

Employee Benefits 2026 Midyear Market Outlook

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Introduction

As 2026 continues, health care costs define the narrative for employers and benefits leaders alike. Organizations face mounting pressure to balance rising health care costs. Prescription drug spending continues to climb, with glucagon-like peptide-1 (GLP-1) medications emerging as one of the most transformative and closely watched categories, reshaping employer costs, vendor strategies and employee expectations around weight management and chronic disease care. New prescription drug platforms, such as TrumpRx, and direct-to-employer (DTE) distribution models are changing the available options and require active monitoring from employers as they make decisions for their 2027 plan design.

At the same time, health plan regulations, litigation and enforcement activity are pushing benefits leaders to rethink compliance strategy, while artificial intelligence (AI) is beginning to reshape how benefits are administered, communicated and personalized for the workforce. Together, these forces are redefining how employee benefits are designed and delivered. Benefits leaders play a critical role in helping their organizations stay competitive while protecting their workforce's health and financial well-being. In addition, 2026 presents unique implications for employers that use a biweekly payroll schedule, as that type of pay cycle doesn't align perfectly with the 365-day calendar year.

The middle of the year is an ideal time to evaluate benefits strategy and recalibrate plan design, vendor partnerships and cost-containment efforts to close out the year strong or prepare for the 2027 open enrollment season. As such, understanding the current state of the employee benefits market can help employers evaluate their offerings to best meet employee needs, respond effectively to their challenges and gain a competitive edge over competitors.

This market outlook explores the key benefit trends to watch in the second half of 2026, outlining their likely impact on employers and how savvy organizations can address them.

Rising Healthcare Costs and 2027 Predictions

Entering 2026, employers braced for another year of rising healthcare costs, and that prediction has more than held up. Zywave's 2026 Broker Services Survey found that healthcare cost management continues to define the market, ranking as the No. 1 benefits challenge for employers for the third straight year. Finding ways to manage rising healthcare costs while keeping benefits affordable for employees is critical for employers as the open enrollment season approaches; however, it won't be easy. Healthcare costs in the United States continue to climb at a staggering pace, and there are no signs that it'll slow down anytime soon. PwC's [annual medical trend](#) report projects that the commercial healthcare cost trend will rise to 9% in 2027, the highest figure in 17 years.

This 2027 projection is an uptick from the 8.5% that has held steady over the past several years. The increase marks the continuation of a sustained run of elevated cost growth. The U.S. healthcare system is heading into another year of powerful inflationary forces.

What's Driving Costs?

There are key factors driving up healthcare spending this year and into 2027.

Chronic Health

Chronic health condition prevalence remains the deepest structural driver of spending. In a recent report published in 2026, the U.S. Centers for Disease Control and Prevention (CDC) shared that 90% of the nation's nearly \$5.3 trillion in annual healthcare spending goes toward people living with chronic and mental health conditions, with roughly 3 in 4 American adults living with at least one, and more than half managing two or more.

The financial weight of individual conditions illustrates the scale. Heart disease and stroke alone account for more than \$223 billion in direct medical costs and another \$191 billion in lost productivity each year, while the total economic burden of diabetes, spanning medical costs and lost productivity, is estimated at \$640 billion. As the population ages, this pressure compounds further. As such, data from the U.S. Centers for Medicare & Medicaid Services (CMS) shows per-person healthcare spending for adults 65 and older runs about five times higher than for children and nearly 2.5 times higher than for working-age adults. For employers, this underscores why prevention and chronic disease management programs, not just plan design tweaks, are becoming central to any credible cost-containment strategy.

Specialty Medications

Higher utilization of specialty medications, particularly GLP-1 drugs, continues to climb. Pharmacy remains one of the clearest sources of medical cost pressure, as more than 85% of PwC survey participants cited a 2027 pharmacy cost trend that was outpacing the overall medical trend. GLP-1 prescriptions have more than tripled since 2020, and roughly 12% of Americans report having used a GLP-1 for weight loss, with another 14% interested in starting. Medications typically cost about \$1,000 per month and are often taken indefinitely to maintain results.

Specialty drugs now account for nearly 80% of all new U.S. Food and Drug Administration (FDA) approvals overall, reflecting a broader shift toward complex, high-cost therapies for chronic and rare conditions.

In response, more employers are layering in prior authorization requirements, weight-management program participation, and tighter formulary management to keep GLP-1 spend in check without restricting access outright.



Cancer Care

Cancer care has been the top driver of employer healthcare cost increases for four years running, according to the Business Group on Health (BGH).

Roughly 1.9 million Americans are diagnosed with cancer each year, and total cancer care costs are projected to exceed \$240 billion by 2030 as incidence rises and treatment grows more advanced.

Diagnoses are increasing not just among older adults but among younger working-age employees, meaning more employees and dependents are entering long-term, intensive treatment. New therapies—including cell and gene therapies, immunotherapies and targeted drugs—can cost hundreds of thousands of dollars per patient, especially in late-stage cases, and don't follow a predictable cost trajectory the way more established treatments do. This unpredictability is pushing more employers toward centers of excellence and specialized cancer care networks designed to improve outcomes while managing cost variability.

Medical Inflation

Medical inflation is outpacing general inflation, with the consumer price index's medical care index, and the CMS projecting overall national health expenditure growth to average roughly 5.4% annually through 2034. That gap between medical and general inflation means healthcare is consuming a growing share of both employer budgets and household income year over year.

The strain is already showing up for consumers directly, as recent West Health-Gallup research found 11% of U.S. adults, nearly 29 million people, can't afford or access quality healthcare, the highest level since 2021, and more than a third of Americans say their most recent care experience wasn't worth what they paid. For employers, that disconnect between cost and perceived value is becoming as important to address as the cost itself.

AI in Healthcare

The use of AI in healthcare is likely to accelerate coding intensity, placing further upward pressure on healthcare spending. As providers adopt AI-enabled documentation and coding tools, they're able to capture greater specificity and reimbursable severity in claims, often without a proportional increase in the actual intensity of care delivered.

In fact, nearly 70% of PwC's surveyed health plans named AI-powered documentation tools a top-three cost driver for 2027.

The dynamic is somewhat inconsistent, though. The same AI capabilities driving up coding intensity on the provider side are also among the tools health plans are using to identify unnecessary spending and fraud on the payer side, meaning the net effect on cost trend depends heavily on which side of the claim is moving faster.



The Future of Healthcare Costs

Healthcare costs are on track to hit \$9 trillion annually by 2035, and the pressure is already reshaping how coverage is priced and structured across the market. Health plans are adjusting benefits and networks, employers are rethinking vendors and funding models, and more costs are shifting directly to consumers through higher deductibles and narrower coverage, raising real concerns about affordability and access.

The broader message is that 2027 should be treated as a turning point. If costs remain on their current trajectory, employers will likely scale back benefits and begin to mirror the cost-control approaches used by government health plans. Every part of the healthcare system will need to adapt. Where possible, leaders are encouraged to collaborate rather than work in silos, with transparency and consumer education as key tools to improve outcomes and reduce administrative burden.

For employers, a 9% trend demands a proactive benefit strategy. In preparation for open enrollment and 2027 plan design, employers are expected to double down on cost-containment strategies. Plan sponsors should evaluate plan design features before compounding cost pressures narrow their options. Staying ahead of rising healthcare costs will require not just tactical adjustments but a strategic rethinking of how benefits are designed, delivered and measured for value. Savvy employers who act now will be better positioned to weather the challenges of 2027 and beyond.



ERISA Fiduciary Litigation Targets Health Plans and Voluntary Benefits

Fiduciary obligations under the Employee Retirement Income Security Act (ERISA) have long been associated with retirement plan management, but that is changing. A growing wave of litigation has begun testing whether those same standards apply to group health plans and voluntary benefits such as accident, critical illness and hospital indemnity insurance. While early cases, including a class action against Johnson & Johnson alleging mismanagement of prescription drug benefits through its pharmacy benefit manager arrangements, were dismissed on procedural grounds, subsequent legal developments suggest that courts are increasingly willing to let these claims move forward.

Health Plan Litigation

In *Barbich v. Northwestern University*, current and former employees filed a class action alleging the university breached its ERISA fiduciary duties by failing to prudently select and monitor the plan's preferred provider organization (PPO) insurance options and failing to disclose material information to plan participants. At issue in the case is the plan's "Premier PPO" option, which had a higher premium and did not provide commensurate benefits as compared to the "Value PPO" option. A federal judge denied the motion to dismiss, marking a departure from prior similar cases that have struggled to get past the pleadings stage.

Voluntary Benefits Cases

Four coordinated class actions were filed against major employers over the management and administration of their accident, critical illness and hospital indemnity insurance programs. Among the allegations are that the employers failed to prudently select and monitor carriers and broker compensation, causing plan participants to pay excessive and unreasonable premiums. The cases are at varying stages and litigation remains ongoing, but additional cases against other employers have followed, suggesting this is an area of litigation that is likely to continue to grow.



Employer Action Items

In light of these developments, employers should take the following steps to evaluate how they currently manage and administer their benefit offerings:

- Audit all health plan tiers to ensure higher-premium options provide commensurate benefits relative to lower-cost alternatives;
- Review plan communications for accuracy and completeness regarding cost and value differences between plan options;
- Document the process and rationale used to select carriers and structure benefit offerings;
- Review broker and consultant compensation for voluntary benefit programs and assess whether fees are reasonable;
- Reassess reliance on the voluntary benefits safe harbor exemption under ERISA; and
- Consult benefits counsel to evaluate potential exposure as litigation progresses.

What This Means for Employers

Taken together, these developments reflect a noteworthy shift in how ERISA fiduciary standards are being applied. The *Northwestern* ruling raises novel questions for employers offering multiple health plan tiers, while the voluntary benefits cases seek to extend ERISA fiduciary obligations to a category of benefits that has generally been regarded as exempt from such requirements. If the plaintiffs in these cases prevail, it could have significant implications for how employers select carriers, oversee brokers and evaluate compensation arrangements. Although both matters remain at early procedural stages, employers should remain mindful of how fiduciary principles may apply across all employee benefit offerings.

AI Continues to Transform Benefits

AI is no longer a future consideration for employee benefits. It's moving fast in 2026, and adoption for employee benefits is picking up right along with it. AI is actively reshaping how benefits are designed, administered and experienced.

While employees experience AI's front-end advantages in benefits, employers are seeing equally powerful changes behind the scenes. AI has the potential to help HR and benefits teams shift their focus from operations to strategy. Adoption is accelerating across both employer and employee-facing functions, and the organizations moving fastest are gaining measurable advantages in cost management, utilization and employee satisfaction.

Adoption Is Growing, But Gaps Remain

Approximately 40% of HR leaders now use AI for benefits administration, according to Mercer's latest Global Talent Trends study. Furthermore, Prudential's 2026 Benefits & Beyond study revealed that 83% of employers want AI to help employees understand benefits, but only 58% of employees say they'd use AI, and just 24% currently use it due to trust and privacy barriers.

There's a visible gap between employer interest and employee adoption, but AI can meaningfully be embedded in benefits strategy versus benefits operations.

Personalization at Scale

On the employee side, the most visible shift is in personalization, and they are likely to be receptive to the technology. Prudential's study found that 65% of employees are comfortable with their employer managing personal data (e.g., age, health status, tobacco use and family history) to receive tailored benefits recommendations, rising to 75% among employees in technology-related roles. AI systems can analyze health claims, lifestyle preferences and engagement history to surface benefit

recommendations tailored to individual needs, whether that's mental health support, chronic disease management or fertility services. For example, an employee who recently had a qualifying life event, such as a new dependent, is nudged to update beneficiary designations and review dependent care flexing spending account elections, rather than missing the enrollment window. AI enrollment tools that factor in an employee's age, family status, anticipated healthcare usage and prior-year claims can deliver the kind of personalized plan guidance that previously required a one-on-one benefits counseling session. The result is higher utilization of relevant benefits and better plan selection decisions, particularly during open enrollment and qualifying life events.

AI-powered virtual assistants and chatbots are extending benefits support year-round.

Available 24/7, these tools help employees compare plans, estimate out-of-pocket costs and navigate coverage questions in real time, reducing the volume of routine inquiries that fall to HR teams. Employers should note, however, that technology adoption requires intentional support. McKinsey reports that more than 1 in 5 employees have received minimal to no support for generative AI use, underscoring the role of training in whether these tools deliver their intended value.

Operational Efficiency and Predictive Insights

Behind the scenes, AI is compressing the administrative workload for benefits teams. A Mercer study found that AI and automation could replace more than half (52%) of a rewards team's workload, including tasks related to benefits administration and routine employee inquiries.



Claims processing, eligibility verification and compliance reporting are among the functions most amenable to automation, freeing benefits professionals to focus on strategy and plan design rather than transaction processing.

Predictive analytics represent the next frontier. By analyzing claims and wellness data, AI can flag emerging health trends within a covered population before they become high-cost events, prompting proactive benefit additions like physical therapy coverage or ergonomic programs. AI compliance monitoring tools can also track regulatory changes in real time, flag upcoming deadlines and alert administrators when action is needed. This is a particularly valuable capability given the volume of benefit-related regulatory activity over the past couple of years.

AI Risks and Guardrails

Even as adoption accelerates, AI in benefits operates in a heavily regulated space, and that calls for guardrails. Prudential's study revealed that trust and privacy are the biggest barriers for employees using AI for workplace benefits-related support. While both employers and employees cite privacy and security as top concerns (49% and 52%, respectively), employees are twice as likely to say they simply don't trust AI (25% versus 12%) in general. Many of today's workers have concerns about inaccuracy, moral/ethical issues and job loss.

Beyond compliance, organizations are now using discernment in building guardrails around transparency (employees should understand when and how AI is shaping their benefits recommendations), human oversight (AI should support, not replace, human judgment for sensitive or complex cases), data security (vendor contracts should specify how data is protected, retained and used) and bias testing (recommendation engines should be regularly audited to ensure they don't disadvantage any group). Treating these safeguards as part of the AI strategy, not an afterthought, is what allows employers to capture AI's benefits without exposing themselves or their employees to unnecessary risk.

2027 Benefits Planning

Healthcare and benefits are not getting simpler, but AI can help. With 2027 plan conversations quickly approaching, forward-thinking employers can consider how AI can help design and administer benefits while also enhancing or creating a hyper-personalized employee experience. In addition, employers evaluating vendors should scrutinize how AI is being used and whether it is aligned with their business priorities.



Fertility Benefits Move From Trend to Rule

The market for employer-provided fertility benefits continues to expand. With infertility affecting roughly 1 in 6 people globally, employers are increasingly considering fertility coverage as a critical component of their benefits package.

According to Maven Clinic's 2026 State of Women's and Family Health Benefits report, employers have expanded family health benefits broadly by an average of 39% year over year.

This growth has been driven by a combination of regulatory guidance making it easier for employers to offer fertility coverage and state legislation increasingly requiring it.

Federal Regulatory Guidance

Increasing access to and reducing costs for infertility treatment has been a stated priority of the Trump administration. In February 2025, an executive order directed agencies to develop policy recommendations to expand in vitro fertilization (IVF) access and reduce out-of-pocket and health plan costs for IVF treatment. Following that directive, in October 2025, the White House announced drug pricing reforms for fertility medications and stated that the FDA will prioritize review of lower-cost fertility drugs. This initiative was behind the launch of TrumpRx.gov in February 2026, which is an online platform designed to offer direct-to-consumer (DTC) purchasing options for key prescription drugs, including fertility medications.

Also in October 2025, federal agencies issued guidance clarifying that employers could offer fertility benefits through three existing "excepted benefit" pathways: (1) a fully insured independent, non-coordinated excepted benefit policy; (2) an excepted benefit health reimbursement arrangement; and (3) an employee assistance program offering fertility coaching and navigator services. Excepted benefits are certain types of employee benefits that are exempt from HIPAA's portability rules (like special enrollment rights and nondiscrimination rules), the Affordable Care Act's market reforms (such as annual limit bans and preventive care mandates), and certain other federal health coverage laws.

Building on that guidance, on May 10, 2026, federal agencies issued a proposed rule that would create a new category of limited excepted benefits specifically for fertility coverage.

To qualify under the proposed new category, fertility benefits would need to meet the following requirements:

- **Substantially all** benefits must be for the diagnosis, mitigation or treatment of infertility or related reproductive health conditions;
- Benefits are **capped at a combined lifetime maximum of \$120,000** for the participant and their beneficiaries, indexed for inflation for plan years beginning after 2027;
- The benefits would be required to be provided under a **separate policy or otherwise not be an integral part of the plan** maintained by the same plan sponsor; and
- The plan or health insurance issuer **must provide a written notice to participants and beneficiaries** that clearly describes the coverage, including its benefits and limitations, how to access in network providers and how to submit claims. This notice must be written in a manner understandable to the average participant and must be provided at the first opportunity to enroll, annually thereafter, and upon request.

Employers offering fertility benefits under this new category would have flexibility in plan design, subject to the requirements above. If finalized as proposed, the rule would apply to plan years beginning on or after **Jan. 1, 2027**, though agencies are seeking comment on whether it should take effect earlier upon finalization. More information is available on the Department of Labor's [Excepted Fertility Benefits webpage](#).

State Mandates

At the state level, insurance mandates regarding fertility treatments continue to expand as well. Earlier this year, California joined more than 20 states requiring fertility benefit coverage, with large group health plans now required to cover fertility services (including IVF) for plans issued, amended or renewed on or after Jan. 1, 2026. Other states, such as Virginia, will require their essential health benefits benchmark plans for 2028 to include fertility treatment and diagnosis (with up to three cycles of assisted reproductive technology per lifetime), among other additions.

Employer Takeaway

As fertility benefits gain traction through both federal initiatives and expanding state mandates, employers have an opportunity to strengthen their benefits offerings in this area. Employers with fully insured plans should assess whether their current plans meet applicable state mandates, while those with self-funded plans that are not subject to state mandates should consider voluntary coverage or supplemental benefits to remain competitive.

Monitoring forthcoming final rulemaking on excepted benefits for fertility coverage can help identify cost-effective strategies for offering these benefits outside traditional group health plans. Budgeting for high-cost treatments (such as IVF) and exploring reimbursement arrangements or partnerships with fertility care platforms can also help mitigate employee out-of-pocket expenses. Overall, clear communication about available benefits and support services reinforces an employer's commitment to family-building and employee well-being, strengthening attraction, retention and productivity.



GLP-1 Trends Transform Employer-sponsored Healthcare

Few developments have reshaped employer benefits strategy as rapidly or as forcefully as GLP-1 medications. What began as a niche diabetes treatment category is now among the most significant cost drivers in employer-sponsored health plans, and the market continues to expand. In 2026, new drugs have entered the market, and pipeline candidates, including triple-agonist retatrutide, continue to advance, with the next generation of therapies approaching approvals in 2027. The market is not slowing down, and therefore, neither are the decisions plan sponsors face.

The Cost Burden Is Already Substantial

The numbers alone make GLP-1s impossible to ignore. According to the International Foundation of Employee Benefit Plans, GLP-1 prescriptions accounted for 10.5% of annual pharmacy claims in 2025 across many employer-sponsored plans, up sharply from 6.9% in 2023. New analysis in the Benefitfocus State of Employee Benefits Report 2026 puts the pressure in even sharper relief. GLP-1 drugs are now driving approximately 20.3% of prescription spending at large self-funded plans, with roughly 6% of plan participants using the medications.

Nearly 8 in 10 employers report that GLP-1s are driving an increase in their company's healthcare costs, according to a 2026 BGH survey of large employers.

While most employers cover GLP-1s for diabetes, 67% currently cover them for weight management. However, that figure may shrink. Of those offering coverage for weight management, 10% say they're unlikely to do so in 2027, and only 72% say they're likely to continue. Meanwhile, 87% of employers expect that the new availability of oral GLP-1 medications will drive higher demand, but only 9% anticipate a price decrease.

Early evidence suggests GLP-1 medications can reduce certain medical costs, particularly hospitalizations tied to diabetes and obesity-related complications; however, for most employers, those savings are outweighed by the average annual drug cost of roughly \$6,000 per active participant. GLP-1s can deliver meaningful clinical benefits, including weight loss, improved metabolic control and reduced cardiovascular risk, but translating those health improvements into measurable financial returns can be unclear. In addition, GLP-1s can impact employee attraction and retention, as well as productivity, though these effects are difficult for employers to measure. Higher medication adherence drives better outcomes but also accelerates claims costs, and the average U.S. worker tenure of roughly four years is often too short a window to recoup drug expenses through reduced utilization. For most employers, the return-on-investment picture depends heavily on workforce-specific factors, making a one-size-fits-all coverage decision difficult to justify on financial grounds alone.

New Drug Developments Signal More Demand Ahead

The Wegovy pill became the first GLP-1 approved for weight loss in pill form in early 2026, and this oral GLP-1 milestone is already registering with employers. In addition, the FDA approved Foundayo, Eli Lilly's GLP-1 weight loss pill, in April. The convenience factor of oral pills has expanded the eligible population, particularly among people who have avoided injections. In fact, a study by the health data firm Truveta found that among early users of the Wegovy pill, 36% had no prior experience with GLP-1 medications, signaling that the oral medication is reaching new patients rather than only taking market share from injectables.

A number of GLP-1s and similar drugs are currently under development and are likely to completely reshape the market. Retatrutide, developed by Eli Lilly, represents one of the most closely watched candidates. Unlike existing GLP-1 medications, it is a triple hormone receptor agonist that activates receptors for glucose-dependent insulinotropic polypeptide (GIP), GLP-1 and glucagon simultaneously. In the TRIUMPH-1 Phase 3 trial, participants on the 12-milligram dose lost an average of 70.3 pounds (or 28.3% of body weight) over 80 weeks, with 45.3% achieving 30% or more weight loss.

CagriSema, from Novo Nordisk, takes a different approach by combining semaglutide (the active ingredient in Ozempic and Wegovy) with cagrilintide, a long-acting amylin receptor agonist. In the REIMAGINE 2 Phase 3 trial, CagriSema produced weight loss of 14.2% over 68 weeks in adults with Type 2 diabetes, outperforming semaglutide alone, and CagriSema for weight management was submitted to the FDA in December 2025. Neither retatrutide nor CagriSema is FDA-approved yet, but their efficacy data signals that the market will likely look meaningfully different within just a few years. For employers already contending with the cost of today's GLP-1s, the pipeline makes long-term benefit strategy planning all the more urgent.

Federal Pricing Policy Enters the Picture

On the pricing side, the Trump administration's most-favored-nation (MFN) policy is beginning to affect GLP-1s, bringing prices in line with the lowest paid by other developed nations. Under a November 2025 agreement with Novo Nordisk and Eli Lilly, patients purchasing GLP-1s through the TrumpRx platform pay approximately \$350 per month for oral and injectable medications, with prices expected to drop to \$245 over the next two years. As of July 1, Medicare is offering injectable weight-loss medications at a monthly cost of \$245 for eligible members, with a copayment of no more than \$50. State Medicaid programs will also have access to these rates.

For employer-sponsored plans, MFN-driven pricing has not yet produced direct relief. The agreements are structured for government programs and DTC channels. However, they add pressure on manufacturers to justify list prices in commercial markets and may accelerate the adoption of direct-to-employer pricing models that bypass traditional pharmacy benefits manager structures entirely.

What Employers Should Do Now

GLP-1 coverage decisions made today will have multiyear financial consequences. Effective strategies include limiting plan eligibility to defined clinical criteria, requiring prior authorization and participation in lifestyle programs, and exploring direct-to-employer platforms that offer fixed, transparent pricing for specific drug classes. Employers should also evaluate flexible spending accounts and health reimbursement accounts as supplemental access tools that preserve some affordability without adding GLP-1s to core major medical coverage.

The business case for GLP-1 coverage remains mixed in the short term as drug costs continue to outpace clinical savings within typical employee tenure windows. However, with next-gen obesity drugs approaching, the decisions employers make about access, eligibility and cost sharing in 2026 will define their exposure for years ahead.



Direct-to-Employer Platforms Reshape Drug Access

For decades, pharmacy benefit managers (PBMs) have served as the primary gatekeepers of prescription drug access and pricing in employer-sponsored health plans, negotiating manufacturer discounts, providing rebates, developing formularies and processing claims. That model is increasingly facing a meaningful challenge. A growing number of drug manufacturers, technology platforms and pharmacy operators are launching DTE prescription drug models that route medications entirely around the traditional PBM channel, intending to offer greater transparency, predictability and control.

What's Driving the Shift?

The pressure point is cost, particularly for specialty drugs and GLP-1s for obesity and cardiometabolic conditions. Under the traditional PBM model, employers often face limited visibility into true net drug costs, delayed or uncertain rebate flows and budget volatility tied to list prices rather than actual spend. New research is underscoring how significant that gap can be. A study published in the [Annals of Internal Medicine](#) found that for insured patients whose generic drug copayments or coinsurance exceeded \$15, a DTC pharmacy offered a lower price nearly 80% of the time. In addition, for drugs with cost-sharing above \$100, patients could save a median of \$119 per prescription. Those findings have accelerated employer interest in DTE platforms, which apply a similar cash-price logic at the plan level.

New Models Are Quickly Emerging

Several platforms have launched or expanded this year. Eli Lilly's [Employer Connect](#) and Novo Nordisk's employer-facing access programs offer discounted, fixed pricing outside PBM channels for their obesity medications. Technology partners like [Waltz Health](#) provide the infrastructure (e.g., eligibility verification, pharmacy routing and clinical safeguards) while maintaining transparent pricing.

The latest entrant signals just how seriously the market is taking this model. [CenterWell Pharmacy](#), Humana's specialty and home delivery pharmacy arm, announced a deepened partnership with Cost Plus Drugs to develop end-to-end employer prescription solutions. The collaboration pairs Cost Plus Drugs' transparent pricing and SwiftyRx technology platform with CenterWell's

distribution infrastructure, with the shared goal of simplifying patient access and lowering prescription costs for employer-sponsored plans.

Lastly, GoodRx introduced [Employer Direct](#), which allows employers to subsidize manufacturer-sponsored cash prices for high-impact brand medications directly, initially focused on GLP-1 drugs. Under the model, employer contributions are applied at the pharmacy counter, lowering employees' out-of-pocket costs without adding the medication to the core health plan. The platform is designed to complement—not replace—traditional insurance.

Impact on Employer-sponsored Drug Models

DTE models illustrate a shift away from the stronghold that PBMs have historically held over prescription drug pricing and distribution. In turn, this gives employers decisions to make that require new assessment. For GLP-1s in particular, where coverage remains inconsistent and demand is surging, DTE models may offer a more predictable path to coverage. Such platforms offer employers advantages, including:

- **Greater pricing transparency**—Employers typically pay a fixed, upfront net price for medications, eliminating rebate reconciliation and reducing uncertainty about true drug costs.
- **Improved budget predictability**—With pricing set in advance and not tied to fluctuating rebates or formulary dynamics, employers can better forecast pharmacy spend and manage financial risk.
- **Reduced reliance on PBMs**—In most cases, the model bypasses the traditional PBM structure, avoiding rebate-driven incentives, spread pricing and administrative fees that can distort some of the cost savings that PBMs provide due to their group discounts.

- **Faster and simpler employee access**—Many platforms streamline utilization management, reducing delays caused by prior authorization or step-therapy requirements common in PBM-managed plans.
- **Flexible benefit design**—Employers can tailor eligibility rules, cost-sharing levels and program scope rather than conforming to a one-size-fits-all formulary approach.
- **Targeted solutions for high-cost drugs**—These platforms allow employers to address specific problem drug classes (e.g., GLP-1s) without overhauling their entire pharmacy benefit.

While the pros are compelling, DTE platforms also introduce new complexities. Many of the challenges stem from operating outside the traditional PBM ecosystem, which, despite its flaws, has long provided rebates, cost discounts, centralized administration, data aggregation and oversight. As such, key trade-offs include:

- **Pharmacy benefit fragmentation**—Drugs obtained through DTE platforms may fall outside the traditional pharmacy benefit, meaning prescriptions may not count toward deductibles or out-of-pocket maximums. This fragmentation also limits employers' ability to capture manufacturer rebates, potentially increasing net plan costs. At this time, it remains unclear how member cost sharing in these programs is applied to deductibles.
- **Loss of consolidated data and reporting**—Bypassing PBMs can create gaps in utilization and cost data, making it harder to track trends, evaluate outcomes or measure long-term ROI. While this platform may provide benefits in some cases, moving away from PBM formularies means losing certainty, standard prescription drug distribution and potential group discounts and rebates.



- **Increased administrative responsibility**—Employers may need to take on greater oversight for vendor performance, clinical safeguards and regulatory compliance.
- **Limited scalability across drug classes**—Most platforms today focus on narrow categories, which can lead to a patchwork of carve-outs as more manufacturers pursue similar models.
- **Employee confusion and communication challenges**—Multiple access pathways for medications can complicate employee understanding of how benefits work and where to go for coverage.

DTE prescription drug platforms reflect a broader unbundling of the pharmacy value chain. Rather than relying on a single intermediary to manage all drug access, some employers are beginning to selectively carve out solutions for the most expensive or strategically important medications. At this time, DTE models are unlikely to significantly impact employer-sponsored prescription drug coverage, although

they will change how a small number of employers procure specific categories of medications. Their growth underscores a fundamental shift: many employers are no longer willing to trade transparency for simplicity when it comes to pharmacy benefits, and they are increasingly open to new cost-saving channels.

As drug manufacturers and employers continue to experiment with these models, the long-term impact may be less about eliminating PBMs entirely and more about adding competition and redefining when and where they add value. Keep in mind that these programs are just a few specific models that have emerged, mostly for specific drugs. Employers should expect this model to expand in late 2026 and beyond as they prepare for 2027 benefits plans.



TrumpRx Adds Competition to Prescription Drug Market

The Trump administration's MFN drug pricing initiative aims to align what Americans pay for prescription drugs with the lower prices paid by other developed countries. According to the White House, the intention of MFN pricing is that the United States should not subsidize cheaper drug prices abroad by paying more at home. The MFN initiative took a tangible form on Feb. 6, 2026, with the launch of [TrumpRx.gov](https://trumpRx.gov), a government website designed to connect consumers directly to prescription drug discounts negotiated with pharmaceutical manufacturers. Since then, TrumpRx has gone from launching an initial list of target drugs to continually adding more. The platform represents one of the most direct federal interventions in drug pricing in recent years, and while its near-term impact on employer-sponsored plans is nuanced, it signals a broader structural shift in how prescription drugs are priced and accessed in the United States.

How TrumpRx Works

TrumpRx operates as a DTC platform. Users visit the site, select a medication and receive either a coupon redeemable at a participating pharmacy or a link to purchase the drug directly from the manufacturer. As such, this is not a direct-to-purchase platform. TrumpRx targets cash-paying patients. Anyone with a valid prescription can use it, but it does not accept insurance. KFF describes it as a portal for checking discounted DTC prices, not a traditional pharmacy storefront.

The platform launched with a focused set of medications and has since expanded rapidly, including GLP-1s for obesity.

Under the administration's agreement with Novo Nordisk and Eli Lilly, injectable GLP-1 medications are available through TrumpRx at approximately \$350 per month, with prices expected to drop to \$245 over the next two years.

Who Benefits and Who Doesn't

KFF analysts note that most consumers with insurance coverage will generally be better served by using their insurance rather than TrumpRx. Purchases made through the platform are out-of-pocket and do not count toward a patient's deductible or out-of-pocket maximum. An employee who is likely to approach their deductible may spend more over the course of the benefit year if they bypass insurance to use TrumpRx. For example,



an employee whose insured cost for a specialty medication runs \$900 per month may find that even if TrumpRx brings that drug into the \$150-\$350 range, bypassing insurance means those payments don't chip away at the deductible or out-of-pocket maximum, potentially costing more over the course of the benefit year.

While many insureds won't benefit as much from TrumpRx, the program could be meaningful to the more than 80 million enrolled in high deductible health plans (HDHPs) and the 27.2 million uninsured Americans who pay full drug costs out of pocket regardless. For those populations, TrumpRx discounts can represent genuine savings in some situations. For employees enrolled in HDHP plans, cash drug purchases are qualified health savings account (HSA) expenses. Therefore, HDHP members can pay with their HSA funds, which is a practical consideration for self-funded sponsors. For employees enrolled in plans with robust drug coverage, the big picture is more complicated. Many patients are already choosing to use TrumpRx even if it doesn't count toward the deductible, because the prices (for example, for GLP-1s) may be much lower than in

the plan. These plan participants still benefit from TrumpRx, even if it isn't designed for them. The new platform adds competition and gives consumers one more option for purchasing medications or comparing prices.

Federal Guidance

Ahead of the platform's launch, the U.S. Department of Health and Human Services (HHS) took a significant regulatory step. On Jan. 27, 2026, the HHS Office of Inspector General (OIG) issued a [Special Advisory Bulletin](#) concluding that manufacturer-led DTC prescription drug programs can be structured to present a low risk of violating the federal Anti-Kickback Statute, even when federal healthcare program beneficiaries participate. The OIG described the bulletin as clearing the path for DTC programs, including TrumpRx. Alongside the bulletin, the OIG issued a companion Request for Information seeking public input on whether a formal regulatory safe harbor for DTC drug programs is needed. The comment period closed on March 30, 2026, and no safe harbor has been finalized to date. The bulletin stops short of a formal safe harbor.



What This Means for Employers

TrumpRx does not directly restructure employer-sponsored pharmacy benefits, but it introduces market pressure and operational considerations that plan sponsors should monitor, including the following:

- **Plan data leakage and lost visibility**—When a member purchases a drug through TrumpRx, the transaction bypasses the plan's PBM entirely, meaning the claim never flows through the employer's pharmacy benefit. Thus, this creates blind spots. Employers lose utilization data for those fills and forfeit any rebate capture tied to that drug, and the purchase generates no accumulator credit toward the member's deductible or out-of-pocket maximum. For employers trying to manage pharmacy spend, that missing data can distort trend analysis and undercut cost-management programs.
- **GLP-1 coverage decisions**—GLP-1s are the most pressing pharmacy question for many employers right now, and TrumpRx adds a new variable. The program offers a cash-pay path for GLP-1s at roughly \$150-\$399, creating two scenarios. For employers that have not yet covered GLP-1s for obesity, that lower cash price may relieve some employee pressure. Members who want the drugs may self-pay rather than request plan coverage. For employers that already cover GLP-1s, a competing cash-pay option at a fraction of the plan cost-share could complicate the benefit and prompt employees to question why their plan's cost sharing is higher.

- **Stop-loss exposure**—For self-funded employers, if high-cost claimants shift drug spend off the plan through TrumpRx, it changes what hits the stop-loss attachment point. Reduced on-plan spend by high utilizers could lower aggregate claims, affecting stop-loss thresholds, changing reinsurance calculations, and potentially altering an employer's risk profile in ways that are difficult to anticipate without the underlying utilization data.

More broadly, TrumpRx reinforces the trend toward transparent, rebate-free drug pricing that is reshaping the PBM model and accelerating employer interest in direct-to-employer platforms.

Conclusion

TrumpRx represents a meaningful shift in how prescription drug pricing is approached, and one that plan sponsors should watch closely. The program was not established through legislation, which leaves its long-term continuity uncertain beyond the current administration. Employers should treat it as a market signal rather than a permanent structural change, but one worth factoring into benefits communications and drug pricing strategy.

What An Extra Payroll Period Means for Employee Benefits

For employers that use a biweekly payroll schedule, 2026 will be an unusual year. Due to the way the calendar falls and the placement of the New Year's Day federal holiday, many organizations that typically run 26 biweekly payrolls will instead issue 27 paychecks during the year.

A biweekly pay cycle does not align perfectly with the 365-day calendar year. Over time, this mismatch results in some years including an additional payroll period. In 2026, this effect is compounded by the fact that Jan. 1, 2027, falls on a federal holiday. Employers that normally pay on Fridays will likely move that payday into late December 2026, resulting in 27 total biweekly pay dates.

Years with an extra biweekly payroll occur roughly every 11 or 12 years.

At first glance, this may seem like a payroll-only issue affecting pay timing or salary calculations. An extra cycle can also have significant downstream effects on employee benefits, including contribution limits, payroll deductions and employee communications. By addressing benefits implications well before December, employers avoid errors and ensure a smooth employee experience during an unusual payroll year.

Health Insurance Premium Deductions

Group health premiums are priced monthly and translated into per-paycheck deductions, a structure that doesn't automatically account for a 27th payroll cycle. Employers that continue deducting premiums across all 27 pay periods will over-withhold employee contributions unless adjustments are made. Many organizations are handling this by completing all health insurance deductions within the first 26 paychecks and issuing the final check without benefit deductions. Microsoft, for example, has publicly confirmed that its 27th paycheck in 2026 will carry no benefit deductions.

Retirement Plan Contributions

The 2026 401(k) elective deferral limit is \$24,500, with catch-up contributions of \$8,000 for employees age 50 and older. Employees who contribute a fixed percentage of pay may hit these ceilings earlier than expected in a 27-period year. As such, those contributing a flat dollar amount per paycheck are at greater risk of exceeding limits if deductions aren't stopped at the right time. Highly compensated employees are particularly exposed. Employers should work closely with plan administrators to ensure systems are configured to halt contributions when annual limits are reached.

HSAs and FSAs

HSA contribution limits are a combined cap covering both employee and employer contributions, meaning an extra payroll cycle increases the risk of excess contributions if per-paycheck amounts aren't adjusted.

The flexible spending account (FSA) math can illustrate the exposure. For example, an employee contributing toward the \$7,500 dependent care FSA limit across 26 pay periods contributes roughly \$288 per check. Run that same amount across 27 periods, and total contributions reach approximately \$7,788, which is \$288 above the IRS limit. The health FSA annual limit for 2026 is \$3,400. Excess contributions are not tax-exempt and must be corrected.

Voluntary and Supplemental Benefits

Dental, vision, life insurance and disability coverage rely on fixed per-paycheck deductions and face the same over-withholding risk as health premiums. These voluntary benefits are often less visible in annual planning discussions, making them easy to overlook. However, without proper configuration adjustments, employees could be charged more than their elected annual amount.



PTO and Leave Accruals

Employers that accrue paid time off (PTO) on a per-pay-period basis will generate one additional accrual cycle, potentially pushing employees into cap thresholds earlier in the year and increasing unbudgeted leave liability. For employers with automated accruals in a payroll platform, verifying that the system does not automatically generate an extra accrual cycle is an important step. Employers that front-load leave at the start of the year are not affected by accrual timing, but should still confirm that policies don't inadvertently trigger additional grants.

Employer Takeaway

The takeaway for employers of all sizes is that benefits systems don't self-correct for an extra pay period. If they haven't already, employers should audit deduction schedules, coordinate with payroll vendors and benefits administrators to confirm their configurations, and proactively communicate with employees before the final paycheck arrives. Some states also require advance notice before altering salary calculations, and some carriers require formal written notice of changes to deductions.

Employer Takeaway

Healthcare costs and the prescription drug market will keep shifting quickly through the rest of 2026, driven by GLP-1 demand, new drug pricing competition and emerging technologies like AI. No organization is immune to these pressures, so savvy employers are always monitoring the latest benefits trends and adjusting their strategies to support their workforce. The second half of the year is a good time to revisit plan design and vendor partnerships before open enrollment begins.

Contact us today for more information.

