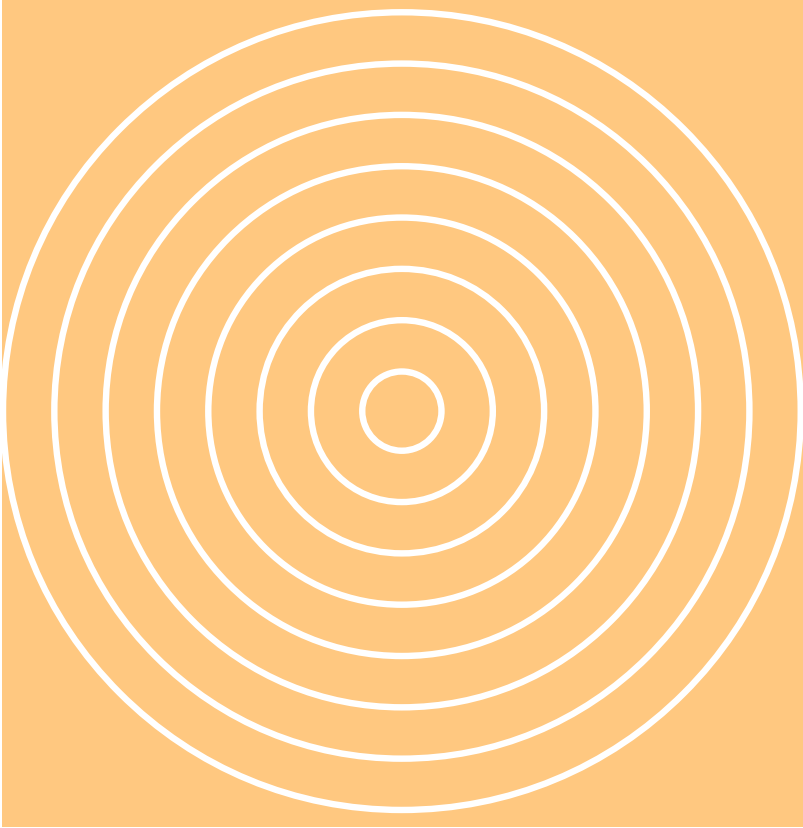




WHITE PAPER

Health Plan Renewals:

Rethinking One of an Employer's Costliest Business Decisions



imagine360

For years, health plan renewals have followed a familiar pattern: Employers received their renewal, reviewed options with their broker, negotiated where they could and made plan changes before open enrollment. The process focused largely on one question: how much of the coming year's increase could the organization absorb or pass on to employees?

That approach is becoming increasingly difficult to sustain. Healthcare costs have continued to rise faster than wages and inflation, and employers face growing pressure from cost drivers that traditional plan changes alone struggle to influence, including hospital prices, pharmacy spending and specialty drugs.

At the same time, employees are already carrying a larger share of healthcare costs through premiums, deductibles and out-of-pocket expenses, leaving employers less room to shift additional costs without affecting affordability or access to care.

Each renewal now carries greater financial consequences. A double-digit increase can strain budgets, margins, hiring plans and other investments. For employees, higher premiums or cost sharing can make an already expensive plan harder to use. As Rachel Hawkins, founder and owner of Angler Insurance, described it, "What once may have been an occasionally difficult renewal has become a recurring cost challenge that more CEOs and CFOs are paying attention to because the implications extend well beyond benefits."

Yet many employers still enter renewals with the same limited set of options: absorb more of the increase, shift more costs to employees, negotiate for a lower increase, or make incremental plan design changes. Those approaches may provide temporary relief, but they do little to address the cost dynamics that lead to another difficult renewal the following year.

That changes the purpose of annual renewals. Rather than viewing renewal only as the point when next year's rates and plan design are finalized, employers can use it to evaluate whether their healthcare strategy is still delivering value for their organization and employees. That means looking beyond the percentage increase to understand cost drivers, employee financial pressure, available decision-making data and the range of strategies available.

Employers are making high-stakes renewal decisions with limited visibility into what is driving increases

According to a recent survey, rising healthcare costs remain a significant concern for employers, with one finding standing out: many still lack a clear understanding of why their health plan costs increase. That uncertainty makes it difficult to determine whether higher costs stem from onetime events, pharmacy trends, provider pricing, utilization patterns, or structural issues within the health plan itself.

The reality behind today's renewal decisions¹

52% of employers are reporting cost increases of 7% or more for 2026 – even after negotiating with carriers or making plan adjustments

28% are unsure what things are driving their health plan increase

42% are responding to renewal increases by increasing employee contributions, and 22% changed plan design

66% have concerns about employee affordability, which has limited the changes employers were willing to make during renewal and highlights how difficult it has become to rely on higher deductibles and greater cost sharing

“For a long time, employers could afford to think about healthcare once a year. An employer would sit down with its broker, review a few options, and make a decision. Today employers are asking different questions: What’s driving the cost? Why are we paying as much as we’re paying? Where is the data? What can we do differently?”

—RACHEL HAWKINS

Founder and Owner of Angler Insurance

When the numbers don’t add up

For employers approaching another health plan renewal, the challenge is no longer just negotiating the annual rate increase. It is managing years of healthcare costs rising faster than wages, inflation and employers’ ability to absorb them. According to industry research, when employers renewed plans for 2026, initial increases averaging 9.2% were common.² Even after employers made cost-cutting changes, average health benefit costs were still expected to rise 6.7% — the highest increase in 15 years.³

The impact extends well beyond a single renewal cycle, and the pressure compounds over time. In 2025, the average annual cost of employer-sponsored health insurance reached \$17,496 per employee — up 6% in a single year⁴ and again outpacing both inflation and wage growth. That figure is expected to exceed \$18,500 in 2026.⁵ Each renewal therefore starts from a higher cost base, making even a moderate increase more consequential to budgets and long-term planning.

Healthcare’s relationship between price and value makes the economics even harder. Unlike most major business expenses, the price paid for a healthcare service can vary considerably from one provider to another without a corresponding difference in quality. Studies have shown that commercial health plans often pay substantially more than Medicare does for the same services,⁶ and prices for identical procedures can vary dramatically across hospitals within the same market. Without greater visibility into those underlying prices, employers have little capacity to determine whether a renewal increase reflects higher utilization, higher prices, or both.

And many employers still do not have that visibility. Surprisingly, a 2026 employer survey found that 28% of respondents were unsure of the primary factor driving their medical plan increase — the largest single response.¹⁰ In other words, employers may know how much more they’re being asked to pay without knowing whether the increase reflects utilization, catastrophic claims, pharmacy, provider pricing or another factor.

Healthcare prices don’t always reflect value

**254% of
Medicare⁷**

Employer-sponsored health plans pay hospitals an average of 254% of Medicare reimbursement for the same inpatient and outpatient services nationwide, with prices often exceeding 300% of Medicare in several states.

**3× price
variation at the
same hospital⁸**

Researchers analyzing federal price transparency data found that prices for the same billed charges can vary 3 to 4x even at the same hospital, depending on the negotiated contract.

**\$15,000–\$50,000
for the same knee
replacement⁹**

Based on hospital price transparency data, the price for a total knee replacement can range from approximately \$15,000 to \$50,000, which illustrates how dramatically prices can vary for the same procedure.

The shifting dynamics reshaping renewal decisions

That lack of visibility changes the nature of renewal. When employers cannot clearly identify what is driving healthcare costs, renewal becomes more than a benefits discussion; it becomes a business decision that affects budgeting, workforce planning and long-term financial strategy. The following dynamics show why renewal conversations now require broader leadership attention, stronger advisor support and better information throughout the year.

Healthcare renewal is now an executive suite decision

Rising costs affect hiring, compensation, profitability and long-term planning, making renewal a business issue that now requires executive oversight

33%

of CFOs now rank health benefit costs among their organizations' top three operating expense concerns — up from 19% in 2024.¹¹

“The numbers don’t lie. Employers need to dive deeper into the data and ask why they’re paying what they’re paying — not just accept another increase.”

—PETE SALVESON

Vice President of Revenue Operations, Imagine360

Health plan brokers and advisors are taking a more proactive role

Employers need advisors who can help them understand what is driving costs throughout the year, not simply explain the renewal once it arrives. Instead of treating increases as inevitable, brokers can help employers ask more strategic questions: Why are costs increasing? Which drivers can be influenced? Are employees getting value from the plan? Does the current model support long-term financial goals?

“Employers should ask whether their partner brokers are helping them gain greater visibility into and control over healthcare spending. Are the brokers reviewing data throughout the year? Are they bringing new ideas and strategies to the table? Are they willing to challenge the way things have always been done?” – Rachel Hawkins

The demand for better information is greater than ever

Better renewal decisions start with better visibility. Employers need this information so they can monitor claims, pharmacy trends and other emerging cost drivers throughout the year, giving them more time to identify patterns, evaluate alternative solutions and make more strategic decisions.

“Data is frustrating. Even as employers have better access to data today, they still don’t get all of the information they need. They receive reports that point to trends, but not enough detail to understand what’s really driving costs or to make well-informed decisions.” —William Buckley, Regional Vice President of Sales, Imagine360



Employers are feeling trapped at renewal time

Historically, employers could respond to difficult renewals with predictable adjustments: higher deductibles, increased employee contributions, plan design changes or utilization programs. One survey found that 55% of employers made cost-cutting changes when renewing for 2026, while another found that 59% planned changes to reduce healthcare cost growth, often through higher deductibles or other employee cost sharing.¹² This leaves many workers with coverage that is harder to afford or use.

When familiar renewal tactics stop working

Together, these dynamics leave employers with less flexibility at renewal and greater pressure to understand what is truly driving the increase. If familiar responses mainly shift costs or manage isolated categories of spend, the next question is whether those traditional levers are still strong enough to change the underlying trajectory.

More than half of large employers expected to make plan changes that would increase employees' share of healthcare costs.¹³ Yet employers also say they remain committed to competitive benefits, underscoring the challenge of controlling costs without making coverage less affordable.

Why traditional cost-saving levers are failing

For years, employers have responded to difficult health plan renewals with a familiar set of cost management strategies: higher deductibles, wellness programs, narrower networks, centers of excellence, pharmacy controls, and newer point solutions such as telehealth. Many of those approaches can indeed produce savings in specific areas or improve access to care. But as renewal increases continue to compound, their limitations are becoming harder to ignore. Most traditional strategies are designed to manage utilization, shift costs or target specific spending categories – not materially change the underlying price of healthcare.

That distinction matters at renewal time. A strategy that reduces one category of spending by 5 or 10% may moderate an increase, but it does not necessarily change the long-term cost trajectory. Employers can make multiple plan changes and still face another substantial increase the following year. The question is not whether these strategies have value, but whether they are powerful enough to materially affect one of the organization's largest and fastest-growing expenses.



HIGH-DEDUCTIBLE HEALTH PLANS: Shifting more of the increase to employees

High-deductible health plans (HDHPs) have long been used to reduce employer premiums and encourage employees to be more cost-conscious. The initial economics can look attractive: lower premiums, reduced utilization, and an immediate reduction in plan costs. But those savings usually come from shifting a larger portion of healthcare spending to employees rather than from reducing the underlying cost of care.

That shift makes HDHPs harder to rely on as a renewal strategy. Employees already facing higher premiums and out-of-pocket costs have limited capacity to absorb another increase. Research shows that employees enrolled in HDHPs were substantially more likely to report cost-related barriers to care, which can lead workers to delay – or avoid – treatment.¹⁴ As deductibles rise, employers risk offering a benefit that costs less on paper but is harder for employees to use when they need care.

At renewal time, the bottom-line limitation is straightforward: an increasing deductible can change who pays the bill, but it does not change what providers charge.



RISING PHARMACY COSTS: Consuming more of employer healthcare spending

Traditional renewal strategies also struggle to keep pace with pharmacy, one of the fastest-growing areas of healthcare spending. Employers use formularies, prior authorization, step therapy, site-of-care optimization and specialized sourcing to manage utilization and steer employees toward lower-cost therapies. But these approaches are struggling to keep pace with rapid growth in specialty drugs, GLP-1 therapies and other high-cost medications, which are consuming growing shares of employer healthcare spending.

Pharmacy now accounts for 24% of employer healthcare spending, and employers project pharmacy costs will increase another 11 to 12% in 2026.¹⁵ Nearly 8 in 10 employers report increased utilization of GLP-1 (glucagon-like peptide-1) medications and say that GLP-1 therapies are contributing to higher healthcare costs, which is reinforcing pharmacy's growing role in driving renewal increases.¹⁶

The challenge in managing these costs extends beyond this year's renewal. Many specialty medications and GLP-1 therapies represent recurring costs that can remain in a health plan for years. Employers therefore need enough visibility to distinguish between temporary claims volatility and long-term cost drivers that will continue affecting future renewals. Without that visibility, pharmacy becomes another area where employers know costs are rising but have limited insight into why.



Employers are responding with growing concern. In one survey, more than three-quarters (76%) report being very concerned about overall pharmacy costs; 58% cite the opacity of the pharmacy supply chain; and 56% worry about the lack of transparency in pharmacy contracting and rebates.¹⁷ Pharmacy spend isn't just growing; it's accelerating faster than any other category of health costs, and employers typically lack the visibility needed to understand what's driving it.

That visibility is why pharmacy management remains essential to renewal planning. Formularies, prior authorization, step therapy, site-of-care optimization and specialized sourcing can improve utilization and reduce unnecessary spending. But they do not necessarily change the economics driving pharmacy costs. Rebate arrangements, specialty medications and high-cost therapies can continue increasing employer spend even when utilization is well managed. At renewal, employers should distinguish between strategies that influence utilization and those that meaningfully reduce net medication prices.



WELLNESS PROGRAMS: **Limited impact on total healthcare spend**

Wellness programs have long been promoted as ways to improve employee health and lower healthcare costs. They may support a broader workforce strategy, especially when employers want to encourage healthier behaviors or strengthen engagement. But evidence that wellness programs materially reduce total medical spending remains limited.

In fact, a randomized, controlled trial involving more than 4,800 employees found no significant differences in healthcare spending, clinical outcomes, or overall medical utilization after 24 months among employees offered a comprehensive wellness program.¹⁸ That finding illustrates the problem when wellness is positioned as a renewal cost solution: healthier behaviors may be worthwhile objectives, but they do not directly address either provider pricing, pharmacy costs, or the high-dollar claims driving many employer increases.

For employers facing another substantial renewal, wellness initiatives can complement a health plan strategy, but they are unlikely to materially reset the cost baseline.

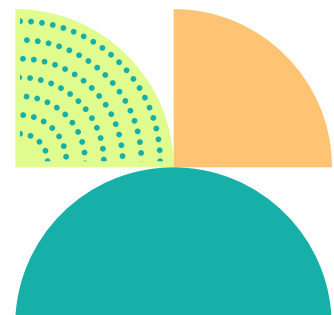


NARROW NETWORKS AND TIERED PROVIDER DESIGNS: **Savings with trade-offs**

Narrow networks and tiered provider arrangements aim to reduce costs by steering employees to selected providers or facilities. Combined with other steerage strategies, these designs can produce meaningful savings on certain procedures by directing care to lower-cost providers.

But the financial impact is limited by how much care can realistically be redirected. Employers must also weigh employee disruption when preferred physicians or hospitals fall outside the network. Effective tiered arrangements also require reliable cost and quality data – information many employers still lack.

That lack of visibility leaves employers with a difficult trade-off. Narrowing a network can reduce spending in targeted areas, but it does not necessarily change prices across the broader plan. Employers may accept more employee disruption for savings that moderate, rather than fundamentally alter, the next renewal.





CENTERS OF EXCELLENCE AND STEERAGE:

Meaningful savings, limited scope

Centers of excellence (COEs) can improve quality and reduce the costs of specific high-cost procedures by directing employees toward providers with demonstrated expertise and favorable pricing. For particular episodes of care, that can be a valuable strategy.

The challenge lies in scale. COEs typically address a defined set of procedures or conditions and therefore affect only a portion of total healthcare spending. Employers may realize meaningful per-episode savings, but the much larger cost base – consisting of hospital pricing, specialty pharmacy, chronic conditions, and other claims – continues to rise.

At renewal, COEs should therefore be evaluated for what they are designed to accomplish. They can improve the economics of specific categories of care, but they are unlikely on their own to offset sustained increases across the entire health plan.



TELEHEALTH AND EMERGING POINT SOLUTIONS:

Added access does not always mean lower cost

Telehealth adoption accelerated rapidly during the COVID-19 pandemic, and employers initially hoped virtual care would substitute for more-expensive settings such as emergency departments, urgent care centers, and specialist visits. Telehealth adoption has unquestionably expanded access for many employees – particularly those in rural or underserved areas. But real-world experience has made the cost story more complicated.

Virtual care has not consistently replaced higher-cost utilization. In many cases, it has served only to add another point of access while employees continue using other healthcare services as well. That means employers can gain convenience and accessibility without necessarily producing a corresponding reduction in total spend.

For renewal planning, the distinction is important. Telehealth care may improve the employee experience, but it should not automatically be treated as a significant cost-containment lever unless the employer can demonstrate that it is actually substituting for more-expensive care.

Renewal implications

None of these strategies is inherently ineffective. Many can improve specific parts of a health plan, reduce certain spending categories or improve access and quality. The problem is expecting them to solve a broader affordability challenge they were not designed to address.

When renewal increases continue despite years of cost-containment programs, employers need to ask a different question: Are we managing around the edges of healthcare spending, or are we addressing the costs driving the renewal itself? That is where the discussion moves from incremental plan adjustments toward strategies that affect the underlying price of care.

Gaining leverage: strategies to drive change

After years of responding to rising healthcare costs via incremental plan changes, employers are beginning to recognize that renewal also presents an opportunity to reconsider how healthcare gets purchased and paid for. New price transparency requirements, growing scrutiny by pharmacy benefit managers, and the emergence of more-transparent funding and payment models are giving employers and brokers new opportunities to challenge the status quo rather than simply negotiate another increase.

For many organizations, moving to a self-funded model is the first step toward regaining control over healthcare costs. Unlike fully insured arrangements, self-funding provides access to claims data and the flexibility to build a health plan around an organization's specific needs. Employers can select partners — including independent third-party administrators, pharmacy benefit managers, and other specialized vendors—that provide greater transparency, reduce administrative complexity, and support benefit strategies aligned with both financial objectives and workforce needs.

With such a foundation in place, employers can begin evaluating alternative approaches that address the underlying cost of care rather than simply managing annual increases. One example is reference-based pricing (RBP).

Unlike traditional, preferred-provider-organization pricing, RBP ties payments to rational, external benchmarks such as a fair margin above a hospital's Medicare reimbursement rate or costs. Rather than relying on negotiated discounts from inflated starting prices, employers gain a transparent methodology for understanding how healthcare services are priced and paid.

That transparency becomes particularly relevant during renewal. RBP offers employers an opportunity to approach the conversation differently. By establishing a transparent pricing foundation, employers can better understand where healthcare dollars are being spent, can reduce unnecessary variation in provider payments, and can align healthcare spending more closely with value.

Third-party experience confirms that employers implementing RBP-enabled health plans have achieved 20 to 30% savings compared with traditional health plan models. Through Imagine360's integrated RBP solution, employers can potentially realize up to 20% savings when RBP is paired with transparent pharmacy benefit management and other cost management strategies.¹⁹ Those savings create opportunities to reinvest in employee benefits, improve affordability, and strengthen long-term financial stability rather than simply absorb another renewal increase.

Changing the conversation

Traditional renewal strategies, including higher deductibles, wellness programs, narrow networks, and incremental plan design changes, have helped employers manage costs at the margins, yet healthcare spending continues to rise faster than most organizations can sustain.

Alternative models such as reference-based pricing change the conversation by addressing how healthcare gets priced rather than simply who pays more. For employers looking beyond another annual renewal negotiation, structural changes to their health plans may offer a more sustainable path to controlling costs while improving affordability for employees.

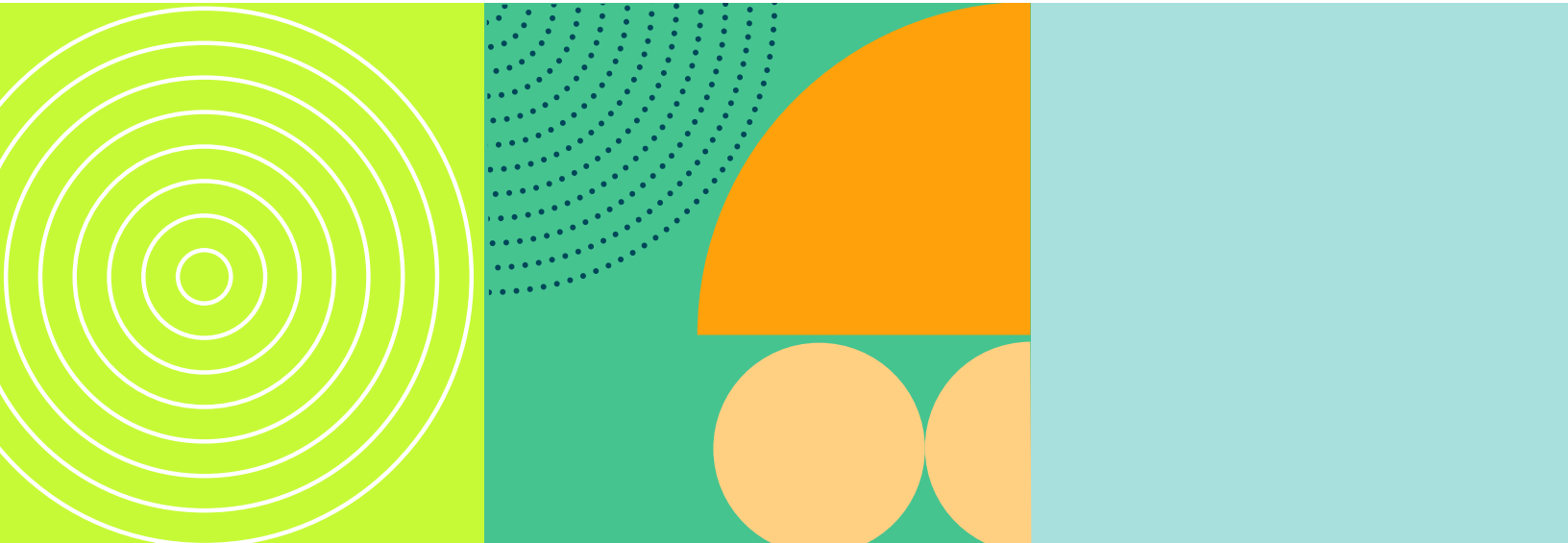
CASE IN POINT

Signature HealthCARE in Louisville, Kentucky, adopted an RBP-based health plan with Imagine360 after experiencing years of rising costs and lack of pricing transparency. The organization reports that the plan has resulted in more than \$11 million in net savings and 20% reductions in premiums and deductibles. The organization reinvested those savings in enhanced employee benefits, including subsidized childcare, tuition forgiveness, wellness programs, and expanded employee support.

[Download the case study](#)

“The healthcare market has changed significantly. It’s no longer just, ‘Here are your options: pick one of the big carriers.’ Alternative models are available today, and employers must ask more questions, have business conversations, understand what those options are, and not just rely on their brokers to give them the CliffsNotes.”

—WILLIAM BUCKLEY



How RBP changes the renewal conversation

TRANSPARENT, KNOWN PRICING

Plans that utilize RBP establish payments by means of fixed, transparent benchmarks rather than negotiated discounts from already-inflated provider charges. That payment method gives employers greater visibility into how healthcare services get priced as those employers evaluate renewal options.

LOWERING OF THE UNDERLYING COST OF CARE

Studies show that plans that access contracts based on hospital charges pay approximately 254% of Medicare reimbursement rates on average,²⁰ and RBP plan designs average payments closer to 140 to 160% of Medicare²¹ plus a fair margin, which reduces costs without sacrificing reasonable provider reimbursement.

TARGETING THE COSTS DRIVING RENEWALS

A relatively small percentage of high-dollar claims account for a disproportionate share of employer healthcare spending. RBP reduces the per-claim cost of those high-cost services by anchoring reimbursement to a Medicare-based benchmark and creating significant savings without requiring employers to redesign their entire benefit plans.

SHIFTING THE CONVERSATION FROM DISCOUNTS TO VALUE

Rather than asking whether a negotiated discount is sufficient, RBP enables employers and brokers to evaluate whether an underlying price being paid is reasonable. The results are greater transparency and increased confidence that healthcare dollars are aligned with value.

REVEALING PRICE VARIATION

Access to RBP data enables employers to identify and challenge significant pricing variation for identical services across providers. Such visibility helps employers better understand the cost drivers behind renewal increases.

REDUCING THE IMPACT OF CATASTROPHIC CLAIMS

Catastrophic claims are among the largest drivers of employer healthcare spending, and they can have significant impacts on future renewals and stop-loss costs. From 2022 to 2026, the frequency of million-dollar-plus claims increased by 46%, making high-dollar claims increasingly important considerations during renewal.²² RBP applies transparent, benchmark-based pricing to those high-cost claims, which helps employers reduce the financial impact of the claims while improving long-term cost predictability.

Conclusion: Renewal is an opportunity to change course

For many years, health plan renewal has been viewed as an annual purchasing exercise — a time to compare options, negotiate rates, and prepare for another plan year. Today's renewal environment demands a broader conversation. Employers have to know not only how much costs are increasing but also why. They need (1) greater visibility into the factors driving healthcare spending, (2) a clearer understanding of how those costs affect both their businesses and their employees, and (3) the confidence to evaluate whether their current approach remains the right one.

Fortunately, employers are no longer limited to the choices they had a decade ago. Greater pricing transparency, improved access to claims data, alternative funding arrangements, and innovative payment models have created new opportunities to take a more strategic approach to healthcare. By working with the right broker or advisor, employers can move beyond reacting to annual renewal increases and begin building health plan strategies that align spending with value and that support long-term business objectives.

The most-successful organizations won't necessarily be those that negotiate the lowest renewal increases this year. They'll be the ones that regard renewal as an opportunity to make smarter decisions — decisions that improve affordability, strengthen employee benefits, and put healthcare spending on a more sustainable path for years to come.

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About Imagine360

Imagine360 is a leading healthcare solutions provider that helps self-funded employers take control of their healthcare costs while delivering better experiences for members. With more than 18 years of expertise in reference based pricing (RBP) and health plan administration, Imagine360 develops fully integrated solutions that combine deep industry knowledge, data-driven strategies and concierge-level support for employers.

The company partners with employers, brokers and consultants to design and manage customized health plans that lower costs, increase transparency and improve outcomes — without compromising quality or access.

Backed by dedicated advocacy, legal protection and proven results, Imagine360 is reimagining what smarter healthcare can look like for organizations and their employees.

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