



Employee Benefits Report



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Benefits Planning

2027 Health Plan Renewals: What Employers Need to Prepare for Now

A More Challenging Renewal Season Ahead

Health plan renewal season is arriving earlier and with more pressure than usual. Carriers are releasing preliminary 2027 trend assumptions, and the message is consistent across the market: medical costs are rising faster than expected, and underwriting is tightening. Employers who be-

gin preparing now will be in a stronger position to negotiate, model alternatives, and avoid last-minute decisions that frustrate employees and strain budgets.

The biggest driver of 2027 trend is specialty pharmacy. GLP-1 medications for diabetes and weight management continue to expand in both volume and duration of use. New gene therapies are entering the market with price tags in the millions. Carriers are also seeing higher outpatient surgery utilization, more complex chronic-condition claims, and persistent mental-health demand. All of this is pushing trend assumptions into the 7–9% range for fully insured plans and similar pressure for self-funded employers.



This Just In ...

IRS Releases Early Signals on 2027 FSA, HSA, and HRA Limits

The IRS is beginning to release early indicators for 2027 inflation-adjusted benefit limits, and benefits managers should prepare now. While final numbers will arrive later this fall, preliminary guidance suggests meaningful increases across FSAs, HSAs, and certain HRA structures.

The biggest expected change is in HSA contribution limits. With medical inflation running higher than anticipated, 2027 HSA limits may rise more sharply than in recent years. Employers offering high-deductible health plans should prepare to update payroll systems, plan documents, and employee communications once final numbers are published.

Flexible Spending Accounts are also likely to see higher contribution caps. This will be welcome news for employees facing rising out-of-pocket costs, but employers will need to adjust open-enrollment materials and ensure payroll systems can accommodate the new limits.

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Underwriting Tightens Across the Market

Underwriting is shifting in ways employers will feel. Carriers are scrutinizing claims experience more closely, especially for mid-market employers. Groups with rising specialty pharmacy claims, unmanaged chronic conditions, or high emergency-room utilization may see steeper increases or more restrictive plan options. Even employers with stable claims histories may face increases simply because the trend is higher than last year.

Carriers are also adjusting how they evaluate risk. Some are placing more weight on chronic-condition prevalence, while others are focusing on avoidable ER visits or gaps in preventive care. Employers who understand these drivers early will be better positioned to respond.

Using Data to Get Ahead of Renewals

The good news is that employers have more tools than ever to manage renewals proactively. The most effective strategies begin with early data review. Employers should work with brokers to analyze year-to-date claims, identify cost drivers, and model how different plan designs will affect both spending and employee experience.

Three early-season steps can make a meaningful difference:

- Review claims trends for chronic conditions, pharmacy utilization, and ER visits.
- Evaluate vendor performance, especially PBMs, care-navigation platforms, and virtual-care providers.
- Model alternative plan designs to understand the impact of deductibles, networks, and care-management programs.

This is also the time to evaluate whether current vendors are performing as expected. Pharmacy benefit managers, care-navigation platforms, and virtual-care providers all play a growing role in cost control.

Plan Design Options That Can Reduce Pressure

Plan design adjustments can help soften renewal increases. Employers are revisiting tiered networks, centers-of-excellence programs, and virtual-first primary care. Some are exploring high-performance networks that steer employees toward providers with better outcomes and lower costs. Others are adding chronic-condition management programs or digital MSK solutions to reduce long-term claims.

Virtual-first care continues to expand, especially for primary care and behavioral health. Employers who integrate virtual care with in-person options often see improved access and lower overall utilization.

Communication Matters More Than Ever

Employees are sensitive to changes in deductibles, copays, and networks. Employers should explain why adjustments are being made and how they support long-term affordability. Clear communication helps maintain trust and reduces confusion during open enrollment.

Simple, direct messaging works best:

- what is changing
- why it is changing
- how employees can get help navigating the plan

Stop-Loss Strategy for Self-Funded Employers

For self-funded employers, stop-loss coverage is becoming a critical part of renewal strategy. Carriers are tightening attachment points and adjusting pricing for groups with volatile claims. Employers should review their stop-loss structure early and consider whether lasering, aggregating specific deductibles, or alternative carriers might provide better protection.

HRAs may see indirect changes as employers adjust integrated HRA designs to align with new HSA and FSA thresholds. Employers offering ICHRAs or EBHRAs should watch for IRS clarifications later in the fall.

Benefits managers should plan for three steps:

- update payroll and HRIS systems once final limits are released
- revise open-enrollment materials and employee communications
- coordinate with vendors to ensure systems reflect new thresholds

More updates will follow as the IRS releases final numbers. Employers should stay alert — these changes will affect nearly every benefits program.■

Preparing Now Will Pay Off Later

The 2027 renewal season will be challenging, but not unmanageable. Employers who start early, use data effectively, and communicate clearly will be able to navigate higher trend without sacrificing employee experience. Preparation is the key — and October is the right time to begin.■



The New Push for Onsite & Near-Site Clinics in Mid-Market Employers

A Growing Solution to Access Challenges

Onsite and near-site clinics are no longer just for large employers. Mid-market companies — those with 300 to 3,000 employees — are adopting clinic models at a pace not seen in a decade. The shift is driven by primary-care shortages, rising chronic-condition claims, and the need for more predictable access to care. Employers are discovering that bringing care closer to the workplace can stabilize claims, improve employee satisfaction, and reduce avoidable medical costs.

Primary-care access has become a serious workforce issue. In many regions, employees struggle to get appointments, leading to delayed care, higher emergency-room use, and worsening chronic conditions. Employers are responding by creating care pathways that don't depend on long wait times or overburdened community clinics. Onsite clinics offer convenience and faster access, while near-site clinics provide shared-site models that reduce cost and serve multiple employers.

Why Clinics Are Gaining Momentum

The appeal is straightforward: clinics improve access, reduce claims, and strengthen employee satisfaction. They can provide preventive care, chronic-condition management, urgent care, lab work, and sometimes even physical therapy or behavioral-health services. When employees receive care early, claims tend to be less severe and easier to manage.

Employers adopting clinics often cite three consistent benefits:

- **Lower emergency-room utilization** due to easier access to same-day care
- **Better chronic-condition control**, especially for diabetes, hypertension, and MSK issues
- **Higher medication adherence**, supported by onsite or near-site pharmacy services

Cost savings are emerging as a major driver. Employers with clinics frequently see fewer high-cost chronic-condition claims and more predictable utilization patterns. Some employers integrate clinics with virtual-care platforms to create a hybrid model that expands access without increasing staffing.

Different Models for Different Workforces

Clinic models vary widely. Some employers choose onsite clinics staffed by nurse practitioners or physician assistants. Others use near-site clinics operated by third-party vendors that serve multiple employers in a region. Virtual-first clinics are also gaining traction, offering digital primary care with in-person follow-up when needed.





The right model depends on workforce needs. Onsite clinics work best for employers with large, concentrated worksites. Near-site clinics are ideal for employers with multiple smaller locations or a distributed workforce. Virtual-first clinics offer flexibility for employers who want improved access without the cost of a physical site.

Which Employers Benefit Most

Three factors determine whether a clinic makes sense: workforce size, geographic concentration, and claims profile. Employers with clustered worksites and high chronic-condition claims often see the greatest benefit. Manufacturing, logistics, and public-sector employers are leading adoption, but interest is growing across industries.

Employers should begin with a simple feasibility review:

- Where are employees located?
- What are the biggest cost drivers in the plan?
- How difficult is it for employees to access primary care today?

Answers to these questions often reveal whether a clinic could meaningfully improve outcomes.

Looking Ahead to 2027

The trend is likely to accelerate in 2027 as employers seek more control over access, cost, and employee experience. Clinics are becoming a practical tool for mid-market employers who want to stabilize claims and support workforce health. As primary-care shortages continue, onsite and near-site clinics will play an increasingly important role in employer health strategies. ■

The Return of Dependent Eligibility Audits: Why Employers Are Doing Them Again

A Cost-Control Tool Making a Comeback

Dependent eligibility audits are making a comeback. After several years of relative quiet, employers are revisiting audits as a practical way to control costs and ensure plan integrity. The reason is simple: dependent claims are rising, and many employers are discovering that a meaningful percentage of dependents on their plans are not actually eligible. In a high-trend environment, employers are looking for solutions that protect the plan without reducing employee benefits — and audits fit that need.

Audits typically uncover 8–12% ineligible dependents. These may include ex-spouses, children who have aged out, dependents covered elsewhere, or individuals added during open enrollment without proper documentation. Removing ineligible dependents reduces claims exposure and helps employers maintain compliance with plan rules.

Why Interest Is Rising Again

The renewed interest in audits is tied directly to the rising medical trend. Specialty pharmacy, chronic-condition claims, and higher outpatient utilization are pushing costs upward. Employers want cost-control strategies that do not shift expenses onto employees. Audits offer a straightforward solution: ensure that only eligible dependents are covered.

Audits also help employers maintain ERISA compliance. Plans must follow their own eligibility rules, and failing to enforce those rules can create legal and financial risk. An audit provides documentation that the employer is administering the plan correctly and consistently.

Three factors are driving the resurgence:

- Higher claims volatility, especially in pharmacy and chronic-condition categories
- Greater scrutiny from carriers, who expect employers to enforce eligibility rules
- Pressure to control costs without reducing benefits or increasing employee contributions.

A Simple, Structured Process

The process is simpler than many employers expect. Vendors handle documentation collection, verification, and communication. Employees receive clear instructions and deadlines, and most audits are completed within 60–90 days. Employers can choose full audits or targeted audits focused on high-risk categories such as stepchildren, dependents added during open enrollment, or dependents without Social Security numbers on file.



Technology has also improved the experience. Many vendors now offer secure portals where employees upload documents, track status, and receive reminders. This reduces administrative burden and improves completion rates.

Communication Builds Trust

Communication is key to a successful audit. Employers should explain why the audit is happening and emphasize that the goal is fairness and compliance, not cost-cutting at employees' expense.

Clear messaging helps reduce confusion and maintain trust.

Effective communication usually includes:

- why the audit is required
- what employees need to provide
- how the audit protects the plan for everyone

A Best Practice Returning to the Mainstream

Dependent eligibility audits are becoming a standard best practice again. For employers facing rising claims and tighter budgets, audits offer a practical

way to ensure plan integrity and manage costs without reducing benefits. As 2027 trend pressures build, more employers are likely to revisit audits as a reliable, low-disruption cost-control tool. ■





The Rise of Fertility & Family-Building Benefits in Blue-Collar and Mid-Wage Workforces

Fertility and family-building benefits are expanding beyond tech and professional services. In 2026, manufacturing, logistics, retail, and public-sector employers are beginning to adopt programs that support IVF, egg freezing, adoption assistance, and surrogacy. The shift reflects changing workforce demographics and a growing recognition that family-building support is not just a “white-collar perk.”

Employees across industries are delaying parenthood, facing fertility challenges, or seeking alternative paths to building families. Employers are responding by adding benefits that support diverse family structures and improve retention. These programs help employees feel valued and supported during major life transitions.

Cost is a factor, but employers are finding that family-building benefits can be structured affordably. Many offer lifetime maximums, carve-out programs, or partnerships with fertility-care vendors that provide bundled pricing. Some employers integrate fertility support with mental-health resources to help employees navigate the emotional side of treatment.

Family-building benefits also support DEI goals. LGBTQ+ employees often rely on adoption, surrogacy, or assisted reproductive technology to build families. Providing inclusive benefits helps employers demonstrate commitment to equity and belonging.

Adoption assistance is gaining traction as a lower-cost option. Employers can offer reimbursements for legal fees, travel, and agency costs. Surrogacy support is also expanding, though typically with capped benefits.

The trend is likely to continue into 2027 as employers compete for talent and seek benefits that resonate across diverse workforces. Fertility and family-building benefits are becoming a practical, meaningful way to support employees and strengthen retention — not just in corporate offices, but on factory floors and in distribution centers.■

