Anticipating Key Employer Trends Through 2025 for 2026

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For various reasons, 2025 marks a dynamic period of change for commercial employer-based plans preparing for 2026. The change is driven by the 2024 presidential election and subsequent government shifts and broader trends underway before and after the pandemic.

Nations around the world have been impacted by rising health care costs, which add pressure to social health systems. This added pressure poses challenges for employers managing health and well-being programs worldwide. From a macroeconomic and global population perspective, groups sought aligned and effective collaborations but often encountered partnerships or contracted relationships that fell short of being mutually beneficial. Specifically for health care, employers want cost-efficient, innovative solutions to aid or support business success.

DOUBLE-DIGIT COST INCREASES CONTINUE AT UNSUSTAINABLE LEVELS

US health spending increased by 7.5% to $4.9 trillion in 2023, driven by an 11.5% rise in private health insurance spending and a large increase in Medicare expenditures, according to a Centers for Medicare and Medicaid Services (CMS) report published in *Health Affairs*.[1]

The ongoing year-over-year rise in commercial health care costs is unsustainable for employers and other commercially insured and managed plans. Similarly, post-pandemic health care cost increases worldwide have raised concerns, prompting countries to seek more effective solutions to address the root causes of this trend.

Manufacturers and pharmacy benefit managers (PBMs) must adapt, change their business models, or face burdensome regulations and negative reactions to non-coverage or limits in use today.

KEY FRAMES FOR EMPLOYER COVERAGE POLICY IN THE US

For employers operating in the US, three major areas of policy could dramatically impact their ability to provide high-quality, affordable health coverage to their employees:

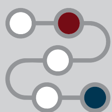
1. Safeguarding the tax-free status of employer health plan coverage;
2. Protecting ERISA preemption[2] and the ability to offer uniform coverage/programs nationally; and,
3. Empowering employers to hold vendors accountable through robust transparency and control over vendor fiduciary positioning.[3]

INSIGHT ON PATHWAY IMPLICATIONS FROM THE MACROECONOMIC PERSPECTIVE

Understanding the evolving health care landscape requires examining key macroeconomic stakeholders, pathway implications, and emerging trends. Regulatory and legislative shifts are shaping the commercial health care sector in significant ways. Government-driven changes, from Supreme Court rulings to shifts in presidential and congressional priorities, are redefining the regulatory environment. The recent overturning of the Chevron doctrine has altered how federal agencies interpret laws, while the 2024 election has already led to rapid policy adjustments. Meanwhile, legislative action at the federal level remains challenging, making state-level initiatives and pilot programs an increasingly viable avenue for policy experimentation.

Shifting Government Frameworks: Regulatory, Administrative, and Legislative Changes

Governmental landscape guardrail changes drive regulatory, administrative, or legislative framework change. In the 2024 case *Loper Bright Enterprises v Raimondo*, the Supreme Court



CLINICAL PATHWAY **CATEGORY**

Business Economic, regulatory, and policy shifts impact employer health benefits, making it a critical consideration for pathway developers and stakeholders navigating the changing health care ecosystem.

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overturned the Chevron doctrine, a 40-year-old precedent that required courts to defer to agency interpretations of ambiguous laws.[4] Implications of this decision changed the federal bureaucratic landscape for regulatory interpretations and rulings when law gaps or omissions occur.

With the transition of presidential and congressional leadership following the recent elections, there have been notable policy changes within the first month of the new administration. Legislative shifts will continue to be unlikely from a federal level through Congress to the states for two reasons: difficulties in getting federal legislation that may not have been proven effective through Congress and passed into law, and ease of developing legislation at the state level based on demonstration or pilot projects in the real-world marketplace.

Trends in the Commercial Health Insurance Landscape

The employer commercial health insurance landscape is impacting more areas of the country. Employers are taking a more active role in shaping health care, recognizing their responsibility as stewards of workforce health. As key drivers of change, they have fueled advancements in value-based care, patient experience, mental health, health equity, innovation, and transparency.

While employers must contemplate and contend with myriad dynamics, no stakeholder has a better track record than employers when making difficult decisions to meet the diverse needs of employees and their families. Supporting employer decision-making is a key opportunity for pathways and their developers. Ultimately, employers will drive the necessary collaboration among all stakeholders to achieve the collective goal of bringing affordable, high-quality health care to all employees worldwide.

The ever-increasing financial risk for commercial employer self-funded plans and those purchasing fully funded coverage continues to loom large on employers and remains a pressure point for market stakeholders. One result has been the risk mitigation trend as it moves from fully funded to self-funding. Despite that, key questions emanating from the cost of care concerns include:

1. Do employers and their vendors have a strategy to be prepared for this continuing shift in benefits?
2. How can medical care providers leverage pathways for optimal clinical efficiency utilizing evidence-based medicine?

Lack of risk predictability around the cost of care is another threat to plan financing. That and ineffective mitigation options coupled with the growth of high cost, but lower population volume therapies have created frustration within benefit design options. Among solutions, there remains a need for more frequent updating of evidence-based pathways for coverage decision-making. For example, employers may need to defend physical well-being programs, opening the door to more sophisticated approaches, including pathways/carepaths.

Key Performance Factors in Employer-Sponsored Health Plans: Mental Health, Engagement, and Business Challenges

The business landscape's key plan performance factors involving employers and employee benefit plan members include mental health, plan member engagement, and core business challenges.

Organizational culture continues to be a strong indicator of high-performing plans. Employers have made progress in addressing mental health, though challenges remain on the horizon for 2026, particularly regarding reducing stigma and boosting access to care. Mental health services have been integrated into primary care, directly at the worksite, and in clinical pathways (when applicable), and are widely available virtually.

This increase in access is promising but has contributed to mental health becoming one of employers' top five conditions driving cost. A range of mental health areas—including child and adolescent mental health, maternal mental health, loneliness, substance use disorder, and suicide—require ongoing focus. Employers must also focus on workplace policies, practices, and norms to protect mental health and reduce risk factors. While the cost and need for robust mental health services are an acute challenge in the US, addressing access, reducing stigma, and providing holistic approaches to mental health are priorities for employers with global workforces.[5]

Consumerism, holistic care coverage, and a lack of member self-care engagement continue to challenge employer plans. Without a strong health culture, employers continue to miss plan performance goals despite the growing desire for consumer-friendly plan offerings. Such disconnects impact preventative care benefits that can mitigate against chronic care, cancer, and novel high-cost solution use that fuels unpredictable plan risk dynamics.

In 2025, human resource and benefit leaders have an opportunity to re-evaluate their organizations' well-being initiatives,[6] especially as health care costs associated with chronic conditions continue to surge worldwide. Employers will use data to gauge how programs perform from a clinical, experience, and/or financial standpoint. Wherever possible, employers will highlight how well-being programs help their workforces to flourish and impact business outcomes such as productivity and retention. Oncology management programs, for instance, will be scrutinized due to the prevalence of cancer claims and the costs associated with novel therapies. To be successful, these programs must incorporate best practices; ultimately bridge the divide between traditional behavior change programs and health care benefits; and, rely on outcome-based contracts from vendors.

Vendor transparency and effective collaboration, or lack thereof, also continue to remain an issue. Employers and their vendors must ensure employees can access the right support at

the right time (and price), particularly for services embedded within a health plan's network. For example, novel specialty therapy solutions offer clinical support for patients with cancer, diabetes, autoimmune, and digestive health conditions. To better integrate all these solutions into the overall employee benefits experience, employers have advocated for these programs to be included as "in-network" services. However, many of these solutions are unknown to participants and difficult to access, becoming "lost in network." Employers must continue to push their health plan and navigation vendor partners to more readily communicate and promote these innovations. The plan year 2025 should see a sharp focus on holding health plans, specialty solutions, and navigation partners accountable to better integrate solutions and to make participants—employers and employees alike—more aware of them.

Employers will hold vendor partners to higher standards for transparency and achieving their fiduciary responsibility. To do that, employers will both reassess and streamline their vendor partnerships into the next year and hold vendors to a higher level of accountability for producing outcomes. Vendor data on benefit plan cost transparency, quality, and outcomes is critical to informed employer decision-making and must be accessible.

Further, employers will explore alternative approaches, including directly contracting with centers of excellence or others, promoting network arrangements that can engage employees toward high-value providers, and looking to emerging equity-based models to address affordability or innovative risk mitigation.

Profitability variation and business model shifts are a threat to all areas of the business, including health care benefits. Economy performance and consumer attitudes on spending can have a direct impact on the business of employers—positive or negative.

Employee benefit plans need to act like a business through its management program as part of a larger enterprise. They can do that by:

1. Seeking out the most productive vendors and collaborators to address the overall plan structure (eg, the purpose of achieving plan performance);
2. Focusing on the process that can deliver desired results, not just process itself; and,
3. Establishing incentives for innovation (eg, use quality improvement as a framework that can improve systems and processes).

SUMMARY FOR ACTION

The macroeconomic trends discussed are already moving and causing dynamic shifts in US health care. While they are important for all stakeholders in the US health care ecosystem, these trends are particularly relevant for employers and manufacturers. Additionally, it will be important for providers and pathway developers to focus on keeping up with novel therapies, supporting benefit transformation, and concentrating on results in 2025.

Rapidly increasing numbers of new therapies are reaching the marketplace out of the US Food and Drug Administration (FDA) approval pipeline, which will require patient care journeys, clinical pathways, and the ability to manage the economic risk associated with them. New and FDA-approved use extensions for existing therapies need up-to-date pathways that are utilized in benefit coverage decision-making.

Benefit transformation beyond simple coverage needs continued support as it evolves toward benefiting the patient for optimal holistic care. Lack of real-world supportive data to inform clinical pathways needs to be solved, and greater collaboration between manufacturers, developers of therapies, employer plan sponsors, and dominant commercial payers need to occur sooner vs later in development.

An overall focus on results by all developers, along with payers, must happen. All key stakeholders cannot remain stuck on structure, process, or outcomes—all classic management strategies for change. The most successful and productive companies understand how to balance risk with efficiency, which means, according to Merriam-Webster, an effective operation as measured by a comparison of production with cost. Employer plans need a focus on patient-centered cost-effective economic analysis to achieve a desired outcome at the lowest possible cost. Easily stated but difficult to execute in health care benefit design when each stakeholder perspective remains operating in a silo for the US market.

Government plan programs can learn the same lessons by re-evaluating how to measure costs through methods such as dynamic scoring—and how to measure the cost of big opportunities that get lost in the bureaucratic labyrinth. Achieving a balance of risk with efficiency can be its innovation pathway toward effectively meeting the challenges faced by market trends into 2026. ◆

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