What Are the Projected Health Plan Cost Trends for 2027?

Projected Medical and Rx Trends Are Approaching 15-Year Highs

Segal

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Introduction

The 2027 *Segal Health Plan Cost Trend Survey* — our 30th annual survey of managed care organizations, health insurers, PBMs and TPAs — shares respondents' projections for 2027 cost trends for medical, prescription drug, dental and vision coverage. It also highlights key cost drivers and reports actual allowed health cost trends for 2025 based on respondents' group health plan experience.

Predicting medical cost trends remains inherently challenging due to the dynamic and interconnected forces driving healthcare spending. Pricing pressures, including provider consolidation, site-of-care shifts and aggressive pricing for specialty drugs and emerging therapies, often exceed historical assumptions. External factors such as regulatory changes and economic conditions further contribute to volatility and limit the predictive value of prior experience. A recent challenge is the rise of artificial intelligence (AI)-driven technologies that are reshaping billing practices and enabling more precise coding, often increasing provider reimbursements. In response, Segal enhanced its trend survey methodology to allow respondents to restate the 2026 forecasts they provided in 2025 for the 2026 survey based on more recent claims data, enabling a more accurate reflection of medical cost trends.

The survey, which we conducted during late spring to summer 2026, reflects input from organizations representing a substantial portion of the commercial insured and self-insured markets. In addition to trend forecasts, the report includes information about actual trends from Segal's SHAPE (Segal Health Analysis of Plan Experience) data warehouse.

Ongoing claims monitoring is critical for identifying emerging cost drivers in today's high-trend environment. Plan sponsors are prioritizing targeted strategies to manage cost trends and preserve affordability. This report highlights practical strategies to track, manage and mitigate rising healthcare costs over time.

Key Findings

Health plan cost trends are approaching 15-year highs, with prescription drugs and medical costs continuing to apply pressure on employer-sponsored plans. Key survey highlights include the following:

- Rx trend is projected to be 11.5 percent in 2027, driven by specialty therapies, expansion of glucagon-like peptide-1 (GLP-1) products and a continued shift toward a high-cost drug mix.
- Projected medical trends are near double digits, which are the highest projections in nearly 15 years, with minimal variation across plan types. The median projected trend for open-access PPO/POS plans is 9.9 percent for 2027.
- Dynamics driving medical trend vary by setting:
  - Hospital trend continues to be driven by price inflation (labor, supply and consolidation pressures). Hospital and physician costs are also driven by growing use of AI for coding.
  - Utilization is accelerating, particularly in physician, outpatient and behavioral health services, driven by expanded access.
- Ancillary trends remain stable, with dental (~3.5–4.5 percent) and vision (~1.5–2.5 percent) reflecting steady utilization and provider cost pressures.

In response, plan sponsors are placing greater emphasis on hard-dollar savings in the near term, prioritizing targeted, data-driven, cost-management efforts, including:

- Evaluating network strategy, such as centers of excellence and bundled payment programs
- Site-of-care optimization and network steerage
- Advanced analytics and AI for payment integrity
- Transparent and performance-based vendor and PBM contracting

What Is Trend?

Health plan cost trend is the measure of **changes in** allowed **per capita claims cost**. Allowed per capita claims cost is eligible billed charges (before participant cost sharing) less provider discounts.

What factors influence trend?

Trend reflects various factors, including:

- New treatments, therapies and technologies
- Medical price inflation, which impacts the cost of delivering care
- Provider consolidation
- AI-driven billing practices allowing more precise coding
- Increased treatment burden due to the aging population and rise in chronic conditions
- Social and economic factors, which can influence utilization or care decisions
- Greater emphasis on detection and diagnoses
- Implications of laws (e.g., unintended consequences of the No Surprises Act)
- Provider cost shifting
- Erosion effect of fixed-dollar deductibles and copayments

For our reporting purposes, trend does not include the impact of PBM rebates.*

What is the relationship between trend and increases in a plan's costs?

Although there is usually a high correlation between a trend rate and the actual cost increase assessed by an insurer, trend and the net annual change in plan costs are **not** the same. A plan sponsor's costs can be significantly different from projected claims cost trends due to such diverse factors as:

- Group demographics
- Impact of high-cost catastrophic claim events
- Participation in disease-management programs and wellness initiatives
- Regional market competition
- Changes in plan design
- Administrative fees
- Changes in participant contributions
- Impact of contract renegotiations or vendor changes

How do plan sponsors use trend projections?

Cost trend assumptions are one element that underwriters and actuaries use to project future costs for plan sponsors. The direction from prior years signals the sentiment about market condition influences. Those assumptions can help set future premium rates or self-funded claim costs for budgeting purposes. Trend projections can also be used to challenge vendor rate renewals.

* We discuss rebates on page 10.

Projected Medical Plan Trends and Cost Drivers

Medical Plans Covered in the Survey

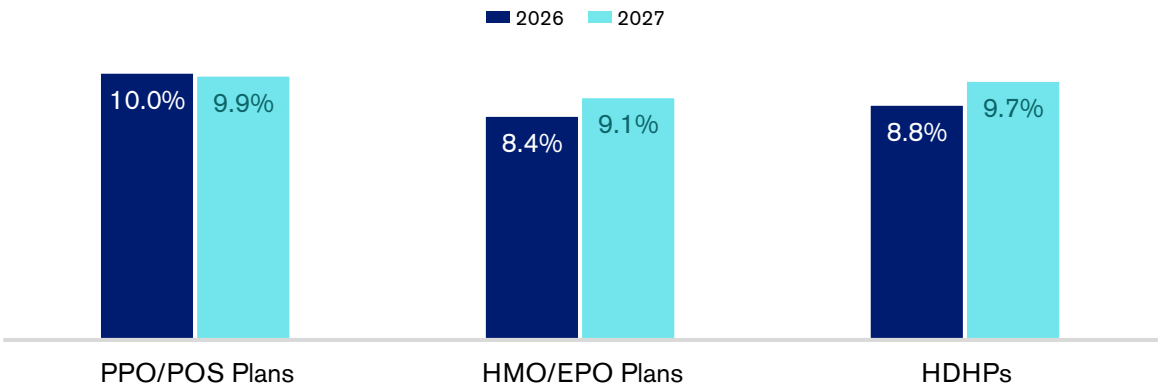
Three categories of active and early retiree coverage are tracked in the survey:

PPO/POS Plans

HMO/EPO Plans

HDHPs

Medical Trend Projections* for 2027 Are Approaching Double Digits, with Narrow Gaps Across Plan Types



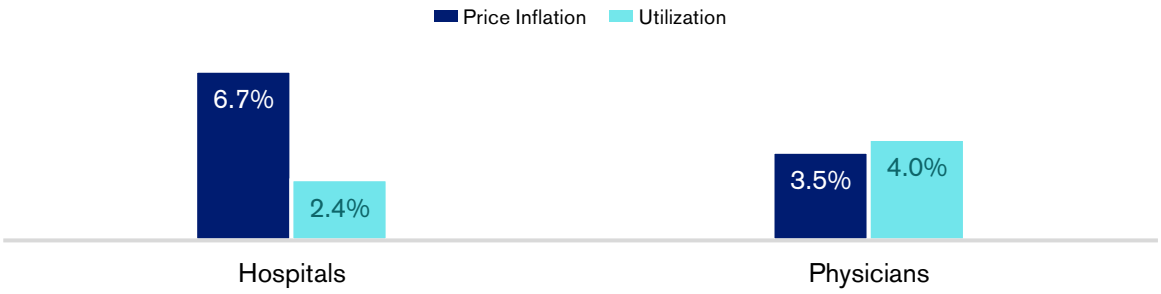
* Projections are for actives and non-Medicare retirees and exclude prescription drugs.

Source: 2027 *Segal Health Plan Cost Trend Survey*

How the cost of provider services is driving projected medical trends

The impact of price inflation and utilization on medical trend differs by the type of provider service. Under the current fee-for-service healthcare system, cost management efforts are failing to keep pace with tactics and technology used by the supplier side of the healthcare industry to drive spending (e.g., AI and direct-to-consumer ads).

What's Fueling 2027 Medical Trend Projections? As Was the Case in Last Year's Survey, Price Inflation for Hospitals, Utilization for Physician Services*



* "Hospitals" includes inpatient and outpatient hospital services combined. The components do not add up to totals for medical trends because there are other components of trend not illustrated, reflecting such factors as the impact of new mandates, treatments and technology changes. Not all survey respondents provided a breakdown of trend by component.

Source: 2027 *Segal Health Plan Cost Trend Survey*

Hospital price inflation remains a leading driver of medical trend, with cost pressures intensifying rather than moderating. Overall medical price growth continues to be driven by sustained increases in labor, pharmaceuticals and supply costs, alongside workforce shortages and ongoing operational inefficiencies. Hospitals report that workforce spending remains their largest expense, representing approximately 60 percent of total costs, with wages rising due to persistent shortages of clinical staff. Hospitals are treating patients with higher clinical acuity, requiring more staff time, monitoring and specialized care, which increases the cost per admission.

Utilization growth, particularly in physician and outpatient services, has also emerged as a significant driver of medical trend. Increased demand reflects rising behavioral health needs, an aging population with greater chronic disease burden and a higher proportion of patients presenting with more complex or advanced conditions. Providers facing sustained margin pressure from rising operating costs and constrained reimbursement are increasingly focused on revenue-preservation strategies, which may include greater service intensity through additional testing, procedures and follow-up care. These dynamics contribute not only to higher utilization, but also to increased intensity per episode of care, reinforcing utilization as a co-equal driver of overall medical trend.

We believe other factors driving medical cost increases in 2027 will include:

- **Private equity and consolidation.** Private equity (PE) is contributing to rising healthcare costs through a combination of price increases, utilization growth and technology-enabled revenue optimization. Evidence shows that PE-acquired practices charge higher prices and experience increased spending, while also delivering more services per patient and generating higher patient volumes. Consolidation strategies strengthen market leverage, driving higher negotiated rates.

- **Use of AI in billing.** The growing use of AI, particularly in coding, documentation and revenue-cycle management, often results in increased coding intensity and improved revenue capture per encounter, sometimes without corresponding clinical changes. A March 2026 Blue Cross Blue Shield Association/Blue Health Intelligence study found that expanded documentation often captures additional diagnoses or comorbidities without corresponding changes in treatment, making patients appear more clinically complex on paper. As a result, approximately 20 percent of inpatient cost growth (within a 9 percent overall increase) was driven by coding intensity rather than more care delivered.

- **Treatment of chronic conditions.** Costs continue to rise as more individuals live longer with chronic illness and an increasing share of the population has multiple conditions, significantly amplifying utilization and the total cost of care. A small number of conditions disproportionately drive this spending, led by cancer cardiovascular disease and diabetes, all of which are fueled by high-cost complications, acute events and expanding treatment intensity. Obesity further drives costs as a root cause of multiple chronic conditions.

- **Higher demand for mental health and substance use disorder services.** Utilization of these services continues to rise due to increased awareness, policy changes and expanded treatment options available. Insurers are also expanding provider networks, revising authorization requirements and adjusting reimbursement rates to meet mental health parity law, which increases both utilization and unit costs.

- **The independent dispute resolution (IDR) process.** The IDR process under the No Surprises Act is contributing to medical trend by increasing both reimbursement levels and overall system costs. Although it has effectively reduced costs related to surprise billing for patients, arbitration outcomes frequently favor providers, who won 88 percent of disputes, with payment determinations often three to four times higher than in-network rates. This dynamic raises the average allowed amount for out-of-network services and puts upward pressure on in-network contract negotiations, as providers gain leverage by threatening to go or remain out of network and pursue IDR. The volume of disputes has far exceeded expectations, reaching millions of cases, and has generated an estimated $5 billion in additional system costs since 2022, including higher provider payments and administrative expenses. These costs ultimately flow through to plan sponsors and premiums, making IDR not just a reimbursement mechanism but an emerging structural driver of price inflation and overall medical trend.

- **ACA changes and Medicaid.** These developments are expected to increase commercial health plan trends, as coverage shifts bring some higher need individuals into employer plans while others become uninsured, driving more uncompensated care and greater provider reliance on commercial pricing. Coverage disruptions suppress care in the near term but lead to higher acuity and costly events over time, reinforcing utilization and severity pressures.

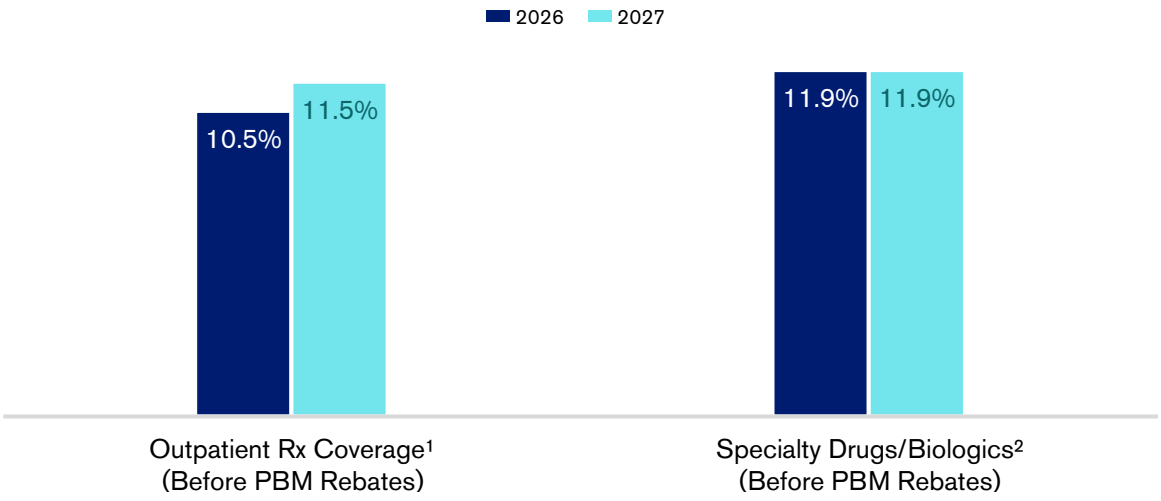
Deflators of trend partially offsetting these increases will include:

- Network optimization, steerage programs and centers of excellence, leveraging available data to direct patients to high-quality, lower-cost providers and reducing unnecessary or inefficient care
- Shift to lower-cost sites of care, including ambulatory surgery centers (ASCs), outpatient and home-based settings
- Value-based care and risk-based payment models, particularly in specialty care, with the potential to reduce avoidable spending and improve outcomes
- AI-enabled payment integrity and cost management tools, including predictive analytics, fraud detection and coding validation

Projected Prescription Drug Plan Trends and Cost Drivers

The projected cost trend for outpatient Rx plans for 2027 is 11.5 percent and continues to exceed other health benefit cost trends.

Prescription Drug Trend Is Projected to Stay in Double Digits for Outpatient Rx Coverage with Specialty Drugs Still a Significant Driver



[1] Outpatient Rx trend is for all prescription drugs (non-specialty and specialty drugs combined) for employer-sponsored plans for actives and non-Medicare retirees.
[2] Specialty drug/biologics trend is for outpatient specialty coverage. This data is for all coverage of specialty drugs for actives and non-Medicare retirees.

Source: 2027 *Segal Health Plan Cost Trend Survey*

What's Included in Outpatient Drug Coverage and What Are Specialty Drugs?

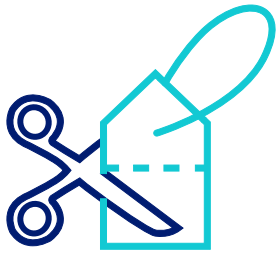
Outpatient prescription drug coverage, which is typically administered by PBMs, include generics, brand-name drugs, biosimilars and specialty drugs dispensed through retail, mail-order and specialty-management pharmacy channels.

Generally, there's an exclusion for drugs administered in a facility or physician office setting because of coverage through a medical plan. However, increasingly, health plans are moving specialty drug coverage to pharmacy benefits to better manage costs and utilization. Pharmacy benefits often allow for more structured management tools, such as prior authorization, step therapy and formulary control. Also, rebates billed under medical may not be realized by the plan sponsor and rebated savings should be captured when moving specialty coverage under pharmacy benefits.

Specialty drugs are generally high-cost drugs for rare conditions or those that require special handling. Often, they're given by injection or infusion.

Most specialty drugs are biologics, which are derived from viruses or living organisms and are significantly more complex and challenging to develop and manufacture compared to non-biologic drugs, resulting in their higher cost.

A biosimilar is a biologic drug that is "highly similar" to another biologic medication (commonly known as the reference or innovator product), which is already licensed by the FDA.



What Are Rebates?

Generally, rebates are payments made by drug manufacturers to PBMs and/or health plan sponsors for preferred formulary placement of certain brand-name drugs. However, other forms of drug manufacturer payments exist, including price inflation rebates, fees for access to drug-utilization data, grants for clinical studies and other fees.

Drug manufacturers and PBMs control the definition of rebates and other incentive payments, which require plan sponsors to set contractual minimum-payment guarantees to ensure they receive payment streams that are predictable and auditable.

Rebates

Prescription drug plan cost trends in our analysis exclude the impact of rebates. Rebates remain a significant offset to prescription drug spending for both specialty and non-specialty drugs, although their value varies widely based on PBM contract terms, formulary strategy, market competition and drug mix. Among survey participants reporting rebates paid to plan sponsors, the median rebate value represented 30 percent of projected 2027 prescription drug allowed costs.

Federal PBM reform enacted in 2026 is expected to materially reshape rebate economics over time. Under the Consolidated Appropriations Act (CAA) of 2026, PBMs serving covered group health plans and issuers will be required to pass through 100 percent of manufacturer rebates, fees and other remuneration to plan clients, with enhanced disclosure and audit rights. However, many of these commercial-market requirements do not take effect until 2028–2029. In Medicare Part D, related reforms delink PBM compensation from drug prices and rebate volume by moving compensation toward bona fide service fees rather than price-based remuneration. State-level reforms, such as spread-pricing bans, pass-through requirements and other transparency mandates, are adding pressure to traditional rebate-driven business models.

Cost-plus and other transparent pricing models reinforce this shift by emphasizing acquisition cost plus a defined fee or markup rather than relying on inflated list prices and retrospective rebates. While rebates are likely to remain important for many brand and specialty drugs, especially where formulary competition exists, the market is moving toward greater transparency, net-cost evaluation and fee-based PBM compensation. As rebate retention opportunities narrow, PBMs may seek to recapture margin through higher administrative fees, service charges, affiliate arrangements and other contract terms. Plan sponsors should therefore focus not only on rebate guarantees, but also on fee definitions, audit rights, pass-through provisions and total net cost of care. For more insights on the new requirements for PBM reporting and fee disclosures under the CAA, see our February 11, 2026 insight.

The leading driver of Rx trend is still drug mix

The primary driver of projected prescription drug trend is the evolving drug mix, characterized by increased use of high-cost, single-source, brand-name therapies and a continued shift toward more expensive treatment options. While offsets from patent expirations, biosimilars and other market dynamics are expected to moderate overall growth, they are not sufficient to fully counterbalance the upward pressure from this ongoing mix shift.

A major contributor is the continued introduction of new high-cost therapies, particularly specialty drugs, that are replacing lower-cost alternatives or expanding treatment into populations that previously had limited or no drug therapy options. Innovation remains especially concentrated in oncology, immunology, rare diseases and cell and gene therapy, where new products often carry very high costs and are increasingly used earlier in the course of treatment. At the same time, some newer non-specialty therapies are also increasing spending, by shifting treatment standards toward more effective but more expensive medications. See more on the impact of new drugs to market under insights of into actual prescription drug trends on page 22.

For non-specialty drugs, one of the most significant drivers of pharmacy trend is the continued growth of GLP-1 therapies for diabetes, obesity and related cardiometabolic conditions. These drugs have moved beyond diabetes management and are increasingly used for obesity, cardiovascular risk reduction, sleep apnea and other emerging indications, materially increasing the number of eligible patients and the duration of therapy. Industry reporting continues to identify GLP-1s as one of the largest contributors to pharmacy spending growth, with demand strong enough to reshape traditional drug trend and, in some cases, push traditional trend above specialty trend.

In our experience, outpatient Rx trend is also driven by the following factors:

- **New therapies for chronic conditions.** Over 76 percent of adults have at least one chronic condition. As such, drug trends are influenced by rising utilization of newer therapies for chronic conditions, including neurology, inflammatory disease and mental health, as treatment guidelines evolve and prescribers adopt more aggressive pharmacologic management earlier in disease progression.
- **Active drug pipeline.** There were 46 new approvals in early 2026, concentrated in rare diseases and oncology.
- **Accelerated launches.** Manufacturers continue leveraging expedited approval and orphan incentives to reach market faster and sustain margins.
- **Aggressive direct-to-consumer campaigns.** Direct-to-consumer awareness and social media-driven demand accelerates the uptake of newer, branded therapies even when lower-cost alternatives remain available.

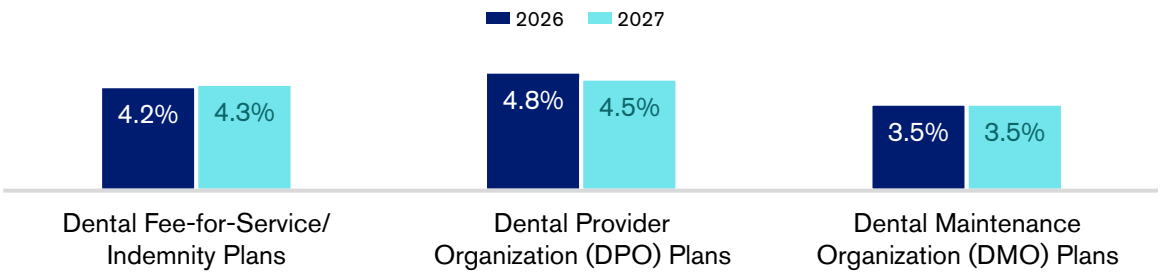
Factors that offset these cost drivers include:

- **Biosimilar adoption.** Biosimilars remain one of the strongest offsets to specialty drug trend, particularly in inflammatory conditions, oncology and supportive care. They are expected to continue lowering net cost where formulary adoption and provider uptake are strong.
- **Generic competition and patent expirations.** Patent losses and continued generic availability can lower net spending and help offset growth from innovation, particularly in traditional drug categories.
- **Utilization-management programs.** Prior authorization, step therapy, reauthorization, quantity limits and evidence-based coverage criteria remain important tools to control inappropriate use and improve affordability, particularly for GLP-1s and specialty products.
- **Tighter formulary management.** Exclusions, preferred product strategies and indication-based formulary decisions can redirect utilization to lower-net-cost alternatives and materially reduce trend.
- **Rising fiscal pressures.** Federal and state budget constraints are intensifying momentum for drug pricing and PBM policy action.
- **Cost-plus and rebate-free contracting models.** As the industry moves to cost-plus and other transparent pricing arrangements favoring lower-cost products without relying on rebate-driven economics, this change may help reduce net cost in selected categories over time.
- **Participant cost-sharing and benefit steering.** Well-designed participant incentives can help promote smart utilization and discourage use of higher-cost, low-value brands when lower-cost options exist, improving alignment between clinical value and plan spending.

Projected Dental Trends and Cost Drivers

Dental trends are projected to be at the same level in 2027 as they were in 2026.

2027 Dental Trends* Are Projected to Hold Steady



* We do not report a trend projection for dental schedule-of-allowance plans this year because we did not receive enough responses about that plan type.

Source: 2027 *Segal Health Plan Cost Trend Survey*

Dental cost trends are expected to remain in the mid-single-digit range (approximately 4.5 percent), with increases continuing to outpace general inflation. This growth is driven largely by provider cost pressures, including rising labor, supply and equipment expenses, which are contributing to higher fees. Increased consumer awareness and demand are leading to greater utilization, particularly for more complex and higher-cost procedures.

In response, plan sponsors are enhancing the value of dental benefits through improved participant engagement and more strategic plan design. This includes expanding access to user-friendly digital tools (e.g., mobile apps) to help participants better understand and use their benefits. Plan sponsors are also emphasizing network steering, transparency and education to guide participants toward high-quality, cost-effective care.

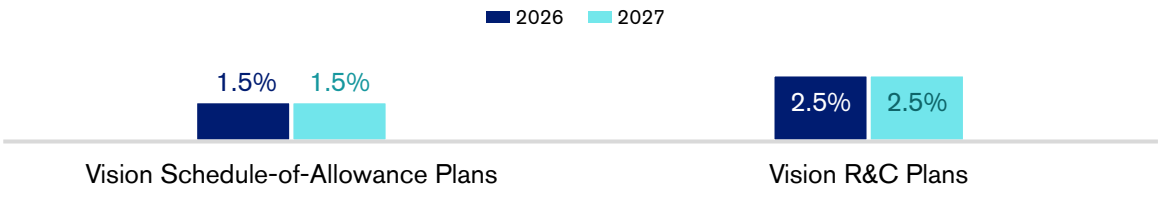
Projected Vision Trends and Cost Drivers

Survey participants' projected cost trends for vision plans, schedule-of-allowance plans and reasonable and customary (R&C) plans remain unchanged.

Vision care trends are being driven by rising digital demands and a growing recognition of vision as a gateway to overall health. With increased screen time and an aging workforce, employers are expanding vision beyond traditional coverage to address eye strain, productivity and preventive care.

Plan sponsors are modernizing vision benefits to align with employee expectations for convenience and personalization. Digital tools, tele-optometry and flexible plan designs (e.g., core coverage with voluntary buy-ups) are becoming more common. As a result, vision care is evolving from an ancillary offering into a high-value, strategic benefit that supports employee health, engagement and overall return on investment.

2027 Trend Projections for Vision Plans Are Consistent with 2026 Projections



Source: 2027 *Segal Health Plan Cost Trend Survey*

Projected Medical Trends for Medicare-Eligible Retirees and Cost Drivers

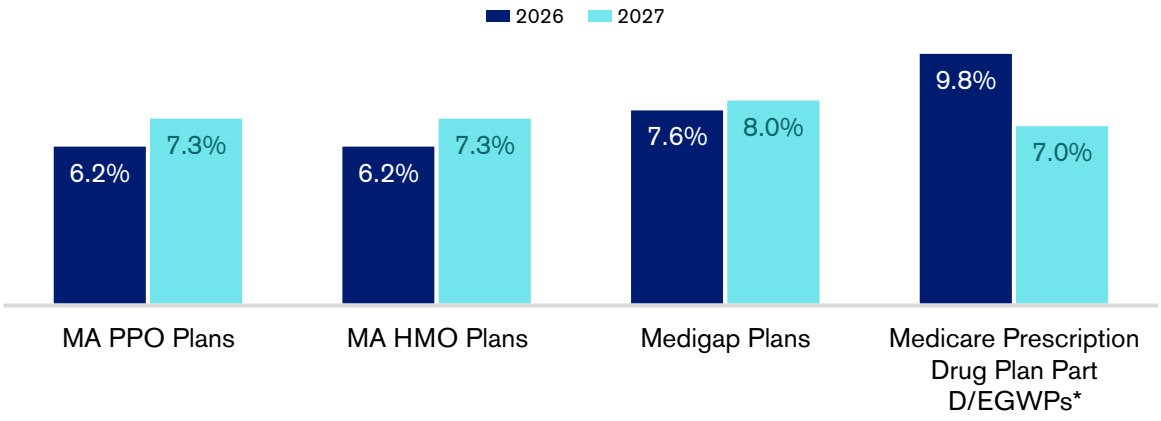
Respondents project that 2027 trend for Medicare Part D for Medicare-eligible retirees will be slightly lower than in 2026, while trends for Medicare Advantage (MA) PPO, MA HMO and Medigap plans are projected to rise.

MA PPO plans' trend are expected to rise slightly in 2027 due to a combination of medical, demographic, regulatory and business factors. Many MA insurers are reporting higher utilization for inpatient admissions and outpatient surgeries, which will carry over into 2026. In addition, hospital and physician groups continue to demand higher reimbursement rates because of wage inflation, staffing shortages, supply costs and technology investments. Even if general inflation moderates, healthcare labor costs remain elevated. Those costs flow through to MA claims expenses since the Center for Medicare & Medicaid Services (CMS) incorporates healthcare utilization and price trends into the MA payment calculations. CMS finalized the 2027 Medicare Advantage (MA) payment increase of 2.48 percent, with an effective increase closer to 5 percent, after accounting for risk score trends. This provided some relief to MA insurers compared with the earlier proposal, that would have been nearly flat.

Unlike MA plans, Medicare Supplement plans do not receive any subsidies from CMS but still experience the same cost drivers. Most Medicare Supplement plans insure older populations where claims frequency and severity rise.

Group Medicare Part D Plans, often called Employer Group Waiver Plans (EGWPs), are projected to see a decrease in 2027. While this may seem surprising, it appears the market has moved from uncertainty to experience. The Inflation Reduction Act effects are becoming more predictable now that the plans have more experience under the redesigned program. In addition, while the Medicare drug price negotiations do not eliminate trend, they can reduce the growth rate for some high-spend drug categories. This decrease does not necessarily signal lower drug costs, but signals that the market expects the rate of increase to moderate as the post-Inflation Reduction Act Part D environment becomes more predictable.

While Most 2027 Projected Trends for Medicare-Eligible Retirees Are Higher than 2026 Projections, 2027 Projected Medicare Part D Trend Is Lower than the 2026 Projection



* Medicare Prescription Drug Plan Part D/EGWPs trend reflects rebates, CMS subsidies and other offsets.

Source: 2027 *Segal Health Plan Cost Trend Survey*

Putting Trend Projections in Context

It is important to view medical trend projections within the context of a highly dynamic and evolving environment. As noted in the introduction, projecting future costs remains challenging given the influence of macroeconomic uncertainty, regulatory changes and shifting market dynamics, including provider consolidation, emerging technologies and evolving reimbursement models.

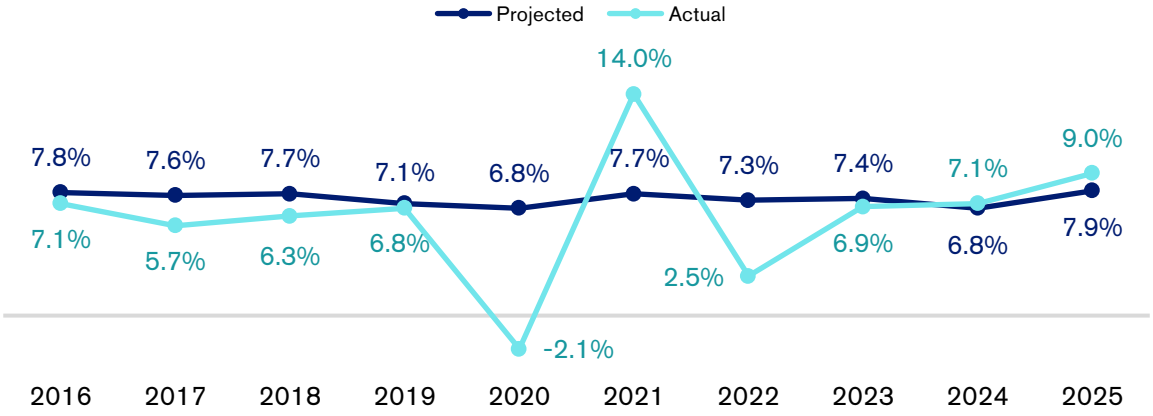
In recent years, these factors have introduced greater volatility into trend performance, with structural drivers such as price inflation, utilization growth and coding intensity exerting upward pressure on costs. As a result, projections do not always align with actual plan experience. Historically, underwriters and actuaries have tended to project conservatively; however, the increasing complexity and pace of change in the healthcare environment have made actual results more variable, with outcomes deviating in either direction depending on how these factors materialize within a given plan year.

2027 medical and Rx trend projections are the highest in nearly 15 years

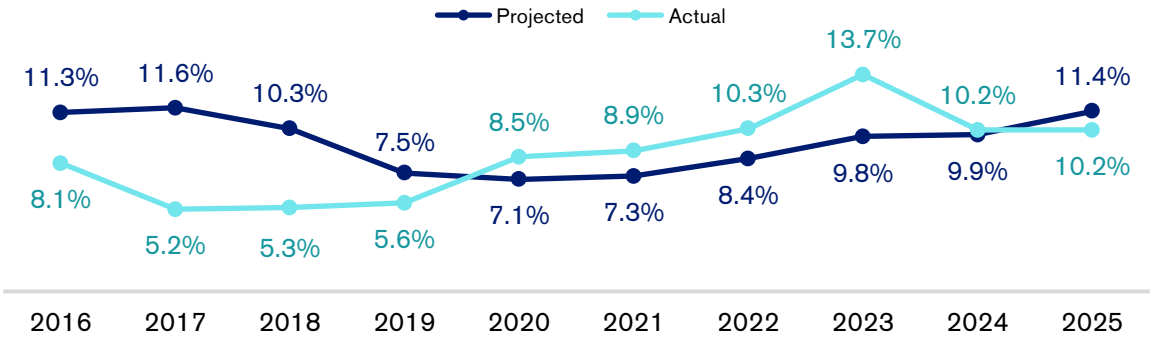
To assess the accuracy of trend projections, we compared 2025 projected trends for medical, Rx and dental plans from a prior survey to the actual average trends for 2025 (the most recent period for which actual data is available), as reported by the survey respondents. The graphs on the next page show those comparisons, as well as similar comparisons for the previous nine years.

When considering trend projections, plan sponsors should take into account this historical pattern of projected trend to actual trends over multiple years.

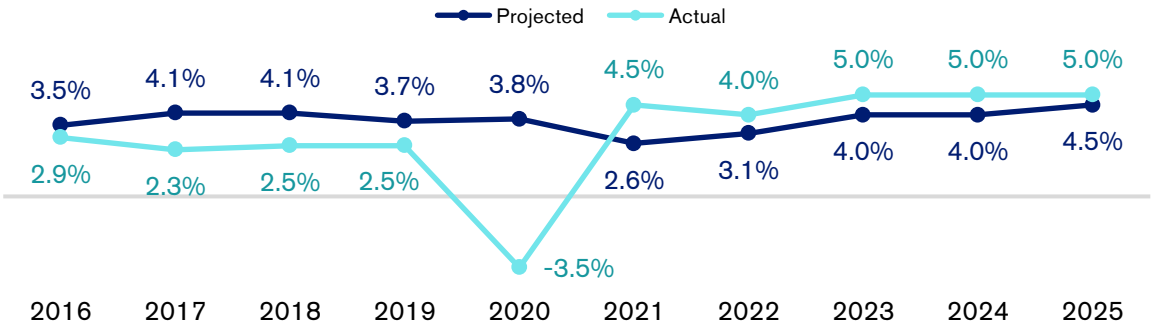
Increased Divergence Between Projected and Actual Medical Trend in 2025 Highlights the Challenge of Predicting the Impact of Macroeconomic Influences[1]



Actual Rx Trends Increased by Double Digits in Each of the Last Four Years and Were Higher than Projections in Three of Those Years[2]



Actual Dental PPO Trends Have Outpaced Forecasts for Five Consecutive Years



[1] All medical trend results exclude Rx.
[2] This data reflects outpatient Rx trend for all prescription drugs (non-specialty and specialty drugs combined). These results do not include the impact of rebates from PBMs.

Source: 2016–2027 *Segal Health Plan Cost Trend Survey*

Historical Survey Data on Selected Medical[1] and Outpatient Rx[2] Trends[3] Reveals Projected Trends Near Record Levels

	Year	PPOs/POS Plans	HMO/EPO Plans	MA HMO Plans	Outpatient Rx Plans	DPO Plans
Actual	2008	9.7%	9.7%	7.7%	7.4%	5.5%
	2009	9.5%	10.2%	4.0%	7.9%	4.7%
	2010	7.6%	8.7%	3.6%	6.4%	3.0%
	2011	7.5%	8.0%	4.5%	5.0%	3.1%
	2012	7.3%	6.7%	3.0%	5.5%	2.6%
	2013	5.7%	6.1%	3.1%	5.5%	2.8%
	2014	6.5%	6.3%	1.9%	10.7%	2.9%
	2015	6.8%	6.4%	4.2%	11.1%	3.0%
	2016	7.1%	6.3%	5.3%	8.1%	2.9%
	2017	5.7%	6.6%	1.8%	5.2%	2.3%
	2018	6.3%	6.0%	4.1%	5.3%	2.5%
	2019	6.8%	6.6%	2.2%	5.6%	2.5%
	2020	-2.1%	0.8%	-4.1%	8.5%	-3.5%
	2021	14.0%	13.3%	9.1%	8.9%	4.5%
	2022	2.5%	3.2%	3.0%	10.3%	4.0%
	2023	6.9%	6.8%	6.0%	13.7%	5.0%
	2024	7.1%	8.2%	7.8%	10.2%	5.0%
	2025	9.0%	8.9%	5.6%	10.2%	5.0%
Projected	**2026**	**10.0%**	**8.4%**	**6.2%**	**10.5%**	**4.8%**
	2027	**9.9%**	**9.1%**	**7.3%**	**11.5%**	**4.5%**

[1] Medical trends exclude prescription drug coverage.
[2] Prescription drugs trends combine non-specialty and specialty drugs. These results do not include the impact of rebates from PBMs.
[3] All trends are illustrated for actives and non-Medicare retirees, except for the MA HMOs. (A graph of this data is available.)

Source: 2010–2027 *Segal Health Plan Cost Trend Survey*

Top Health Plan Cost-Management Strategies in 2026

We continue to observe that plan sponsors using multiple cost-management strategies have lower plan cost trend rates than those taking a more hands-off approach. Survey participants were asked to identify the top strategies group health plans are implementing or considering for 2026. The chart below highlights the top five cost-management strategies being used for medical and pharmacy benefits.

Ranked number one under medical is use of digital health solutions for improving participants' well-being. Digital well-being programs reduce medical trend by shifting care from episodic, high-cost interventions to continuous, lower-cost management, improving chronic disease control, reducing avoidable utilization (i.e., ER visits, hospitalizations and surgery) and addressing underlying risk factors, such as behavioral health and obesity, that drive sustained cost growth. For more on how plan sponsors can maximize the value of their digital health solutions see the Segal article published in the First Quarter 2026 issue of *Benefits Quarterly*.

AI is becoming embedded across the health benefits ecosystem, with significant implications for plan sponsors. AI tools are reshaping how participants engage with their health, how claims are processed and how vendors manage utilization and payment. Used thoughtfully, AI can improve participants' experience, increase engagement in underutilized programs and support cost management. Used without appropriate governance, it risks accelerating cost growth by protecting intermediary margins rather than delivering savings to plan sponsors and participants. For more on how plan sponsors are leveraging AI to improve healthcare costs and outcomes, see our April 23, 2026 insight.

New to the list of the top five medical strategies is site-of-care steerage. Through coordinated use of benefit design, incentives and utilization controls, plan sponsors can direct care to the highest-value setting, shifting volume from hospitals to lower-cost settings, such as ASCs, physician offices or even the home, while maintaining clinical appropriateness and patient choice. ASCs in the commercial market continue to gain momentum with the steady expansion of Medicare's ASC covered procedures list and reimbursement changes. However, this has also made them a target for private equity and a focus area for major health systems, as they attempt to keep utilization in house.

Just below the top five, plan sponsors are increasingly using transparency tools and data to track price variation, strengthen contract negotiations and guide participants to more cost efficient providers.

Given the continued acceleration in prescription drug costs, plan sponsors are deploying a range of strategies to better manage pharmacy spending. Ranked number one under pharmacy are strategies to address diabetes and anti-obesity GLP-1 medications. Additionally, survey participants rated various strategies used to address the rising cost of anti-obesity GLP-1s in 2026, which are highlighted on page 23 in the section on GLP-1s.

Beyond the top strategies noted below, recent regulatory changes will fundamentally reshape future PBM contracting. Plan sponsors should proactively adopt contract terms that move away from inflationary pricing constructs and toward transparent, pass-through models. Scrutinize per member per month (PMPM) fees, specialty pharmacy charges, clinical program fees and affiliate arrangements that may replace lost rebate margin.

Top Five Health Plan Cost-Management Strategies Are Focused on Mitigating Rising Health Costs Without Compromising Quality of Care

2026 Top Five Medical	2026 Top Five Pharmacy
1 Implement well-being services utilizing digital health solutions for conditions including behavioral health, diabetes, weight management, musculoskeletal and/or cardiology.	1 Implement strategies to address -diabetes and anti-obesity GLP-1 medications.
2 Target high-cost claimants with specialized care management.	2 Implement strategies for specialty drug management (e.g., channel management, formulary management, copayment assistance and step-therapy management).
3 Use artificial intelligence to detect fraud, improve outreach, target communications and/or improve claims processing.	3 Control specialty drug mix through use of biosimilar strategies (e.g., lowest net cost, mandatory biosimilars for new patients).
4 Contract with narrow or limited provider network.	4 Expand pharmacy-management programs services (e.g., quantity limits, prior authorization, step therapy, “early-refill” or “stockpiling” strategies).
5 Site-of-care steerage (e.g., hospital → ASC, hospital → home infusion, in person → virtual care).* Use cost-management negotiation service for out-of-network services*	5 Adopt a custom or narrow drug formulary.

* Site-of care-steerage and use cost-management negotiation services for out-of-network services were tied for number five.

Source: 2027 *Segal Health Plan Cost Trend Survey*

Most of these cost-management strategies will still be relevant for 2027 and beyond.

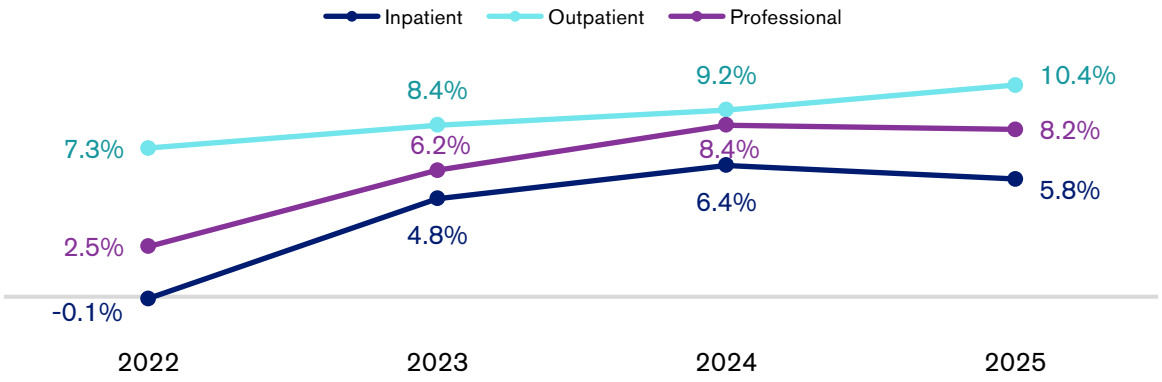
Insights into Actual Medical and Prescription Drug Trends

Segal's SHAPE data warehouse is a repository of detailed medical and prescription drug claims data for a sample of large, self-insured plan sponsors that provides insights into the drivers of healthcare costs and the quality of care that participants are receiving.

Actual medical trends by site of service

Segal's SHAPE data warehouse found medical trend was 8.9 percent in 2025, up from 8.0 percent in 2024. In 2025, medical trend was primarily driven by outpatient hospital expenses. Professional expense trend has also increased significantly over the last four years, from 2.5 percent in 2022 to 8.2 percent in 2025.

Outpatient Care Is a Greater Driver of Medical Trend than Care Received at Other Sites



Source: Segal's SHAPE data warehouse

Historically, medical trend has been heavily influenced by rising unit costs, driven by sustained provider price increases, labor pressures and ongoing margin recovery efforts by provider systems. While these factors remain relevant, recent data suggests a more balanced shift, where both price and utilization are now contributing meaningfully to overall trend.

Over the past few years, utilization has reemerged as a significant driver in many service categories and continues to accelerate. This reflects a combination of structural and emerging forces, including expanded access to care, evolving treatment pathways and changing provider practice patterns.

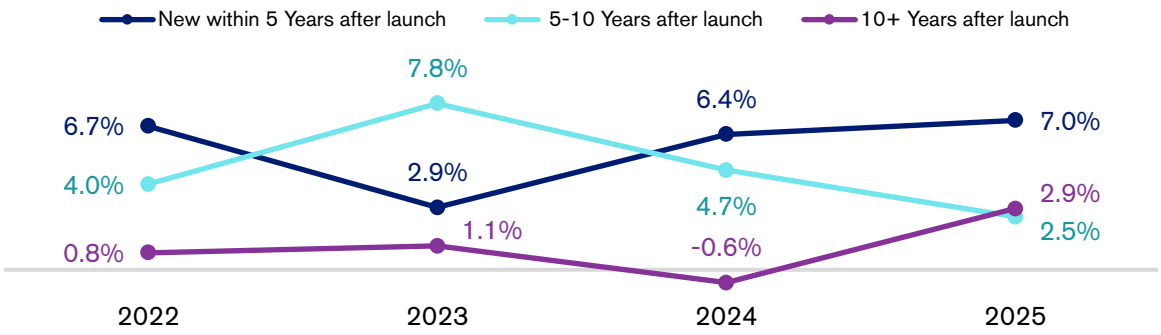
Some level of increased utilization was expected due to an aging population and the growing prevalence of chronic conditions; however, the persistence and breadth of this increase points to more durable demand.

Actual prescription drug trends

Prescription drug trend remained in the double digits, increasing from 10.4 percent in 2024 to 12.4 percent in 2025, driven primarily by greater utilization of new therapies entering the market at higher price points, rather than price increases on existing drugs.

New-to-market drugs released in the last five years accounted for almost 60 percent of prescription drug trend in 2025 (i.e., 7.0 percent of 12.4 percent).

Prescription Drugs Driven by New Drugs to Market within the First Five Years After Launch



Source: Segal's SHAPE data warehouse

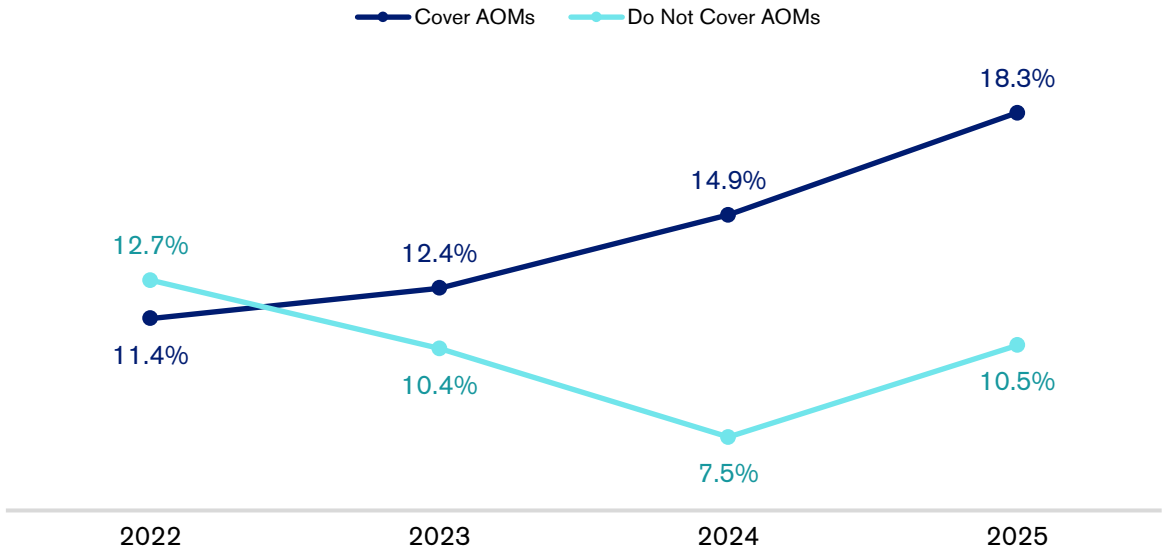
GLP-1s

Over the past several years, GLP 1 therapies have fundamentally reshaped the prescription drug landscape due to their strong clinical effectiveness in both glycemic control and weight management. Expanding indications have further accelerated demand, with additional potential uses such as substance use disorders and depression under active investigation.

As utilization continues to broaden, this class is expected to remain a significant driver of pharmacy cost trends for the foreseeable future, raising concerns around affordability and long-term sustainability. While broader regulatory (e.g., CCA-driven transparency and rebate reform) and market changes may exert downward pressure over time, plan sponsors should closely monitor the long-term financial impact of these therapies and assess appropriate management strategies.

According to data in Segal's SHAPE data warehouse, plans that covered GLP-1s for obesity management had a prescription drug trend rate of 18.3 percent in 2025, with 8.8 percent of that trend attributable to GLP-1s. Comparatively, among plans that did not cover GLP-1s for obesity management, prescription drug trend was 10.5 percent, with 1.2 percent attributable to GLP-1s (covered for diabetes).

Prescription Drug Trends Are Much Higher for Plans that Cover Anti-Obesity Medications (AOMs) than for Plans that Do Not Cover AOMs*



* Plans that added or rescinded AOM GLP-1 coverage during 2023–2024 are excluded.

Source: Segal's SHAPE data warehouse

Although the graphs show a steep cost of coverage for AOMs, coverage criteria vary widely and can ultimately help mitigate some of these trends. Plan sponsors that elect to cover AOMs with minimal criteria may see higher trends than those shown, whereas plan sponsors that cover AOMs with strict requirements will likely see significantly lower trends.

We asked survey participants about GLP-1 coverage criteria being implemented in 2026. Here's what they told us:

While Use of Step Therapies/Prior Authorization Is the Top Strategy Being Used to Manage the Cost of AOMs, Some Plan Sponsors Are Exploring Direct-to-Consumer Payment Reimbursement Options

Strategy	Mean Rating*
Step therapies/prior authorization	4.2
Participate in lifestyle modification program	3.7
No coverage	3.5
Require stricter body mass index (BMI) criteria (e.g., BMI of 35+)	2.9
Higher participant cost-sharing	2.6
Require higher participant copayments/cost sharing for weight-loss drugs	2.4
Only covering for obesity/overweight with cardiovascular disease or obstructive sleep apnea	2.3
Carve-out and cover through separate health reimbursement account	1.7
Provide a separate direct-to-consumer payment reimbursement option with defined annual or monthly allowance amount	1.6
Dollar limits (e.g., annual and/or lifetime)	1.6

* Mean of responses, with range of responses of 1 — not applied — to 5 — frequently applied.

Source: 2027 *Segal Health Plan Cost Trend Survey*

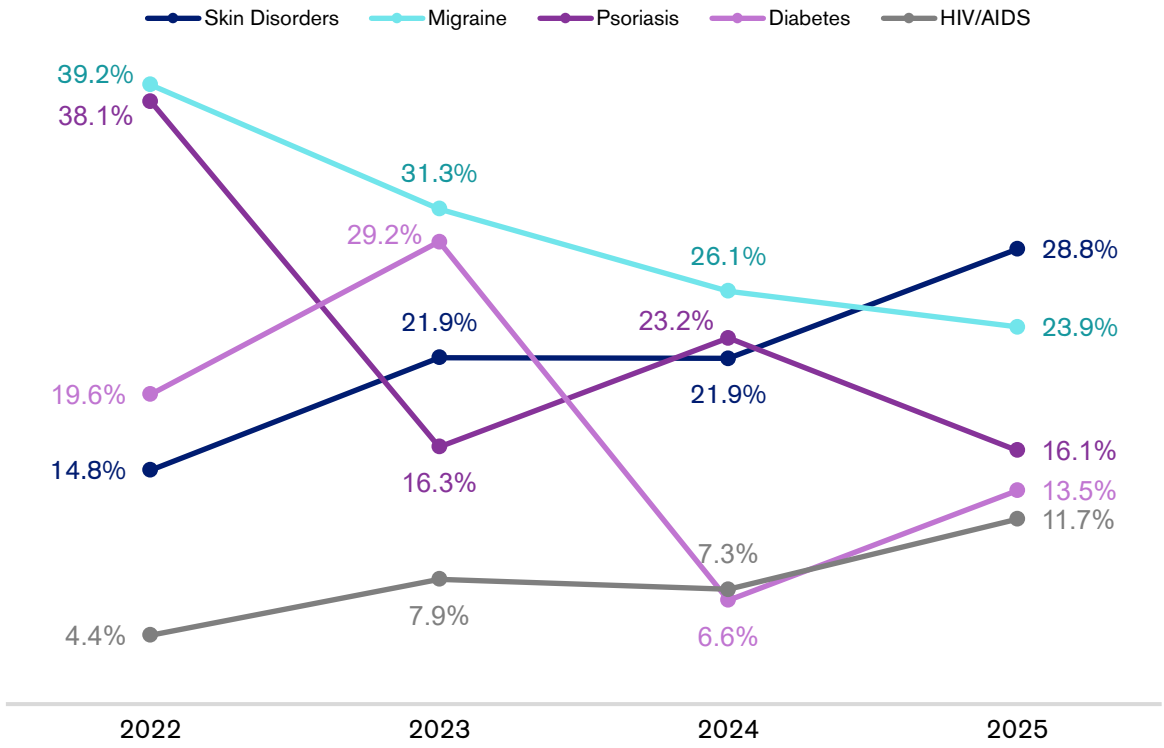
Drug trend by disease indication

While obesity is a trend driver for plans that cover AOM, when looking at overall drug trends, skin disorders, migraines and psoriasis are increasing significantly.

Rising pharmacy trend in dermatology (e.g., skin disorders and psoriasis) is primarily driven by a shift toward high-cost specialty therapies and expanded treatment utilization. Across dermatology, conditions like psoriasis and eczema are increasingly treated with biologics and targeted agents, significantly elevating drug spending despite relatively stable prevalence.

Psoriasis, in particular, is a major contributor due to early and sustained use of IL-17 and IL-23 inhibitors, which command high annual costs and are being used more broadly, including for associated conditions like psoriatic arthritis. Concurrently, drugs such as dupilumab (Dupixent®) are amplifying trend across multiple indications, as its use has expanded beyond atopic dermatitis to include asthma, chronic rhinosinusitis and other inflammatory conditions, driving both increased utilization and cross-condition spend. Stelara® has historically been a major contributor to dermatology pharmacy spending due to its high cost and strong clinical efficacy. However, its use in psoriasis is increasingly being competed with (and sometimes replaced by) biosimilar alternatives, as discussed in the next section.

High-Cost Specialty Drugs to Treat Skin Disorders Are Driving Rx Trends



Source: Segal's SHAPE data warehouse

Biosimilar adoption varies by PBM

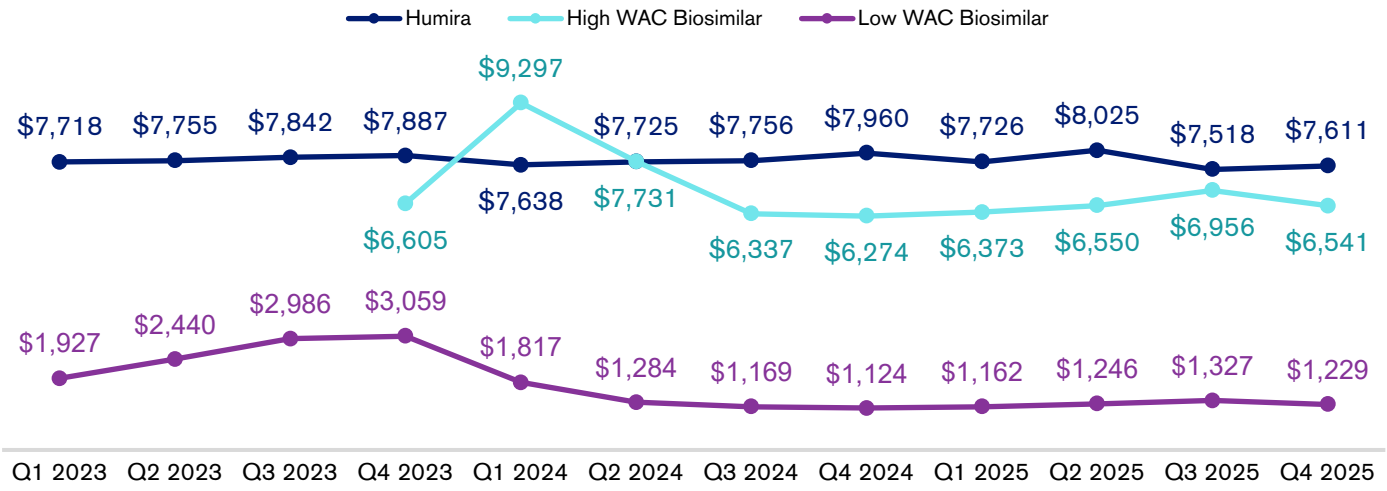
Biosimilar adoption is an increasingly critical lever in mitigating prescription drug cost growth, particularly as high-cost biologics continue to drive trend. Biosimilars are now available across key therapeutic areas including autoimmune disorders, oncology and dermatology (e.g., psoriasis). Recent launches, most notably for Humira® and now Stelara®, have accelerated the opportunity for savings — though results vary significantly based on formulary strategy, pricing approach (high vs. low Wholesale Acquisition Cost (WAC)) and PBM alignment.

Realizing biosimilar savings requires a deliberate strategy that includes:

- Formulary positioning and exclusion strategies that prefer biosimilars over reference products
- Benefit design alignment, including differential copayments/coinsurance to steer utilization
- Clinical management programs, such as prior authorization and step therapy, to ensure biosimilar-first use
- Site-of-care optimization for provider-administered products
- Stakeholder education to address provider and participant concerns about safety and efficacy

Biosimilar strategy should be a core component of PBM contracting, as financial outcomes vary widely depending on rebate structures and pricing models. While some high-WAC biosimilars preserve rebate economics, low-WAC biosimilars, often priced 80–90 percent below the reference product, can produce lower net costs despite reduced rebates, particularly as market momentum shifts toward transparent, net-cost-focused models.

Humira® and Biosimilar Average 28-Day Cost*



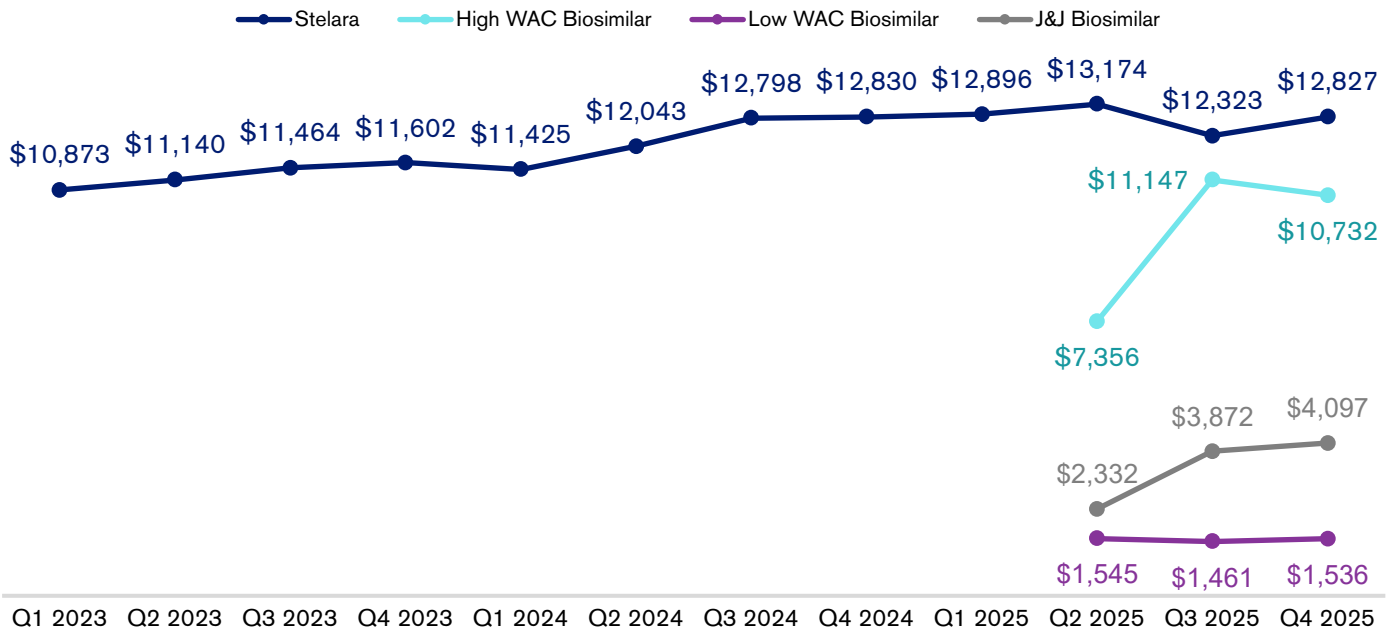
* The costs are shown before rebates. Gross- to- net difference may not be made up by rebates.

Source: Segal's SHAPE data warehouse

Experience with Humira® biosimilars demonstrates the impact of aggressive strategy, with meaningful cost reductions achieved when plans actively steer utilization. The next wave is now emerging with Stelara® (ustekinumab), where multiple biosimilars entered the market beginning in 2025. In addition to traditional biosimilars, Johnson & Johnson, the maker of Stelara®, has introduced an unbranded ustekinumab at approximately one-third the cost of Stelara® (as noted in the chart below), signaling a more competitive pricing environment.

As biosimilar competition expands across additional categories, plan sponsors that take an active, net-cost-driven approach (rather than relying on PBM default strategies) are best positioned to capture sustained savings.

Stelara® and Biosimilar Average 28-Day Cost



* The costs are shown before rebates. Gross-to-net difference may not be made up by rebates.

Source: Segal's SHAPE data warehouse.

Managing Rising Health Plan Costs with a Data-Driven Strategy

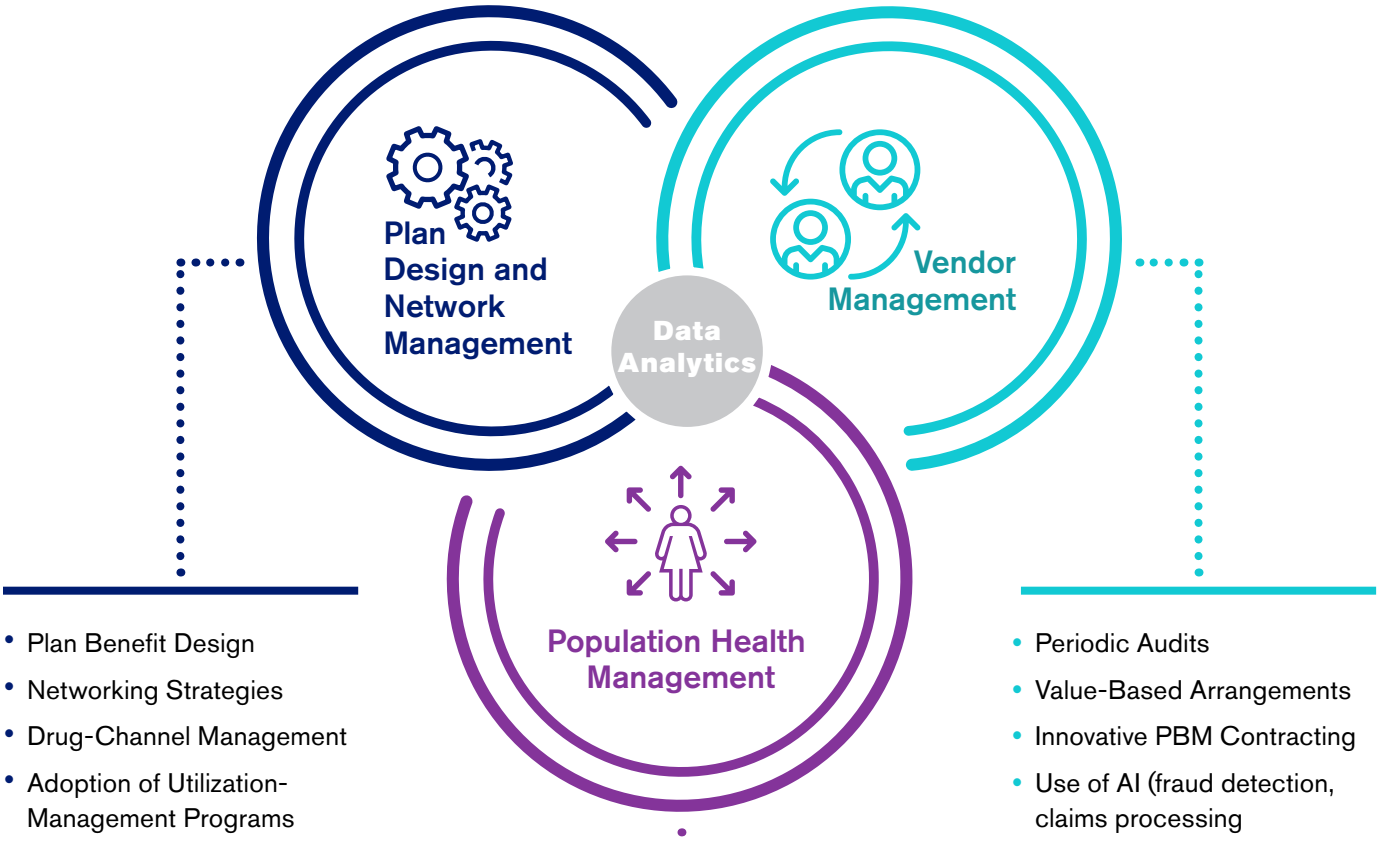
Health plan cost trends remain persistently elevated, with outpatient prescription drug costs continuing to drive double-digit increases, fueled by specialty therapies, expanded indications for GLP-1s and immunologics and a shifting drug mix toward high-cost treatments. Medical trends are also now close to double-digit increases due to sustained provider price inflation and increased utilization of outpatient and behavioral health services.

Regulatory changes and market dynamics are further complicating the landscape. Evolving transparency requirements, PBM reforms and continued disruption from the No Surprises Act and IDR processes are introducing both opportunities and new cost pressures. Provider contracting arrangements are becoming more complex, often embedding unit-cost escalators, performance guarantees and carve-outs that can materially impact total cost if they are not actively managed.

A data-driven approach is more critical than ever. Plan sponsors must leverage their own data to isolate key cost drivers, distinguishing price, utilization and drug mix, while monitoring quality, provider performance and emerging risks. Advanced analytic platforms, such as SHAPE, enable deeper insights by identifying high-cost provider patterns, flagging anomalous billing or compliance risks and benchmarking utilization and unit-cost variation, supporting more targeted and timely interventions.

To navigate this environment, plan sponsors should prioritize strategies that deliver measurable value. Segal continues to recommend a balanced, three-pronged approach: actively managing plan design and networks (including site-of-care and steerage strategies), strengthening vendor and PBM alignment with greater accountability and advancing population health initiatives, anchored by robust analytics to drive decision-making across all areas.

Our Approach to Effective Healthcare Cost Management



- Plan Benefit Design
- Networking Strategies
- Drug-Channel Management
- Adoption of Utilization-Management Programs
- Out-of-Network Cost Management

- Periodic Audits
- Value-Based Arrangements
- Innovative PBM Contracting
- Use of AI (fraud detection, claims processing improvement, enhanced participant communications)

- Digital Therapeutics
- Enhanced Behavioral Health
- Virtual Primary Care
- Improving Wellness Program Engagement Rates
- On-Site Clinics

Healthcare benefits continue to be a major investment in attracting and retaining talent. Balancing the need to provide competitive healthcare benefits with prudent cost-management strategies continues to be a significant challenge for plan sponsors.

Meeting that challenge requires a data-driven approach to identifying the most effective evidence-backed strategies, as well as negotiating strong performance-based vendor contracts to maintain trend at manageable levels.

The Survey Respondents

Sixty-five health insurance providers and other healthcare management organizations participated in the survey. As a group, the survey respondents represent a substantial portion of the commercially insured and self-insured market.

Medical Plans

39	32	36
PPO/POS plans	HDHPs	HMO/EPO plans

Rx Plans

43
Outpatient Rx drug plans

Dental Plans

35	14	14
DPO plans	Dental fee-for-service/ indemnity plans	DMO plans

Vision Plans

24	12
Vision schedule of allowance plans	Vision reasonable and customary plans

The following chart shows a count of respondents by plan type.

Aetna

Ameritas Life Insurance Corp.

Arkansas Blue Cross and Blue Shield

Benecard PBF

Blue Cross Blue Shield of Alabama

Blue Cross Blue Shield of Arizona

Blue Cross Blue Shield of Illinois

Blue Cross Blue Shield of Kansas City

Blue Cross Blue Shield of Montana

Blue Cross Blue Shield of Michigan

Blue Cross Blue Shield of New Mexico

Blue Cross Blue Shield of North Carolina

Blue Cross Blue Shield of Oklahoma

Blue Cross Blue Shield of Texas

Blue Shield of California

Capital Blue Cross

Capital District Physicians' Health Plan, Inc.

Cigna

CVS Health

Elevance Health

EmblemHealth

Evernorth Health Services/Express Scripts, Inc.

Excellus Health Plan

Group Vision Service

Guardian Life Insurance Company

Harvard Pilgrim Health Care, a Point32Health Company

Health Net of California, Inc.

Highmark Blue Cross Blue Shield of Delaware

Highmark Blue Shield of Central Pennsylvania

Highmark Blue Shield of Northeast New York

Highmark Blue Cross Blue Shield of Northeast Pennsylvania

Highmark Blue Cross Blue Shield of Western New York

Highmark Blue Cross Blue Shield of Western Pennsylvania

Highmark Blue Cross Blue Shield of West Virginia

Humana

Independence Blue Cross

Kaiser Foundation Health Plan, Inc.

Liberty Dental Plan

Medical Mutual of Ohio

MedImpact Healthcare Systems, Inc.

Metropolitan Life Insurance Company

National Vision Administrators

Navitus Health Solutions LLC

OptumRx

Premera Blue Cross Blue Shield of Alaska

Trustmark Companies

United Concordia Dental

United Health Group

Voya Financial

VSP

Author Contact Information

If you have questions about medical cost-management strategies or about the 2027 *Segal Health Plan Cost Trend Survey*, contact your Segal consultant or the authors of this report:

Eileen Flick
Senior Vice President
and Leader of Healthcare
Informatics
eflick@segalco.com
212.251.5120

Eileen possesses specialized expertise in healthcare cost-management strategies, with a focus on healthcare informatics, pricing and plan design. She oversees SHAPE, Segal's proprietary health data warehouse, as well as Segal's analytical tools and benchmarks, which are used to help clients measure, monitor and forecast the costs of health and welfare benefit programs.

Edward A. Kaplan
Senior Vice President,
National Health
Practice Leader
ekaplan@segalco.com
212.251.5212

Ed, who created the annual *Segal Health Plan Trend Cost Survey*, has specialized expertise in pricing and plan design strategies for managed medical, dental and prescription drug programs. He works with companies, governments and collectively bargained plans. Ed leads Segal's Medical Stop Loss Leadership Group.

Eric Miller, FSA, CERA, MAAA
Vice President and
Consulting Actuary
emiller@segalco.com
737.701.2089

Eric is a Vice President and Consulting Actuary in the National Health Consulting and Analytics practice, where he provides thought leadership and develops and oversees Segal's health actuarial models. He has expertise in investigating trends, benefit pricing, evaluating medical networks, provider contracting and alternative payment models.

Jason Jossie, ASA, MAAA
Vice President and
Consulting Actuary
jjossie@segalco.com
312.877.3553

Jason is a credentialled actuary who has special expertise in SHAPE's data analytics, identifying healthcare cost drivers and monitoring the quality of care participants are receiving. His data-mining insights allow clients to monitor the performance of their plan and associated population health management programs to provide comprehensive health benefits in an inclusive, efficient and sustainable way.

Matthew Nguyen, PharmD, BCPS, CEBS
Vice President and Consultant
Healthcare Informatics
mnguyen@segalco.com
267.473.1765

Matt is a Vice President and Consultant in Segal's National Health Consulting & Analytics group. He has over 15 years of experience in healthcare, providing direct patient care, managing pharmacy benefit services and performing clinical analyses. He also has expertise in data analytics and predictive modeling, supporting cost-management solutions through Segal's SHAPE services.

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Segal's Health Benefits Consulting Services

Today's benefits environment demands a comprehensive approach to formulating health plan design strategies that leverage innovative approaches as well as the power of data analysis, modeling and benchmarking.

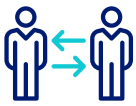
Our professionals can help your organization plan, design and strategize by providing:

Plan design and analysis. Are you providing high-quality, cost-effective healthcare to your plan participants? Segal's health professionals can help plan sponsors with the design and redesign of health benefit plans, including medical, dental, prescription drug, vision, behavioral health, short- and long-term disability, life, accidental death and dismemberment and flexible benefits.

Strategies for improving workforce wellness and well-being. To improve participants' and their families' physical health, are you offering wellness programs that focus on fitness, nutrition and weight management? Are you offering benefits, which may include voluntary benefits, designed to promote well-being? Such offerings can include stress management, caregiver benefits, paid leave and student debt relief as well as other financial well-being services. Do your health benefits address the unique needs of every segment of your workforce, including those living in underserved communities?

Cost and utilization modeling. Has your plan modeled plan sponsor expenses or calculated the out-of-pocket cost of plan changes to participants? Segal's consultants and actuaries can help you evaluate the financial impact of plan design modifications, predict future utilization patterns and estimate changes in claims costs.

Financial monitoring. Does your plan have the proper budgeting tools in place to ensure long-term financial stability? Segal can assist in reviewing or developing your plan's reserve policy and analyzing the impact of proposed plan design changes on future expenses.



Service provider and insurer competitive bidding. When was the last time you put your plan out for a competitive bid? Segal brings industry-leading expertise and innovative contracting to secure highly competitive pricing and service terms for our clients.

Data mining and analysis. Are you getting the information you need to make important plan design decisions? Segal can provide data-mining services through our proprietary warehouse, SHAPE — such as exploring emerging population health-risk factors that impact utilization and uncovering potential fraud and abusive provider practices — to help you better manage future healthcare expenses.

Benchmarking. Have you compared your policies and initiatives to what other plan sponsors are offering? Segal provides benchmark assessments that provide a unique and invaluable understanding of how benefit programs compare to others.

Benefit audits. We perform a range of claims audits, including medical plans, health accounts (FSAs, HSAs and HRAs), PBMs, dental plans, vision plans, short- and long-term disability programs and life insurance audits.

Our communications consultants work closely with our health consultants to develop communications campaigns that capture the attention of participants and their families to support desired behaviors.

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