THE BENEFITS CEO

2026 EDITION · FOR 20–500 EMPLOYEE COMPANIES

The 2026 Employer Benefits Playbook

The renewal levers, plan-design moves, funding frameworks, and compliance checkpoints we use to turn benefits from a runaway cost into a managed, strategic asset.

Smarter Benefits. Stronger Businesses.

A strategy brief by The Benefits CEO

23-PAGE GUIDE

BEFORE YOU START

Most employers don’t overpay because they’re careless. They overpay because they’re working blind.

Every page in this playbook exists to fix that. It's the same thinking we bring to client engagements — distilled into the moves you can start making before your next renewal cycle begins.

WHAT YOU’LL WALK AWAY WITH

The 9 renewal levers

With the exact language to use with carriers and brokers.

A pharmacy lens

The five Rx metrics that explain most of your cost trend.

A funding framework

Fully-insured vs. level-funded vs. self-funded, decided on data.

A compliance calendar

Month-by-month, plus a checklist and a self-scorecard.

CONTENTS

What’s inside

A LETTER FROM THE FOUNDER

Benefits deserve the same rigor as every other line on your P&L.

For most companies between 20 and 500 employees, health benefits are the second-largest expense after payroll — and the least managed. The renewal arrives, the number is bigger, and there's rarely time or data to do anything but sign.

I started The Benefits CEO because that's backwards. A CEO would never accept a double-digit increase on their biggest investments without challenging the assumptions, shopping the market, and reading the data. Benefits should be no different.

This playbook is the field guide I wish every employer had before renewal season. It won't replace a strategist who knows your specific situation — but it will change the questions you ask, and that alone is worth more than most increases.

Read it with a pen. Mark the levers you've never pulled, the metrics you've never seen, and the compliance items you're not sure about. Then let's talk about the ones that matter most for your company.

[Your Name]
Founder, The Benefits CEO

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PART ONE

Why your renewal keeps rising

Understand the forces moving your cost before you try to fight them. Trend is the tide — but it's not the whole story.

PART 1 · THE COST PROBLEM

The four forces behind your increase

Renewals feel arbitrary, but they're not. Four structural forces drive almost every increase — and knowing which one is hitting you hardest tells you which lever to pull.

1. Medical trend

The baseline rate at which care costs rise — running high-single to low-double digits. It compounds on your entire premium base every year, before any plan changes.

2. High-cost claimants

For a midsize group, one catastrophic claim — a transplant, a NICU stay, a specialty drug — can reshape an entire renewal. These are the rogue waves under the tide.

3. Provider consolidation

As hospitals and physician groups merge, price competition falls and negotiated rates climb. You feel it as "unit cost" creep you never agreed to.

4. Pharmacy & specialty

Specialty drugs and the GLP-1 wave are the fastest-moving line in the budget — used by few members, but consuming an outsized share of dollars.

The midsize blind spot

Companies between 20 and 500 employees are too big for the carrier's simplest pooled pricing and too small for the attention enterprises get. The result: enterprise-grade problems handled with small-business tools. The rest of this playbook is about closing that gap.

PART 1 · THE COST PROBLEM

The 5 numbers every employer should know

If you can't recite these from memory, you're negotiating from the dark. Ask your broker for each one — and notice how specific (or vague) the answer is.

01 Cost PMPM (per member per month)

Total plan cost ÷ members ÷ months. Your single best trend line. Track it over years, not in isolation.

02 Loss ratio

Claims paid ÷ premiums paid. Below ~75–80% and you may be subsidizing the carrier's margin — a signal to shop or change funding.

03 Your renewal trend vs. book trend

The increase you were quoted vs. the carrier's average. If yours is higher, demand the claims story that justifies it.

04 Generic dispensing rate (GDR)

Share of prescriptions filled as generics. A low GDR is money left on the table in the pharmacy line.

05 Employer contribution %

What share of premium you cover, by tier. The lever you fully control — and the one most tied to recruiting and retention.

02

PART TWO

The 9 renewal levers most employers never pull

Your renewal is a negotiation, not a number you accept. Each lever includes language you can use verbatim.

Levers 1–3 · Create competition

01 Market the plan — every year

Taking your group to competing carriers changes the conversation even if you intend to stay. An incumbent that knows you're shopping prices differently than one that assumes you'll auto-renew.

SAY THIS

"We're taking the plan to market this year as a matter of policy. We'd like your most competitive offer, not your opening one — we'll be comparing it directly against three alternatives."

02 Challenge the trend & pooling assumptions

Trend, pooling charges, and reserve factors are negotiable inputs, not facts. A point off the trend assumption compounds across your whole premium base.

SAY THIS

"Walk me through the trend and pooling factors in this renewal. Our own claims experience doesn't support that number — show me the data that does, or adjust it."

03 Put alternative funding on the table

Even raising level- or self-funding shifts the dynamic. A carrier that knows you're seriously evaluating an alternative has a reason to sharpen its pencil.

SAY THIS

"We're modeling a level-funded option alongside this renewal. If we stay fully-insured, the rate needs to reflect that we have somewhere else to go."

Levers 4–6 · Reshape the spend

04 Model plan-design changes before you need them

Small moves to deductibles, copays, or out-of-pocket maximums can offset much of an increase — but only if modeled early so you trade consciously, not reactively.

ASK FOR

"Show me three plan-design alternatives that each take 3, 5, and 8 points off the renewal — with the exact member impact of each."

05 Use network & steerage options

Narrow networks, tiered networks, and centers-of-excellence lower cost in exchange for steering members to efficient providers. Signaling openness gives the carrier room to offer a better rate.

ASK FOR

"Price this with a tiered or narrow-network option. We'll consider steerage if the savings are real and the disruption is manageable."

06 Separate and scrutinize pharmacy

Pharmacy is often the fastest-growing, least-examined part of the spend. Reviewing or carving out the PBM can unlock savings the medical carrier was never going to surface.

ASK FOR

"Break out our pharmacy spend separately. I want PMPM, specialty share, rebate flow, and whether the PBM contract is pass-through or spread-priced."

Levers 7–9 · Lock in the win

07 Redesign the contribution strategy

How you split cost across tiers steers enrollment toward efficient plans, protects lower-paid staff, and manages total cost without dumping the full increase on employees.

MODEL THIS

"Show me how a defined-contribution approach changes our total cost and the typical employee's paycheck across each plan tier."

08 Negotiate rate caps & multi-year terms

You can negotiate more than this year's rate. Caps on future renewals, multi-year guarantees, and locked admin fees turn a one-year transaction into budget certainty.

ASK FOR

"What will you put in writing on next year's cap? I'm willing to commit for two years in exchange for a guaranteed ceiling."

09 Win on timing & data

The earlier you start, the more of every other lever you can use. Walking in with your own claims and large-claimant data is the difference between negotiating and being told.

THE RULE

Start 120–150 days out. Leverage is a function of time and information — and both run out fast as renewal approaches.

PART 2 · RUN THE PROCESS

Your 150-day renewal timeline

Levers only work inside a disciplined process. This cadence consistently beats the auto-renewal — work backward from your effective date.

150 days out — Prepare
Pull experience and large-claimant data, define cost and design goals, and decide which alternatives you'll seriously consider.

120 days out — Go to market
Take the plan to competing carriers. Request alternative funding and plan-design quotes alongside the incumbent's renewal.

90 days out — Model & negotiate
Compare finalists, pressure-test assumptions, and open the negotiation with the incumbent armed with real competition.

60 days out — Finalize
Lock plan design and contributions with enough runway to communicate clearly to employees.

30 days out — Communicate
Run a clean open enrollment. Frame the changes around value, not just cost — your benefits are a recruiting asset.

The single biggest predictor of a good renewal is how early you start. Everything else in this playbook depends on having time on your side.

03

PART THREE

The funding decision

The highest-leverage choice most midsize employers never seriously evaluate. Decide it on data, not default.

PART 3 · THE FUNDING DECISION

Three ways to fund the same plan

The old rule — small groups buy fully-insured, big groups self-fund — is out of date. For 50–250 employees, level-funding is now often the smart middle path.

	Fully-insured	Level-funded	Self-funded
How you pay	Fixed premium	Fixed monthly amount	Actual claims + fees
Who holds risk	Carrier	Shared (stop-loss caps it)	Employer (stop-loss caps it)
Surplus in good years	Carrier keeps it	Refunded to you	Stays with you
Claims data	Rarely shared	Full visibility	Full visibility
Cash-flow variability	None	Low (capped)	Moderate
State premium tax	Applies	Generally avoided	Generally avoided
Best fit	Smallest / highest-risk	50–250, healthier groups	250+ with risk appetite

The real unlock isn't the surplus — it's the data

The moment you move off fully-insured, you start receiving the same claims and pharmacy detail the carrier has used to price you all along. That visibility is what makes every other lever in this playbook sharper.

The funding decision framework

Five questions to tell whether alternative funding deserves a serious model this year. The more you answer "yes," the stronger the case.

01 Do you have 50+ enrolled employees with stable headcount?

Scale and stability make claims more predictable and stop-loss more affordable.

02 Is your workforce healthier or younger than average?

If so, fully-insured pooling may be making you subsidize less-healthy groups.

03 Can you tolerate modest month-to-month variability?

Costs can run to the funding cap in a bad month — still protected by stop-loss.

04 Do you actually want the data — and will you use it?

The advantage is wasted if no one reviews utilization and acts on it.

05 Has your loss ratio been consistently strong?

A low loss ratio under fully-insured is a flashing sign you're leaving savings behind.

Three or more yeses? Alternative funding is worth a real, side-by-side model this renewal — read the stop-loss contract terms (attachment points, lasering, run-in/run-out) carefully before deciding.

04

PART FOUR

Pharmacy & plan design

The fastest-growing line in your budget — and the one most employers can't yet read.

PART 4 · PHARMACY

How to read your Rx spend

When you get a pharmacy report, most of it is noise. Find these five numbers first — they explain most of your trend.

- **Pharmacy PMPM.** Your headline Rx trend line. Track it over time, not in isolation.
- **Specialty as a share of dollars.** Often a tiny share of prescriptions but a huge share of spend. The gap shows where the pressure is.
- **Generic dispensing rate (GDR).** Higher is better — the clearest sign the plan steers toward lower-cost equivalents.
- **Top therapeutic classes.** Which categories drive spend, and how much is GLP-1s. Where the real decisions get made.
- **Rebates — and where they go.** How much manufacturer rebate flows back to your plan versus staying with the intermediary.

The PBM transparency problem

Traditional PBM contracts can earn margin in ways you never see — spread pricing, retained rebates, and elastic definitions of "generic" and "specialty." Moving to a transparent, pass-through arrangement is often the single highest-leverage pharmacy move an employer can make. You can't negotiate what you can't see.

Ask your PBM: Is our contract spread-priced or pass-through — and can you prove it? What share of rebates reaches our plan? What's our GLP-1 exposure and trajectory?

PART 4 · PLAN DESIGN

Plan-design moves that protect both sides

Good plan design lowers cost without gutting value. These moves protect the budget and the employee at the same time.

Right-size the plan menu

Offer a smart spread — a lean HDHP/HSA, a core PPO, and a buy-up — so employees self-select by need instead of everyone defaulting to the richest plan.

Pair an HDHP with a funded HSA

A lower-premium HDHP plus an employer HSA seed can beat a richer plan on total cost while building employee savings.

Add voluntary & supplemental

Accident, critical-illness, and hospital-indemnity coverage — funded by employees — fill gaps and feel like a raise at little employer cost.

Steer to high-value care

Telehealth, navigation, and centers-of-excellence lower cost and improve outcomes when the plan design nudges members toward them.

Set a deliberate GLP-1 policy

Decide coverage criteria intentionally — with clinical guardrails — instead of letting demand set your policy by default.

Audit your point solutions

Many employers pay for three tools that overlap with single-digit utilization. Consolidate to what employees actually use.

05

PART FIVE

Compliance, on a calendar

Treat compliance as a quarterly discipline, not an annual scramble. Here's the year at a glance.

PART 5 · COMPLIANCE

The annual compliance calendar

Exact dates vary by plan year and size — confirm yours — but the rhythm holds. Map these to your own plan year.

Window	What's due
Q1 (Jan–Mar)	Form 1095-C / 1094-C furnishing & filing (ACA); finalize prior-year payroll data.
Q1–Q2	RxDC prescription-drug data reporting (annual); Medicare Part D disclosure to CMS within 60 days of plan-year start.
Mid-year	Form 5500 filing for calendar-year plans (with extension as needed); non-discrimination testing check-in.
Annually	Gag-clause prohibition attestation; Mental Health Parity (MHPAEA) comparative analysis on file.
~60 days pre-renewal	Begin renewal process (see Part 2); refresh SPD/SBCs for any plan changes.
Open enrollment	Distribute SBCs, required notices (CHIP, WHCRA, Part D creditable coverage) and updated SPDs.
Ongoing	ACA affordability check vs. current safe-harbor %; new-hire eligibility & waiting-period tracking.

Why it matters now: recent transparency rules put fiduciary responsibility on the plan sponsor — you. Demonstrating that you shopped, compared, and decided prudently is no longer optional.

PART 5 · COMPLIANCE

The compliance checklist

Run this annually. If you can't confidently check a box, that's exactly where to start the conversation.

- [ ] ACA forms 1095-C / 1094-C filed & furnished
- [ ] ACA affordability tested vs. current safe harbor
- [ ] Form 5500 filed (or Schedule A data gathered)
- [ ] RxDC prescription-drug data report submitted
- [ ] Gag-clause attestation completed
- [ ] Mental Health Parity analysis on file
- [ ] SBCs distributed at enrollment & on change
- [ ] Medicare Part D creditable-coverage notices sent
- [ ] CHIP, WHCRA & required notices distributed
- [ ] SPD current and reflects all plan changes
- [ ] COBRA notices & process documented
- [ ] Section 125 / POP plan document in place

A missed filing is cheaper to prevent than to fix

Penalties for late or missed ACA, 5500, and RxDC filings add up quickly — and they're entirely avoidable with a calendar and an owner. If no single person owns this list at your company, that's the real exposure.

This checklist is a general guide, not legal advice, and is not exhaustive. Requirements vary by plan size, funding type, and state. Confirm your obligations with qualified counsel or your benefits advisor.

SCORE YOURSELF

Your benefits self-assessment

Check every statement that's true today. Be honest — the gaps are where the savings and the risk both live.

- [ ] We start our renewal at least 120 days before the effective date.
- [ ] We marketed our plan to competing carriers within the last 2 years.
- [ ] We can state our PMPM, loss ratio, and renewal-vs-book trend from memory.
- [ ] We've modeled level- or self-funding against our actual claims data.
- [ ] We know our pharmacy PMPM and whether our PBM is pass-through.
- [ ] We have a deliberate, written GLP-1 coverage policy.
- [ ] One named person owns our annual compliance calendar.
- [ ] We hold quarterly or mid-year reviews — not just an annual renewal.

6–8

Strong. You're running benefits like a CEO. Let's find the last few points.

3–5

Real upside on the table. A focused engagement pays for itself quickly.

0–2

You're likely overpaying and over-exposed. Start with a strategy call.

Whatever your score — the next page shows exactly how to turn it into a plan. The lower the number, the more there is to gain.

Now let's put it against your actual numbers.

Book a 30-minute strategy call. We'll review your current program, flag the biggest cost and compliance risks, and show you which levers move the needle most — no obligation.

Book a Strategy Call →
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↓ 18%
avg. reduction vs. initial renewal

98%
client retention rate

20–500
employees — our focus

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