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How Healthcare Shifts Will Affect Employer Costs

by Michael Rachesky, Regional Vice President of Sales

The employer-sponsored healthcare market is rapidly shifting, and businesses are feeling it first. Policy change, post-pandemic hospital economics, pharmaceutical expansion and shifting consumer behavior are all contributing to a volatile cost environment. These healthcare shifts will impact employers both large and small.

Understanding these forces and acting early will be essential to protecting budgets and maintaining plan value.

A Post-COVID Financial Hangover

Today's cost landscape cannot be separated from the pandemic's lingering effects on health systems. During COVID-19, hospitals postponed elective procedures—their most reliable revenue source—and faced an unprecedented workforce crisis. Burnout and staff shortages forced providers to offer costly retention bonuses, raise wages and rely heavily on temporary contract labor, such as travel nurses. These short-term fixes drove labor expenses sharply higher, compounding elevated supply costs.

Insurers and public payers infused billions into health systems to stabilize them. Those temporary lifelines now factor into renewed rate negotiations as providers seek to recover lost margins, resulting in tighter carrier underwriting and rising renewal costs for employers.

The Maryland Model in Transition

Maryland provides a clear example of how policy shifts can reshape employer health costs. For decades, the state's Health Services Cost Review Commission (HSCRC) has overseen an all-payer model setting uniform hospital rates for Medicare, Medicaid and commercial insurers. As a result, overall hospital spending has remained below national averages.

That structure is evolving. In 2026, Maryland will implement the federal States Advancing All-Payer Health Equity Approaches and Development (AHEAD) model. While HSCRC will retain some rate-setting functions, its authority will narrow as the state transitions toward broader population health and total cost-of-care targets set by the federal government.

Because employer plans nationally pay roughly two to three times Medicare rates for comparable services—while Maryland's all-payer model has long kept commercial reimbursement near parity—any shift toward national pricing levels would represent a dramatic increase in employer costs. Even modest adjustments could create significant upward pressure on premiums. Multi-state employers may also feel indirect effects as carriers reprice Maryland network costs across broader risk pools.

Although the AHEAD model takes effect on January 1, 2026, the transition of HSCRC responsibilities will continue through 2028, giving employers a rare opportunity to plan ahead. Early market projections indicate potential premium increases of around 20% for Maryland-based employees once these changes take full effect, reinforcing the importance of proactive, strategic preparation.

National Headwinds That Amplify the Challenge

The Maryland transition is a microcosm of what's happening nationwide. Several factors are compounding the upward pressure on employer health costs:

Rising pharmaceutical and specialty drug spend

GLP-1 medications, now widely prescribed for obesity and cardiovascular risk reduction, are driving significant pharmacy cost increases. Broader coverage could raise premiums by 5-14%, depending on program design and utilization. Employers are applying new coverage criteria and behavioral support programs to manage access without limiting appropriate care.

Care avoidance and deferred care

Even before the pandemic, delayed preventive screenings and inconsistent chronic condition management drove avoidable, high-cost claims. As members return to care later and sicker, more advanced diagnoses and higher-cost interventions are increasing overall claim severity.

Provider consolidation and the risk of deteriorating care

Ongoing mergers among hospitals and physician groups, often backed by private equity, are reshaping the delivery landscape. Larger systems can standardize processes and technology, but consolidation and investor-driven ownership can prioritize financial returns, raising negotiated rates and, in some cases, reduced staffing levels that affect quality and outcomes.

Policy and subsidy uncertainty

If Congress does not extend the enhanced Affordable Care Act premium tax credits (eAPTCs) set to expire at the end of this year, individuals receiving subsidies on the marketplace will face higher premiums. Many may forgo coverage or move to a spouse's employer plan instead. For employers that share costs for spouses and dependents, this shift could increase total benefits spending and add new budget uncertainty.

What Employers Can—and Should—Do Now

Employers cannot control macro trends, but they can take specific actions to limit the impact on their health plans.

1. Engage in scenario planning
Work with advisors to model renewals under multiple scenarios. Identify where employees seek care and how much spending is concentrated in high-cost regions—especially states facing policy transitions like Maryland. Include 2026 budget discussions with your CFO to prepare for potential policy shifts, such as the expiration of marketplace subsidies or enhanced tax credits.

2. Deploy smarter healthcare navigation
Guidance that points employees to high-value physicians, centers of excellence and evidence-based care reduces wasteful utilization. In a market where consolidation limits choice and transparency, navigation programs help employees identify quality care options. When paired with well-structured plan designs, these programs can lower total spending while improving the employee experience—often resulting in richer benefits and better outcomes.

3. Rebaseline aggressively

Before larger escalations set in, pursue near-term savings. Every dollar saved today lowers tomorrow's baseline. Potential levers include:

- Pharmacy benefit redesign that negotiates stronger PBM terms, tightens formularies and considers specialty carve-outs
- Early investments in long-term employee health, such as GLP-1 coverage for weight loss, which may increase short-term costs but can lower medical trend over time
- Preventive care incentives that refresh annual wellness exams and lab work to identify issues early and avoid costly interventions
- Data-driven provider performance programs that guide members to high-quality, cost-efficient physicians

4. Evaluate self-funding and reference-based pricing strategies

As regulatory rigidity loosens, self-funding and reference-based pricing become more viable. For the first time, reference-based pricing may represent a practical option for Maryland-based employers, offering an alternative to traditional contracts. Both approaches provide deeper claims transparency, greater contracting flexibility and stronger control over cost variation.

5. Communicate transparently

When rates rise, clear messaging matters. Position increases as a response to market pressures, not discretionary cuts. Explain the steps being taken to protect value and encourage the use of high-value care. A straightforward, well-framed narrative can reduce backlash and drive cost-conscious behaviors.

While some policy reforms may eventually improve sustainability, current trends point to higher costs and greater volatility. Employers cannot control regulation or drug pricing, but they can control preparedness. Early planning, awareness of policy shifts and proactive cost management will sustain benefits and strengthen long-term stability.

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