# Employee Benefits Report

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Volume 24 · Number 03

MARCH 2026


Cost Control

## The 2026 Specialty Drug Surge: What Employers Need to Prepare For

### A New Cost Landscape Emerges

Specialty drugs have been a major cost driver for years, but 2026 marks a significant shift in both scale and urgency. With GLP-1 medications expanding into new indications, gene therapies entering the market at record pace, and oncology drugs continuing to rise in both cost and utilization, specialty medications are projected to account for more than 60% of total pharmacy spending this year. That's a dramatic change for employers, especially considering that specialty drugs represent fewer than 5% of total prescriptions.

This shift is not simply a continuation of past trends — it reflects a new era in which breakthrough therapies, precision medicine, and chronic-condition management are converging to reshape the pharmacy landscape. Employers are finding that strategies that worked even a few years ago are no longer sufficient to manage the financial and operational impact.

### What's Driving the Spike

The most visible driver is the continued surge in GLP-1 medications. Originally prescribed for diabetes, these drugs are now widely used for weight man-

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### This Just In ...

**New Guidance Issued on 2026 Pharmacy Benefit Transparency Rules**

Federal regulators have released new guidance clarifying the pharmacy benefit transparency requirements taking effect later this year. The rules aim to improve visibility into drug pricing and PBM practices by requiring group health plans to report detailed information on rebates, fees, and prescription-drug spending.

The guidance outlines what information must be included in annual reports, how data should be categorized, and what documentation employers must maintain. It also clarifies expectations for plans that use third-party administrators or PBMs to manage pharmacy benefits.

One notable update is the requirement for plans to disclose how manufacturer rebates affect employee cost-sharing. Regulators emphasized that

agement and are expected to receive additional approvals for cardiovascular and metabolic conditions. As demand grows, employers are weighing whether to cover these medications broadly, how to structure utilization controls, and how to balance short-term costs with potential long-term health improvements such as reduced obesity-related claims.

Gene therapies are also reshaping the cost curve. Many of these treatments exceed $1 million per patient, and more are entering the market each quarter. While they can offer life-changing outcomes, they also introduce significant financial volatility.

A single claim can dramatically affect a self-funded employer's annual spend, even with stop-loss protection in place.

Oncology drugs add another layer of complexity. Targeted therapies and immunotherapies continue to improve survival rates, but they often come with high price tags and require ongoing monitoring. Employers are increasingly turning to centers of excellence (COEs) to ensure consistent, high-quality care and reduce unnecessary variation in treatment costs.

## Rethinking PBM Relationships

Pharmacy benefit managers (PBMs) are under heightened scrutiny, and many employers are re-evaluating their contracts. Transparency has become a priority, with organizations seeking clearer insight into rebate structures, administrative fees, and the true net cost of medications. Some employers are considering pass-through PBMs, while others are exploring carve-out models that separate pharmacy benefits from the medical plan.

**Key areas employers are reviewing include:**

- Rebate and fee transparency
- Spread pricing practices
- Reporting and data-sharing capabilities

These reviews are prompting many employers to renegotiate terms, seek more frequent reporting, or explore alternative PBM models that offer greater visibility and alignment with plan goals.

## The Growing Role of Data and Predictive Tools

Predictive analytics is becoming a practical tool for employers of all sizes. These platforms help identify high-risk populations earlier, anticipate future claims, and support targeted care management. When combined with COEs and improved care coordination, analytics can help reduce avoidable high-cost events and improve outcomes for employees with chronic or complex conditions.

Employers are also using data to evaluate the long-term value of specialty medications. For example, some GLP-1 programs now integrate coaching, nutrition support, and biometric monitoring to improve adherence and maximize clinical benefit.

## Communication Matters More Than Ever

Employees often struggle to understand why certain medications require review or why coverage criteria change. Clear, empathetic communication can reduce frustration, improve adherence, and build trust in the benefits program. Employers are updating plan materials, offering decision-support tools, and working with vendors to simplify the member experience. Transparent communication also helps employees understand the value of programs such as COEs, care management, and step therapy.

employers must be able to demonstrate how rebates are applied and whether they reduce premiums or out-of-pocket costs.

**Employers are encouraged to:**

- Review PBM contracts
- Confirm data-sharing capabilities
- Prepare for potential audits

With reporting deadlines approaching, employers should ensure they have the systems and documentation needed to comply with the new rules.

## Looking Ahead

Specialty drug management will remain a defining challenge throughout 2026. Employers that take a proactive, data-driven approach — blending financial protection, clinical oversight, and thoughtful communication — will be best positioned to manage rising costs while supporting high-quality care for their workforce. As innovation accelerates, the employers who adapt early will be better equipped to navigate the next wave of specialty-drug evolution.

# The New Era of Mental Health Parity Enforcement in 2026

## Regulators Are Increasing Scrutiny

Federal agencies have made mental health parity enforcement a top priority in 2026, and employers sponsoring group health plans are feeling the impact. Regulators are no longer satisfied with high-level assurances that plans comply with the Mental Health Parity and Addiction Equity Act (MHPAEA). Instead, they expect detailed, data-driven documentation showing that mental health and substance-use-disorder benefits are truly comparable to medical and surgical benefits. This includes not only the written plan design but also how rules are applied in real-world scenarios.

The shift reflects a broader national focus on mental health access, driven by rising demand, persistent provider shortages, and growing concern about barriers to care. As a result, employers are encountering more audit activity, more data requests, and more pressure to demonstrate that their plans support equitable access.

## Where Regulators Are Focusing

Recent audits have centered on several recurring themes. Network adequacy remains one of the most challenging areas. Many plans still struggle to maintain sufficient numbers of in-network mental health providers, particularly in rural or underserved regions. When employees cannot access in-network care, they often turn to out-of-network providers — a situation that can trigger parity concerns if medical networks are more robust.

Prior authorization and utilization management practices are also under close review. Plans must show that their criteria for mental health services are no more restrictive than those applied to comparable medical services. Historically lower reimbursement rates for mental health providers are another area of scrutiny, as they can contribute to network shortages and reduced access.

Provider directory accuracy has also emerged as a key issue. Regulators are examining whether directories accurately reflect which mental health providers are accepting new patients, participating in the network, or offering timely appointments.

## The Rise of Comparative Analyses

One of the most significant changes in 2026 is the heightened requirement for detailed comparative analyses of non-quantitative treatment limitations (NQTLs). These analyses must be written, comprehensive, and supported by data. Regulators expect plans to demonstrate not only how NQTLs are designed but how they operate in practice.

**Employers should ensure they can document:**

- How NQTLs are designed
- How they are applied in practice
- Supporting data and metrics

For many employers, this level of documentation requires close coordination with carriers, TPAs, and legal advisors. Some organizations are conducting proactive internal audits to identify potential gaps before regulators do.

## Supporting Employees Through Better Communication

While compliance is essential, employee experience remains a critical part of the equation. Many employees struggle to understand their mental health

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benefits, especially when faced with prior authorization requirements or limited provider availability. Clear, accessible communication can help employees navigate their options and seek care earlier.

Employers are updating plan materials, hosting informational sessions, and promoting employee assistance programs (EAPs). Some are also offering mental health literacy tools to help employees better understand symptoms, treatment options, and available resources.

### Action Steps for Employers

As enforcement intensifies, employers should take a structured approach to compliance. This includes reviewing plan designs, confirming carrier or TPA support, and ensuring they have the documentation needed to demonstrate parity. Strengthening mental health networks, improving provider directory accuracy, and enhancing employee communication will also be essential.

**Key priorities for 2026 include:**

- Conducting or updating NQTL comparative analyses
- Reviewing network adequacy and reimbursement practices
- Enhancing communication around mental health resources

The goal is not only to avoid penalties but to support employee well-being in a meaningful and sustainable way. With thoughtful planning and strong vendor partnerships, employers can navigate the new enforcement landscape while improving access to vital mental health services.

# The Return of Onsite and Near-Site Clinics in 2026

### A Shift Back Toward Local Care

After several years of virtual-first care, onsite and near-site clinics are making a strong comeback in 2026. Employers are rediscovering the value of providing convenient, high-quality care directly to employees — and in many cases, their families. While telehealth remains an important part of the care ecosystem, many organizations are recognizing that virtual care alone cannot fully address rising healthcare costs, chronic-disease management challenges, or the need for more coordinated, relationship-based care.

This renewed interest is driven by several converging trends: higher claims costs, increased chronic-condition prevalence, and persistent access challenges in many regions. As primary-care shortages continue to grow, employers are turning to onsite and near-site clinics as a way to ensure timely access to care and reduce reliance on emergency rooms and high-cost specialists.

### Why Employers Are Reinvesting

Onsite clinics offer a broad range of services, from primary and urgent care to chronic-disease management, occupational health, and preventive screenings. Near-site clinics — shared facilities serving multiple employers — provide similar services with greater scalability and lower operating costs. Both models are proving effective at reducing unnecessary ER visits, improving medication adherence, and supporting early intervention for chronic conditions.

**Employers cite three primary advantages:**

- Improved access and reduced absenteeism
- Better chronic-disease management
- Lower overall claims costs

These benefits are particularly meaningful for employers with large populations managing diabetes, hypertension, obesity, or musculoskeletal conditions — all of which are major contributors to long-term healthcare spending.

### Integrated Care Models Gain Traction

A growing number of employers are using clinics to support integrated care models that combine primary care, behavioral health, and wellness programs under one roof. Mental health services, nutrition counseling, and physical therapy are increasingly common additions. This integrated approach helps employees receive coordinated support across multiple dimensions of health, reducing fragmentation and improving outcomes.

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Clinics also allow employers to implement population-health strategies more effectively. For example, onsite care teams can proactively reach out to employees who are overdue for screenings, struggling with medication adherence, or managing multiple chronic conditions. This level of engagement is difficult to achieve through traditional network-based care alone.

## Technology Enhances the Experience

Modern clinics often blend in-person care with virtual visits, remote monitoring, and digital health tools. This hybrid model allows employees to receive continuous support, particularly for chronic conditions such as diabetes, hypertension, and obesity. Remote monitoring devices, app-based coaching, and integrated care platforms help clinicians track progress and intervene earlier when issues arise.

Technology also improves the employee experience by simplifying scheduling, reducing wait times, and enabling more personalized care plans. Many clinics now offer mobile check-ins, digital follow-ups, and integrated wellness programs that make care more accessible and engaging.

## A Strategic Investment for the Future

Employees consistently report high satisfaction with onsite and near-site clinics, citing convenience, shorter wait times, and more personalized care. For employers competing for talent, these clinics can be a meaningful differentiator, signaling a strong commitment to employee well-being and long-term health.

**For many organizations, clinics are becoming a cornerstone of benefits strategy because they:**

- Strengthen recruitment and retention
- Improve care continuity
- Support long-term cost control

As healthcare costs continue to rise and access challenges persist, onsite and near-site clinics offer employers a practical, high-impact way to improve outcomes while managing expenses. In 2026, they are no longer viewed as a niche benefit — but as a strategic investment in workforce health and organizational performance.

# Voluntary Benefits in 2026: Expanding Choice Without Raising Costs

Voluntary benefits continue to gain momentum in 2026 as employers look for ways to expand support without increasing core medical plan costs. Employees are seeking more personalized options, and voluntary benefits offer a flexible way to meet diverse needs.


Popular offerings such as pet insurance, identity-theft protection, legal services, and supplemental health plans remain in high demand. These benefits allow employees to tailor their coverage based on their life stage and financial situation.

A notable trend this year is the rise of lifestyle-focused benefits. Programs supporting student-loan repayment, financial wellness, and caregiver responsibilities are becoming more common. Employers are also exploring benefits that support everyday needs, such as transportation assistance and discount programs.

**Technology is improving the voluntary benefits experience by:**

- Simplifying enrollment
- Offering side-by-side comparisons
- Providing personalized recommendations

For employers, voluntary benefits offer a cost-effective way to enhance the overall benefits package. They can improve retention, support recruitment, and demonstrate a commitment to employee well-being — all without increasing premiums or plan expenses.