Reprice the employer's claims budget alongside that reduction and compare expected total cost, maximum exposure and cash needs. The result may be lower, unchanged or higher total cost. Separately, check any changes to employee deductibles or networks. This is an illustration, not a savings estimate.

02 / BENEFIT-BY-BENEFIT OUTLOOK

Outlook by Benefit

The most useful comparison is what each option costs, what it covers and how it works for your employees.

Medical

Rising / 8.2% projected 2027 cost growth after changes [1]

Published forecasts remain high, but your renewal will reflect your insurer or administrator, provider contracts, plan design and employees. Smaller groups should be especially careful about using large-employer surveys to predict their own pricing. [1, 3]

Ask for a clear explanation of the renewal. Compare credible alternatives, including which employees would have to change providers and what their total annual costs would be.

Our view: Give yourself time to compare options before renewal. Directing care to appropriate settings, using centers of excellence for planned procedures and helping employees find care can lower total costs without putting more of the bill on employees least able to afford it.

Pharmacy

Rising / 12% estimated 2026 drug cost growth [2]

Employers are taking another look at how they buy pharmacy benefits. Mercer (now Marsh) found that 41% of large employers were evaluating new contracting models from major PBMs and 37% were evaluating emerging PBMs. [5]

The Consolidated Appropriations Act, 2026 makes rebate pass-through the default for employer plans governed by ERISA, the federal benefits law, and adds PBM reporting duties. Provisions phase in over several years. In October, the Labor Department finalized a rule requiring PBMs to disclose fees and compensation to large self-insured plans, starting in July 2027. [14, 15]

Ongoing specialty drug costs increasingly drive large claims in our client work. Ask how the PBM and its affiliates get paid: admin fees, drug markups or spread (what the plan pays above pharmacy reimbursement), retained rebates and other payments. Assess whether total compensation is reasonable for the services provided. A disclosed admin-fee arrangement can make compensation easier to evaluate, but confirm whether it replaces other revenue and compare total net cost. Include covered drugs, specialty terms, data and audit rights, GLP-1 clinical support and continuity of care.

Our view: For a self-funded plan, the PBM contract is a fiduciary decision. Ask for full rebate and fee disclosure and audit rights now. Under any funding arrangement, make a deliberate decision about GLP-1 coverage criteria.

Ownership matters, too. The three largest PBMs share parent companies with major insurers: CVS Caremark with Aetna, Express Scripts with Cigna and Optum Rx with UnitedHealthcare. Ask which services use affiliated companies, how each is paid and whether independent alternatives are available. Compare total net cost and access to claims data before choosing a bundled arrangement. [11]

Stop-Loss and Large Claims

Rising / 12.7% average premium increase, latest survey [13]

Stop-loss pricing is rising faster than medical trend. Segal reports an average premium increase of 12.7%, up from 9.7% a year earlier. Sun Life's research identifies secondary conditions, prolonged hospital stays and injectable drugs as contributors to claims exceeding $3 million. [6, 13]

In the plans we review, a small number of claimants can determine the year's result. Million-dollar claims are no longer unusual, and some specialty drug expenses continue year after year. Budget for the ongoing costs as well as the one-time events.

Review both specific and aggregate protection, when reimbursements arrive and any higher deductible for an individual claimant, often called a laser. Make sure the proposed contract covers the benefits your plan offers and the periods when claims will be paid.

Our view: For self-funded employers, this is a decision to make before renewal, alongside the pharmacy review. Revisit the deductible at every renewal. As claims costs rise, an unchanged deductible sends more claims to the stop-loss carrier, which can push premium increases above medical trend. When testing higher specific or aggregate deductibles, reprice the employer's retained claims budget, premiums and fees together. Lower stop-loss premiums alone are not budget savings. Also compare a separate cell and gene therapy policy, no-new-laser terms and renewal rate caps.

Dental and Vision

Plan specific / Confirm any rate guarantee

A small premium difference does not tell you much about the value of these plans. Check whether employees can use their dentists and eye doctors, what allowances will buy and what the coverage terms mean in practice.

Review annual maximums, waiting periods and replacement frequencies. Confirm any rate guarantee before assuming next year's price will hold.

Our view: Start with the network gaps employees have reported. Weigh any premium savings against the disruption of changing providers and what employees would pay out of pocket.

Life and Disability

Plan specific / Seek multi-year rate guarantees

Higher medical costs can leave employees with less to spend on other benefits, a pressure LIMRA identifies in its market outlook. State paid leave is also expanding. Minnesota and Delaware began paying benefits in January 2026 and Maine in May 2026, while Maryland's program has been delayed. [7, 16]

Check which earnings are covered, monthly benefit caps, evidence-of-insurability requirements and the definition of disability. Make sure leave administration and state paid leave programs work with benefit eligibility and return-to-work practices.

Our view: Use renewal to address how the plan treats commissions and bonuses. An employee can misunderstand how much income the plan would replace if those earnings are excluded. Seek multi-year rate guarantees where available.

Behavioral Health and Employee Assistance

Access matters / Check how soon employees can get an appointment

Employees may seek care through the health plan, an employee assistance program (EAP) or another vendor. Look at how those services work together, including whether referrals lead to appointments.

Ask about wait times, support outside normal working hours and what happens after an EAP visit. Employees should know where to start and how to continue care.

Our view: Track the wait for a first appointment across these services. Having several vendors is only useful if employees can get help.

Voluntary and Supplemental Benefits

Affordability matters / Look at total payroll deductions

Voluntary products come out of the same paycheck as medical contributions. Before adding choices, consider employee interest, total deductions and the gaps the core plan already covers. [7]

Use simple examples to explain when a benefit pays, what it excludes and its limits. Check participation and whether employees understand the products already offered.

Our view: Add a product when it fills a clear gap, such as hospital indemnity alongside a high-deductible plan. Keep the full payroll deduction in view when deciding what employees can afford.

03 / WHAT WE'RE WATCHING

Issues to Watch for 2027

Some developments call for a decision now. Others are questions to keep in front of your carrier or administrator.

Decisions to Make Now

GLP-1 coverage. In a Business Group on Health survey, 67% of large employers covered GLP-1s for weight management in 2026; 72% of those expect to continue in 2027, and none plan to add it. Marsh attributes about one point of the 2027 cost increase to these drugs. Set coverage criteria and clinical support deliberately. [1, 17]

Specialty care and pharmacy contracts. Review expensive therapies under both medical and pharmacy benefits. For self-funded plans, examine ongoing drug costs alongside stop-loss coverage and PBM terms. [6]

Marketplace pressure. Enhanced Affordable Care Act (ACA) premium tax credits expired at the end of 2025, and insurers proposed a median 15% marketplace increase for 2027. Some employees and dependents may join the employer plan. Model higher enrollment, especially for lower-wage and variable-hour groups. [18]

Mental-health parity. September Labor Department guidance confirms that the underlying law still applies while the 2024 rule's new provisions are not enforced. Keep the comparative analysis of treatment limits current and ready to produce on request. [10]

Questions to Keep Asking

Hospital prices. PwC identifies pressure on provider payments and consolidation as 2027 cost drivers. Ask where spending is concentrated and whether care can move to appropriate, lower-cost settings. This deserves particular attention when employees are spread across expensive markets. [3]

Behavioral health use. PwC expects greater use to add to 2027 trend. Ask whether the network and EAP can handle more demand and how long employees wait for appointments. [3]

AI-assisted billing. The Blue Cross Blue Shield Association estimates that more complex hospital coding added $942 million in Blue plan spending from 2023 to 2025. PwC also lists AI coding tools among its 2027 cost drivers. Ask how coding is checked and how recoveries are reported after fees. [3, 12]

Out-of-network disputes. PwC identifies payment disputes as another 2027 cost driver. Ask how surprise-billing disputes are handled and what settlements add to plan costs. [3]

03 / WHAT WE'RE WATCHING

Compliance Calendar

> Recurring deadlines and recent changes to keep on the plan-year calendar. Your Virtus team can confirm who files each item for your plan and build a calendar around your plan year.

Item	Timing	Action
Gag clause attestation	Annually by December 31	Confirm your carrier or administrator attests for the plan, or file it yourself. [20]
Prescription drug data (RxDC) report	Annually by June 1	Confirm who submits the prior year's report for your plan. [21]
ACA reporting (Forms 1094-C and 1095-C)	Employee forms by early March; IRS filing by March 31	For employers with 50 or more full-time employees, including equivalents. Most must file electronically; you may post a notice that employee forms are available on request. [23]
Form 5500 and PCORI fee	By July 31 for calendar-year plans	Confirm whether a Form 5500 is required and who files it. Self-funded plans also pay the Patient-Centered Outcomes Research Institute (PCORI) fee. [24, 25]
Medicare Part D creditable coverage notice	Annually before October 15	Recheck creditable status, notify Medicare-eligible members and file with CMS, Medicare's agency, within 60 days of the plan year start. [22]
Mental-health parity comparative analysis	On request	Keep the analysis current and ready to produce. [10]
ACA affordability	10.22% for 2027 plan years	Test contributions against your chosen safe harbor. [8]
Health savings account (HSA) and high-deductible plan (HDHP) limits	Calendar year 2027	Update payroll, plan documents and employee materials. [9]
Dependent care flexible spending account (FSA)	$7,500 limit since 2026	If you adopt the higher limit, amend the cafeteria plan and watch the 55% nondiscrimination test, now harder to pass. [19, 26]
Telehealth with an HSA plan	Permanent, plan years from 2025	Consider covering telehealth before the deductible. [27]
Direct primary care with an HSA plan	From 2026	Fees up to $150 a month ($300 family) in 2026, indexed from 2027, no longer block HSA eligibility. [27]

Dates reflect federal requirements. State rules and your plan's own contracts can add others.

04 / INDUSTRY FOCUS

Real Estate

Benefits need to work at every property, through acquisitions and management changes as well as at renewal.

A medical network that works near headquarters may leave maintenance and property teams with fewer choices. Check providers near employees' homes before choosing a carrier or plan. An attractive quote is less useful if employees have to travel farther or leave established doctors.

With Virtus's assistance, employers are increasingly testing separate insurance plans for locations that drive costs, including those in particularly expensive parts of the country. For a dispersed workforce, compare location-specific options alongside a single plan. Check network access, employee costs and added administration before making a change.

As 2027 costs rise, compare payroll deductions and deductibles across office, maintenance and property teams. Check disability benefit amounts for each employee class, too.

Acquisitions and management changes are a good time to reconcile payroll, eligibility and enrollment. For teams in several states, coordinate new state paid leave programs with disability coverage. [16]

What to Do

Check the network first. Identify who would lose access to a provider before making a plan decision.

Compare the full employee cost. Look at deductions and deductibles together, by coverage tier and employee group.

Clean up records during transitions. Resolve inconsistent hire dates, classes and dependent records across properties and entities.

Reach every property. Give site teams access to enrollment help rather than relying on a headquarters meeting.

How Virtus Can Help

Our Benefits Strategy & Analytics team can work through claims, contributions and funding across your properties, then help you compare the options.

04 / INDUSTRY FOCUS

Hospitality

For hotels and restaurants, the benefits decision starts with what employees can afford and who is eligible for coverage.

Variable schedules make eligibility administration especially important. For variable-hour staff, the ACA look-back measurement method determines who must be offered coverage. Payroll needs to apply the measurement periods and the 130-hour monthly standard correctly.

Before raising cost sharing, look at the effect on lower-paid employees and family coverage. Compare contributions by coverage tier and pay level, including whether salary-banded contributions would help. Additional voluntary benefits should fill a clear need without making the package harder to afford.

Lower-wage employees who bought marketplace coverage may return to the employer plan as marketplace premiums rise. Include that possibility in enrollment planning. [18]

What to Do

Run contribution scenarios. Compare payroll deductions and expected care costs at different pay levels.

Connect scheduling and payroll. Make sure benefits administration uses consistent hours and eligibility records.

Make enrollment understandable. Use plain language, provide language support where needed and reach employees across properties and shifts.

Explain where to get care. Show employees how to find care around their schedules and what services will cost.

How Virtus Can Help

We can help set contributions and build an enrollment process that works across properties, pay levels and shifts.

04 / INDUSTRY FOCUS

Private Equity

Build benefits costs into the deal model and operating plan before counting on savings from a change in ownership.

A national trend assumption is a starting point. For each target or portfolio company, review current claims, renewals, funding obligations and benefit commitments. Separate recurring costs from unusual claims and timing differences.

Put covered employees, dependent enrollment, employer contributions and retained claims risk on the same basis before comparing companies. Purchasing scale may create options, but consolidation can also change networks, employee costs and administration. A single arrangement may not suit every location; compare alternatives for sites in high-cost markets before assuming consolidation will save money.

Check whether common ownership creates a controlled group for ACA and nondiscrimination purposes. Portfolio-wide options, including a group captive for stop-loss, still require a review of each company's claims and contracts.

What to Do

Establish the baseline. Reconcile enrollment and costs, and identify funding and benefit obligations.

Test the savings. Include fees, transition costs, changes in employee costs and who would have to change providers.

Review the exit terms. Confirm responsibility for claims paid after termination, claims reserves, stop-loss terms and who carries COBRA for the transaction.

Plan the integration. Leave time for administration and employee communication before making changes.

How Virtus Can Help

Our Benefits Strategy & Analytics team can review claims, funding and contributions company by company so the deal assumptions reflect the obligations you are taking on.

04 / INDUSTRY FOCUS

Retail Distribution

Benefits and enrollment support need to reach employees in stores, warehouses and on the road, as well as those at the home office.

For a workforce spread across several markets, compare location-specific insurance options where a site is driving costs. Check employee access and added administration before carving a location into a separate plan. Start by checking medical and dental providers where employees live. A network that looks strong around headquarters may offer fewer choices elsewhere. Enrollment support also needs to accommodate different shifts and locations.

For 2027, compare the full payroll deduction before adding benefits or changing medical contributions. Weigh employer premium savings alongside employee cost sharing and access to care. Part-time and lower-wage staff who bought marketplace coverage may return to the employer plan as marketplace premiums rise. [18]

What to Do

Map provider access. Check medical and dental networks across employee locations.

Review income protection. Confirm how variable pay is treated in covered earnings and where benefit caps apply.

Offer enrollment help across shifts. Give employees options beyond a single daytime meeting.

Check the records and results. Reconcile enrollment with payroll, then review participation, employee questions and access problems after enrollment.

How Virtus Can Help

We can compare plans and contributions with your locations in mind and help arrange enrollment support that reaches the whole workforce.

04 / INDUSTRY FOCUS

Construction

For mobile crews, check where employees can get care and how their income is protected when they cannot work.

Review medical providers near home communities and project locations. Then compare disability coverage with the work employees perform, including covered earnings, benefit caps, exclusions and waiting periods.

Seasonal changes, employee classes and collectively bargained arrangements can affect administration and whether a proposed plan fits the workforce. On prevailing-wage projects, qualifying benefits can count toward fringe obligations. Confirm how contributions are credited before comparing options.

What to Do

Read the disability terms. Check definitions, covered earnings, limits, waiting periods and exclusions.

Coordinate work and nonwork injuries. Short-term disability usually excludes work injuries. Align it with workers' compensation and return-to-work processes.

Reach the field. Explain care options away from headquarters and provide enrollment help directly to crews.

Check eligibility and funding. Validate employee classes and seasonal changes, and test funding alternatives against a bad claims year.

How Virtus Can Help

We can review funding and plan design against the needs of field and office employees, including where crews work and how employment changes during the year.

04 / INDUSTRY FOCUS

Business Owners and Executives

A group disability plan's stated replacement percentage may overstate how much of an owner's or executive's income it would actually replace.

Monthly maximums can leave highly compensated employees with a larger gap than expected. Check which earnings count, especially commissions and incentive compensation, before relying on the stated percentage.

Ownership also affects eligibility and tax treatment. Partners, sole proprietors and more-than-2% S corporation shareholders cannot participate in a cafeteria plan. Nondiscrimination rules can limit richer benefits for owners and executives. Review these questions with the company's tax and legal advisers.

What to Do

Calculate the income gap. Compare the group disability benefit with actual earnings and covered earnings. Consider individual disability coverage to address a shortfall.

Review group life. Check benefit amounts, evidence-of-insurability requirements and imputed income above $50,000.

Allow time for underwriting. Start evidence-of-insurability reviews early enough to resolve outstanding items.

Plan for transitions. Review continuation and conversion options around retirement or ownership changes. Confirm eligibility and tax effects with your advisers before changing benefits.

How Virtus Can Help

We can review the group program with you and coordinate benefits questions with your tax and legal advisers.

04 / INDUSTRY FOCUS

Food and Beverage

For plant and distribution teams, benefits need to work around each site's providers, production shifts and language needs.

Check access near plants, warehouses and field locations, including when employees can get care. Give employees practical instructions for finding a provider and understanding what they will pay.

Pharmacy and high-cost claims need attention before renewal. Employer drug costs rose an estimated 12% in 2026, faster than overall health costs. Use your own claims experience to assess clinical support and contract options while protecting employee health information. [2]

What to Do

Look for recurring claims patterns. Separate ongoing costs from one-time events before making funding or clinical decisions.

Compare pharmacy contracts fully. Include fees, rebates, specialty exposure and access to covered drugs.

Work around production shifts. Schedule enrollment help when employees can attend and provide language support where needed.

Connect administration. Coordinate disability and leave, and check that elections, payroll deductions and carrier records match.

How Virtus Can Help

Our Benefits Strategy & Analytics team can use your claims and pharmacy data to help you evaluate funding, contributions and clinical support for your workforce.

05 / PLANNING YOUR NEXT RENEWAL AND ENROLLMENT

Renewal and Enrollment Checklist

If your January renewal is finalized, focus on enrollment, payroll setup and confirming coverage in steps 5 and 6. For mid-year renewals, start now so there is time to compare options and explain the decisions to employees.

1 Gather Current Costs

Confirm enrollment, plan costs, contributions and available claims data. Ask the carrier to explain its trend assumptions and distinguish recurring large claims, including specialty drugs, from one-time costs. Separate medical, pharmacy, administration and stop-loss costs where the funding structure allows.

2 Set the Budget and Decide How Much Risk to Take

Compare the current plan with practical alternatives and a bad claims year. Where appropriate, include self-funding and separate insurance options for high-cost locations. Include the most the business could owe under each contract and when cash would be needed.

3 Compare Proposals on Equal Terms

Review networks, pharmacy terms, service, fees and contract protections. Make sure projected savings use comparable benefits and enrollment.

4 Check What Employees Will Pay

Look at payroll deductions, deductibles and employer account funding together. Complete affordability and plan-design checks before setting contributions.

5 Plan Open Enrollment

Set an owner and date for each task, including final decisions, plan materials, payroll setup, eligibility files and employee meetings. Leave enough time to complete them before coverage starts.

6 Check the Results

Reconcile elections, deductions and carrier records. Resolve evidence-of-insurability items, schedule a post-enrollment review and set regular claims and vendor meetings.

Questions About Your Program?

Bring your upcoming 2027 renewal to your Virtus team. We can help explain the main cost drivers, compare practical alternatives and show how each affects employees. For self-funded plans, include the PBM contract, disclosures and stop-loss terms in that discussion.

Push Forward. We've Got Your Back.

About Virtus

Virtus is a modern insurance brokerage and risk consulting firm helping clients across the U.S. navigate complex risk and people decisions. We combine industry expertise with technology and data to bring the issues into focus. Our advisors explain what matters, why it matters, and what we recommend, then help put those decisions into practice.

SOURCE NOTES

Sources

> Numbers in brackets refer to these sources. The recommendations in this update are Virtus's own.

[1] Marsh (formerly Mercer) preliminary national employer survey
September 2, 2026. More than 1,800 employer responses; average expected 2027 per-employee health benefit cost growth, before and after planned measures. Read the source (mercer.com)

[2] Business Group on Health 2027 survey
August 25, 2026. 127 employers covering 8.7 million US lives. Large-employer forecasts and pharmacy findings; not representative renewal quotes. Read the source (businessgrouphealth.org)

[3] PwC Behind the Numbers 2027
June 11, 2026. Health-plan research on underlying medical cost trend; distinct from employer premium changes. Read the source (pwc.com)

[4] MetLife 2026 employee benefits research
January 7, 2026. Initial findings from 2,541 full-time employees surveyed in October 2025; self-reported care avoidance. Read the source (metlife.com)

[5] Mercer 2026 health and benefit strategies
June 11, 2026. PBM findings refer to large employers with 500 or more employees. Evaluation does not establish adoption or savings. Read the source (mercer.com)

[6] Sun Life high-cost claims research
May 21, 2026. More than 70,000 high-dollar claims from over 3,300 self-funded employers; carrier-specific experience. Read the source (sunlifeus.mediaroom.com)

[7] LIMRA workplace benefits outlook
February 26, 2026. Employee affordability and market outlook. Market premium growth does not equal renewal pricing. Read the source (limra.com)

[8] IRS Revenue Procedure 2026-26
July 27, 2026 Internal Revenue Bulletin. Required-contribution percentage for plan years beginning in 2027. Read the source (irs.gov)

[9] IRS Revenue Procedure 2026-24
2027 HSA contribution and HDHP limits. Contribution limits include employer and employee contributions; eligibility and other rules apply. Read the source (irs.gov)

[10] DOL Field Assistance Bulletin 2026-03
September 8, 2026. Mental-health parity enforcement priorities and continuing statutory requirements. Read the source (beta.dol.gov)

[11] UnitedHealth Group 2025 results
January 27, 2026. Describes UnitedHealthcare and Optum's pharmacy and care-delivery businesses; cited for the Optum example. Ownership is context for purchasing questions, not evidence that a specific arrangement overcharges employers. Read the source (unitedhealthgroup.com)

[12] BCBSA analysis of hospital coding
September 24, 2026. Insurer-association analysis of coding complexity and spending. Raises concerns about AI-assisted documentation without isolating AI as the sole cause. Read the source (bcbs.com)

[13] Segal medical stop-loss premium survey
June 8, 2026. 225 health plans; average stop-loss premium increase of 12.7%, up from 9.7%. Segal client data, not a renewal quote. Read the source (segalco.com)

[14] Consolidated Appropriations Act, 2026: PBM provisions
Signed February 3, 2026. Law-firm summary of the PBM rebate, reporting and fiduciary provisions for ERISA plans; several provisions phase in over time. Read the source (dwt.com)

[15] DOL final PBM fee disclosure rule
October 29, 2026. PBMs must disclose drug maker rebates, spread compensation and pharmacy recoupments to large self-insured plans, with fiduciary audit rights; takes effect July 2027. Read the source (dol.gov)

[16] Epstein Becker Green 2026 state leave law updates
2026. Summary of state family and medical leave programs and their start dates. Read the source (ebglaw.com)

[17] Business Group on Health GLP-1 survey
2026. 105 large employers surveyed in February and March 2026 on GLP-1 coverage for weight management and their 2027 plans. Read the source (businessgrouphealth.org)

[18] KFF analysis of 2027 marketplace premiums
2026. Proposed 2027 ACA marketplace rates from insurer filings, after the enhanced premium tax credits expired. Read the source (kff.org)

[19] One Big Beautiful Bill Act: employee benefits provisions
Signed July 4, 2025. Law-firm summary of the HSA, telehealth, direct primary care and dependent care changes effective in 2026. Read the source (venable.com)

[20] CMS gag clause prohibition compliance attestation
Annual attestation for fully insured and self-funded group health plans, due December 31. Read the source (cms.gov)

[21] CMS Consolidated Appropriations Act, 2021 requirements
Plan and issuer requirements, including prescription drug data collection (RxDC) reporting. Read the source (cms.gov)

[22] CMS creditable coverage guidance
Employer requirements for the annual Part D creditable coverage notice and the disclosure to CMS. Read the source (cms.gov)

[23] IRS instructions for Forms 1094-C and 1095-C
Employer information reporting requirements and filing deadlines for applicable large employers. Read the source (irs.gov)

[24] DOL Reporting and Disclosure Guide for Employee Benefit Plans
Form 5500 filing requirements, exemptions and due dates for welfare plans. Read the source (dol.gov)

[25] IRS PCORI fee questions and answers
Fee owed by issuers and sponsors of self-insured health plans, reported on Form 720 by July 31. Read the source (irs.gov)

[26] Proskauer on dependent care nondiscrimination testing
Law-firm summary of proposed IRS rules for dependent care assistance testing, including the 55% average benefits test. Proposed, not final. Read the source (proskauer.com)

[27] IRS Notice 2026-5
December 2025 guidance on the HSA telehealth safe harbor, bronze and catastrophic plans and direct primary care arrangements. Read the source (irs.gov)

This update provides general information based on sources available through November 1, 2026. Published forecasts are not guarantees of renewal pricing, savings or coverage. Results depend on your workforce, claims, geography, plan design and contracts. Industry considerations are practical planning recommendations, not sector-specific rate forecasts. Coverage is subject to applicable plan and policy terms. It is not legal or tax advice; consult qualified advisers regarding legal and tax requirements.