Alliant

The 2026 Employee Benefits Midyear Review

Alliant
Employee Benefits

What's Real, What's Noise, What's Next

The first half of 2026 did not deliver uncertainty. It delivered confirmation — most of it uncomfortable.

Costs are concentrating faster than plan projections assumed, and the concentration is now visible across claims, drugs, care pathways, absence, analytics, coding, AI-enabled decision support, and funding structures.

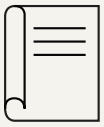
That matters because the market is still saturated with tools, dashboards, PBM reviews, navigation vendors, and funding mechanisms. Employers do not need more activity; they need a better-designed benefits ecosystem with the visibility, governance, and clinical discipline to change outcomes.

This review covers the six themes Alliant tracked through the first half of the year — large medical claims, pharmacy volatility, healthcare navigation, leave cost exposure, analytics and clinical support, and funding strategy — plus the regulatory, economic, coding, and AI-driven disruption that has added urgency to every one of them.

The Scorecard

For each, we ask: What did we say? What did the market confirm? Where is the market heading? And what should employers do before renewal?

The picture is clearer in some areas than others. That asymmetry is not a caveat. It is the insight — and it is why the second-half conversation should lead with precision, proof, and plan redesign rather than generic cost-containment claims.

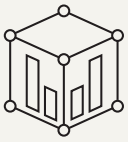


Large Medical Claims

Why a handful of claims drives most of your cost volatility – and how to plan for it.

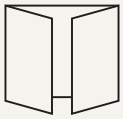
Pharmacy Costs

The fastest-growing line item – and the levers that actually bend the curve.



Healthcare Navigation

Turning access and guidance into measurably lower avoidable spend.



Leave Management

Where compliance, cost, and employee trust collide.

Analytics and Clinical Support

Making the invisible visible – where spend really comes from.

Funding Strategy

Moving beyond premiums to a risk strategy you actually control.

Large Medical Claims

Where the market is heading: High-cost claims are becoming a persistent strategy problem

We said large claim acceleration was not an anomaly. It was a compounding structural shift — driven by cancer rates in younger populations, specialty drug pricing, hospital consolidation, and a growing cohort of members with chronic conditions crossing high-cost thresholds.

The data has since become more specific, and more pointed. Members with more than **$1 million in annual claims grew by 68% over two years**. The average cost for that cohort reached **$1.647 million**. Cancer represents 29% of high-cost claim expense — while mental health and gastrointestinal disorders are accelerating, pointing toward a younger high-cost population and a behavioral health surge that has not peaked.

What clarified in the first half of the year

This concentration is persistent, not episodic. Of high-cost claimants in 2025, 37% were also high-cost the prior year. 25% were high-cost for three or more consecutive years.

> ***Employers who treat large claims as unpredictable spikes are systematically underinvesting in the strategies that would actually change the trajectory.***

What employers need to see now: stop-loss can protect the balance sheet, but it cannot diagnose condition concentration, steer care, or manage the pharmacy–medical interaction. Employers whose strategy stops at medical stop-loss may be misreading where their actual exposure sits.

AI Trend to watch: AI-enabled documentation and coding support may make visit complexity more consistently captured, increasing the frequency of higher-severity E/M levels or longer-time visit codes. Even when clinically appropriate, this can shift paid claim patterns. Employers should monitor coding-intensity by provider, site of care and condition before assuming trend is purely utilization-driven.

Related article:

What's really driving large medical claims?

Alliant Position

Large claims are not random spikes; they are signals that the plan needs better clinical visibility, site-of-care alignment, and provider-quality decisioning.

Alliant Insight

1.2% of plan participants generated more than one-third of total employer healthcare spend in the 12 months ending June 2025 — a figure that has grown by 40% in two years. Addressing it requires visibility into condition concentration, site-of-care alignment, and provider quality. Stop-loss structuring is not a substitute for any of those.

The second-half priority is condition-specific review, pharmacy–medical integration, site-of-care strategy, provider quality, and stop-loss structuring that reflects actual risk.

Pharmacy Costs

Where the market is heading: From PBM negotiation to clinical and financial governance

We said pharmacy was no longer just a cost category. It was a structural financial exposure — driven less by broad utilization and more by a small number of high-cost drugs, specialty therapies, and members. GLP-1s and specialty drugs are not line items; they are plan-architecture questions that require governance before renewal pressure narrows the options.

That has been validated. Pharmacy now exceeds a quarter of total health plan spend for many employers. Ten drugs drive roughly 35% of overall pharmacy cost. GLP-1 utilization has not stabilized, and coverage choices are being stress-tested by both cost pressure and clinical expectations.

What shifted

The conversation. Early in the year, most employers were still treating pharmacy as a PBM contract problem. That framing is losing ground. The employers seeing different outcomes are the ones who recognized that pharmacy is a utilization management problem first and a pricing problem second. Those are not the same intervention, and conflating them is expensive.

What remains murky

GLP-1 outcomes data for weight management is still emerging and evolving. The question is not simply whether to cover these drugs. It is how to build coverage that is clinically defensible, financially bounded, and durable — with utilization management, care access, risk protection, adherence expectations, biosimilar strategy, and PBM governance working together.

The window for meaningful pharmacy strategy before January 1 renewal is narrower than it feels. Formulary decisions, PBM structure evaluation, and specialty drug governance all require runway that doesn't exist in November.

Related article:

The Pharmacy Cost Problem Employers Think They're Solving – and the One They're Not

Alliant Position

Pharmacy strategy should be governed as an exposure-management discipline, not handled as a once-a-year contract review.

Alliant Insight

Employers applying robust utilization management protocols see savings of $144–$240 per employee per year. Where employers have moved decisively to biosimilars, savings of 15–35% are common. The difference between those outcomes and the alternative is not access to data. It's governance.

Healthcare Navigation

Where the market is heading: From support tool to embedded plan infrastructure

We argued that healthcare navigation has been systematically mispositioned — introduced as a support tool layered onto existing plan architecture, when the only version that delivers financial impact is one embedded at the system's control points: primary care, referral flow, site-of-care alignment, and incentive design. The scale of what's at stake makes that distinction consequential.

The market has no shortage of advocacy lines, portals, and digital tools. The problem is that many sit outside the moments that determine cost: primary care access, referral flow, site-of-care selection, incentive design, and follow-through. At the employer level, those structural inefficiencies show up in avoidable referrals, higher-cost sites of care, and utilization the plan was never designed to question.

> ***Navigation doesn't fix that by existing. It fixes it by being built into the architecture that shapes those decisions before they're made.***

That argument is confirmed by the spread in employer outcomes. Passive navigation — an advocacy line, a digital portal — continues to operate in the single digits on utilization. Employers who built navigation into plan design and aligned incentives to reinforce engagement are seeing adoption in the 20–60% range, with corresponding movement in referral patterns and downstream cost.

What 2025 and early 2026 made clearer

Site-of-care remains one of the most underused cost levers. Redirecting imaging and routine outpatient procedures away from higher-cost hospital outpatient settings can create meaningful savings without sacrificing outcomes.

What remains a problem

Employers keep adding tools instead of redesigning the system. Navigation only works when it sits inside the plan architecture that shapes decisions before they happen.

Related article:

What's really driving large medical claims?

Alliant Position

Navigation should sit at the points where decisions are made, not in the back of the benefits guide.

Alliant Insight

For an employer, 10–20% of total spend is tied to outcomes that can be influenced through plan design. When navigation adoption is reinforced through aligned incentive design, modeled net impact can approach $1,900 savings per employee per year — approximately $1.9M per 1,000 employees annually.

AI Trend to Watch: AI is becoming part of the benefits front door. Its value is not smarter technology, but better decision support: explaining benefits, surfacing cost and quality differences, prompting next steps and steering members into the plan pathways employers designed. Employers should measure whether AI improves primary care, referral, site-of-care and incentive decisions — not just digital engagement.

Leave Management

Where the market is heading: From HR administration to measurable cost exposure

We said leave management is not merely an HR administration problem. It is a cost system — one that intersects compliance, compensation, disability, state mandates, productivity, and employee experience in ways that no single vendor typically integrates end to end. The market is moving toward visibility and coordination because the hidden costs are too large to leave unmanaged.

The CFOs and CHROs who looked at the full picture found the numbers clarifying. Benefit overlap and duplication — employees receiving overlapping payments across company-paid leave, state programs, and disability — create $100,000–$300,000+ in annual overpayments for mid-sized organizations. That is not a rounding error. It is a governance failure.

What intensified in the first half of the year
The state mandate landscape. New paid family and medical leave programs are creating coordination requirements that employers with distributed workforces are still working through. Leave-related litigation can reach seven-figure settlement territory.

> *For organizations operating across multiple jurisdictions, miscoordination is no longer a theoretical risk.*

The question we posed in April still stands
If you had to quantify — today — the full cost of absence across your organization, including overpayments, productivity loss, compliance exposure, and operational disruption, could you? For most employers, the answer is no. That uncertainty has a dollar figure attached to it.

AI Trend to Watch: Leave management AI is moving beyond workflow automation into absence forecasting, eligibility guidance, compliance routing and return-to-work coordination. The opportunity is reduced friction; the requirement is auditability across company-paid leave, state programs, disability and accommodations. AI can flag patterns sooner, but it cannot replace coordinated leave governance.

Related article:
Leave Management Isn't an HR Function. It's a Cost System.

Alliant Position

Leave should be evaluated like any other financial exposure — measured, coordinated, and governed across programs.

Alliant Insight

In a review of a 3,000+ employee organization, Alliant identified $57,000 in overpayments across just 8 leave cases — with estimated annual financial leakage of $175,000–$225,000. Root cause: lack of coordination between company benefits and statutory programs. In larger populations, this scales into seven-figure exposure.

Analytics and Clinical Support

Where the market is heading: From retrospective reporting to decision-grade stewardship

We closed the first half with the argument that should have opened every benefits conversation this year: healthcare cost does not rise evenly. It concentrates.

The employers who outperform are not the ones making the broadest cuts. They are the ones using analytics to identify where cost is spiking — across large claims, pharmacy, site-of-care, leave, funding and provider variation — and intervening before it compounds.

What the first half clarified
Most employers are still reacting to headline trend. Without clear visibility, they default to higher contributions, tighter benefits or broad cutbacks. Those moves may feel decisive, but they rarely address the real cost drivers.

What remains the gap
Employers do not need more reporting. They need a unified view of utilization, pricing, incentives, provider quality, clinical risk, pharmacy and outcomes that supports decisions.

A high-performing health plan requires diagnosis before intervention, precision instead of broad cuts and measurement of outcomes rather than activity. That is where Alliant can separate — beyond reporting, benchmarking and point-solution dashboards.

> ***A high-performing health plan requires the same discipline applied to any critical business investment: diagnosis before intervention, precision instead of broad cuts, and measurement of outcomes rather than activity.***

That discipline is not a question of technology. It is a strategy question — and it is where Alliant can separate from approaches that stop at reporting, benchmarking, or point-solution dashboards.

Related article:
Alliant Clinical Analytics — The data is there. The question is whether you're looking

Alliant Position

Analytics should not be positioned as technology; it should be positioned as the foundation for plan stewardship.

Alliant Insight

In most plans, a small subset of claims, providers, and treatment decisions drives a disproportionate share of total cost. When employers rely on aggregate reporting, this concentration is easy to miss. Trend masks where costs originate and where they can be influenced. The employers who will be better positioned at 2027 renewal are the ones building analytical infrastructure now — not in November.

AI Forecasting Lens: Predictive analytics can surface emerging risk earlier — high-cost claimants, specialty drug shifts, site-of-care leakage, leave recurrence and provider variation. Its value depends on clean data, clinical review, financial modeling and a process that turns signals into action before renewal pressure limits options.

Funding Strategy

Where the market is heading: From renewal structure to active risk management

Everything in this review concentrates into a single structural choice: how the plan is funded, how risk is transferred or retained, and how actively the plan is managed across the year. Large claims, pharmacy exposure, site-of-care variation, and leave leakage do not stay abstract once they land inside a funding structure that was not built to absorb or respond to them.

We said the funding conversation starts too narrow. Most begin with a structure — fully insured, level-funded, self-funded, captive — before the more important questions have been asked: what can this organization absorb, what does it have the infrastructure to manage, and what should a better outcome look like three years out? Structure is a mechanism. It either supports the employer's goals and risk tolerance, or it quietly works against them.

What the first half made undeniable: the market is hardening, and passive funding strategies are getting more expensive. Carriers are pricing more conservatively and underwriting more selectively. Employers that invested in clinical oversight, claims visibility, and disciplined plan stewardship are entering renewal from a position of strength. Those that did not are more exposed — to higher premiums, tighter terms, and fewer options.

> ***The funding answer is not one size fits all. This is not which "structure wins" — it is which structure fits your organization, and what has to be true for it to perform.***

What employers still get wrong

Treating stop loss as the strategy, or treating structure as the starting point. Stop loss, captives, level-funding, and fully insured arrangements all have a place; the work is understanding the organization well enough to know which place that is, and what management infrastructure is required for it to perform.

Related article:

The Funding Answer Is Not One Size Fits All. It Should Fit Your Organization.

Alliant Position

The right funding structure is not the one that looks most innovative; it is the one that fits the organization's risk tolerance, claims profile, cash-flow capacity, and governance maturity.

Alliant Insight

A mid-sized employer with roughly 330 covered members faced 12–14% renewal projections driven by high-cost musculoskeletal, oncology, and cardiac claims. Through a phased transition — level-funding with active claims monitoring into a group captive with a high-performance network and transparent PBM — total spend fell 47% in the first six months ($977K against $1.86M projected). The structure didn't move the number on its own. The fit did, and the management behind it.

Regulatory Roundup

Fine Print, Big Picture

The American Medical Association has approved a significant restructuring of maternity care CPT codes, effective January 1, 2027. The change will move maternity care away from traditional global billing codes and toward more granular, phase-specific reporting across antepartum care, labor management, delivery, and postpartum care.

For employers, this is more than a coding update. It is expected to create greater visibility into maternity-related utilization, risk, and cost patterns and may create additional reimbursement opportunities for providers, driving higher overall plan spend.

Early carrier feedback suggests the unbundling could create additional cost pressure, with some estimates pointing to a potential 5% to 10% increase, though actual impact will vary by plan, population, contracts, and utilization. More importantly, the change comes as maternity and neonatal costs are already rising due to increasing rates of high-risk pregnancies and complex maternal health conditions.

> ***AI Forecasting Lens:*** *The 2027 maternity CPT transition will also make coding-pattern analytics more important. As maternity care shifts from global billing to phase-specific reporting, employers should monitor visit frequency, service mix, labor-management complexity, postpartum follow-up, and neonatal outcomes. The goal is not to challenge coding optimization; it is to understand whether the new visibility is translating into better maternal health outcomes, predictable plan performance, and clinically aligned reimbursement.*

Midyear action step: Employers should use this window before the coding transition on January 1, 2027 to evaluate their full maternity strategy, including carrier programs, care management resources, maternity navigation, doula support, postpartum care, and whether network strategies and clinical resources are aligned. Organizations that act now to improve maternal health outcomes will be better positioned to manage both clinical risk and future cost escalation in 2027.

Where does your plan stand at the halfway point?

Alliant's midyear plan review identifies where cost is concentrating in your specific population, which levers are actionable before renewal, and what a credible second-half strategy implementation looks like.

Request a mid-year review

> *Most advisors help employers manage complexity. Alliant helps organizations redesign the ecosystem their population moves through — using data to diagnose, clinical expertise to intervene, and governance to measure financial and human impact.*

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