

BENEFITS REPORT



Because You're Different

HEALTH PLAN DYNAMICS

DELAYED CARE FUELS CHRONIC CONDITIONS, HIGHER COSTS

DURING THE last three years, a new driver of health plan costs has emerged: a growing share of employees are postponing doctor visits, screenings and even medications until conditions worsen.

Instead of early, lower-cost intervention, employees are entering the system later and sicker. This is fueling more catastrophic claims, higher utilization of emergency services and ultimately higher costs for employer-sponsored plans.

Across the country, providers report more late-stage diagnoses and unmanaged chronic conditions. When symptoms become severe, they often require more intensive treatments that drive up costs, including:

- Hospitalization,
- Advanced imaging, and
- Specialist care,
- Expensive drug regimens.

Delayed care domino effect

The reasons for this trend are well documented. Polling by KFF found that 36% of adults say they have skipped or postponed needed care due to cost, and about one in five have not filled a prescription for the same reason.

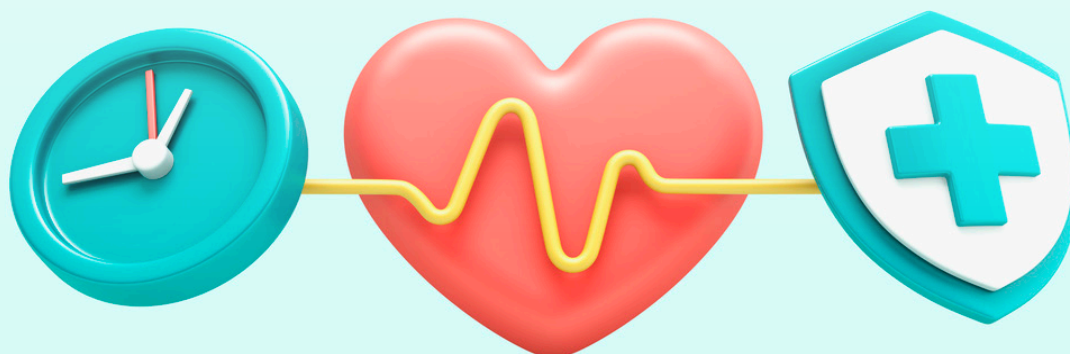
High-deductible health plans are a major factor. While they have lower premiums, they also require employees to pay sometimes thousands of dollars out of pocket before coverage begins. That can lead workers to put off care, particularly if they are unsure whether a visit is necessary.

Also, about one-third of adults report skipping doses or delaying prescriptions due to costs, according to KFF. This can worsen chronic conditions and lead to hospitalizations that could have been avoided with consistent treatment.

What employers can do

- **Lower financial barriers to preventive care** – Waive or reduce cost-sharing for primary care visits, screenings and chronic condition management.
- **Promote and simplify primary care access** – Offer telehealth, onsite or near-site clinics and easy scheduling to reduce friction.
- **Educate employees on how their plans work** – Many workers do not understand deductibles, health savings accounts or covered services, which can hit them with unexpected bills.
- **Encourage medication adherence** – Consider programs that reduce or eliminate costs for essential medications tied to chronic conditions.
- **Use data to identify gaps in care** – Analyze claims to find employees who are missing preventive services or managing chronic conditions poorly.
- **Steer employees to high-value providers** – Offer insurance from carriers that offer networks or incentives that guide workers to high-quality, lower-cost settings for procedures and treatments.
- **Leverage wellness and condition management programs** – Programs that help employees manage diabetes, musculoskeletal issues or cardiovascular health can improve outcomes and reduce long-term costs.

Employers have more influence than they may realize in addressing delayed care. The goal is to reduce barriers and make it easier for employees to access care early.



NEW RISK

NEW PBM RULES RAISE COMPLIANCE STAKES FOR EMPLOYERS

EMPLOYERS THAT sponsor health plans will face a new layer of compliance risk under the Consolidated Appropriations Act of 2026, which imposes sweeping transparency and reporting rules on pharmacy benefit managers (PBMs).

The law aims to open up the “black box” of prescription drug pricing, but it also puts both self-insured and fully insured employers closer to the compliance line, with potential civil monetary penalties that can reach \$10,000 per day for reporting failures and \$100,000 per violation for knowingly providing false information.

At the core of the law are three major requirements that directly affect how employer health plans interact with PBMs:

- **Full rebate pass-through:** PBMs must pass 100% of rebates, discounts and other compensation back to the health plan.
- **Detailed reporting:** PBMs must provide semiannual reports outlining drug spending, utilization and compensation structures.
- **Audit rights:** Plan sponsors have the statutory right to audit PBM records at least annually.

These provisions should give employers clearer insight into plan drug costs, but they also create new fiduciary responsibilities.

How this affects employers

Self-insured employers that contract directly with PBMs will feel the most immediate impact. They must ensure they receive required reports, review them and make summary information available to plan participants. They must also document compliance efforts.

Employers that purchase fully insured plans are not off the hook. While carriers and PBMs handle much of the administration, the law still applies to the plan sponsor in certain cases, particularly around participant disclosures and ensuring compliance upstream.

The law does not clearly assign liability for penalties in all situations. As a result, PBMs and insurers may attempt to shift risk to

employers through contract language.

Specifically, some PBM agreements may include indemnification provisions that require the employer to cover penalties — even if the PBM failed to meet its reporting obligations.

Employers may avoid penalties if they can demonstrate a “good faith effort” to comply. That makes documentation critical.

New risks

Employers should pay close attention to several emerging risks:

- **Contractual liability:** PBMs may try to transfer penalty exposure to plan sponsors.
- **Reporting gaps:** Failure to obtain or share required data could trigger fines.
- **Notice requirements:** Employers must inform plan members about available prescription drug data.
- **Fiduciary exposure:** Plan sponsors must act prudently in overseeing PBM arrangements.

What employers should do now

With most provisions taking effect in 2029 for calendar-year plans, employers have time to prepare:

- Review PBM contracts and renegotiate any indemnification clauses that shift compliance risk.
- Establish a compliance process to retain PBM reports and allow employees to request copies.
- Keep records of communications and efforts to obtain required data.
- Ensure summary benefit information and required notices include information on the new law.
- Work with us to better understand compliance issues.
- Notify participants about their right to access PBM plan-level summary data. We can help you integrate this into your next open enrollment or summary plan documents update.



Employee Health Care Literacy Key to Containing Costs



FOR MANY U.S. workers, health insurance remains confusing, intimidating and underutilized. Despite the billions employers spend on benefits each year, a large share of employees does not fully understand how their coverage works or how to use it effectively.

According to a report by Aflac, only 38% of employees said they understand their benefits, suggesting that most workers need more guidance on how their coverage works. When employees lack health care literacy — the ability to find, understand and use health information and services — they are more likely to delay care, make poor medical decisions and incur unnecessary costs.

For employers, that translates into higher claims costs, lower productivity and frustration with benefit programs.

The Centers for Disease Control and Prevention has estimated that better health literacy could prevent nearly 1 million hospital visits annually and save more than \$25 billion in health care costs.

The cost of confusion

Employees who do not understand their benefits often:

- Use out-of-network providers unnecessarily, which often means that insurance won't cover the visit or pay very little.
- Choose higher-cost care settings, like emergency rooms for non-emergencies.
- Skip preventive care that could head off more serious conditions later (see story on page 1).
- Misinterpret bills or fail to challenge incorrect charges.

Open enrollment is not enough

Many employers concentrate their communication efforts during open enrollment. While important, that once-a-year push is not enough to build true understanding.

Employees make health care decisions year-round, like when they schedule a test, fill a prescription or choose where to seek care. Without ongoing education, even well-designed benefit plans can go underutilized and employees may make costly choices.

Employers that take a continuous approach to education are more likely to see employees engage with their benefits and make smarter decisions.

How to educate staff on benefits

Use plain language. Rewrite benefit materials to eliminate jargon and explain key terms like deductibles, copays and coinsurance in simple terms. Aim for a sixth- to eighth-grade reading level.

Educate year-round. Provide monthly or quarterly communications that focus on one topic at a time, such as preventive care, telemedicine or how to read an explanation of benefits.

Show real-world examples. Compare costs for common scenarios like urgent care vs. emergency room visits so employees see the financial impact of their choices.

Promote in-network savings. Use visuals or tools that highlight how much employees can save by staying within network providers.

Leverage multiple channels. Combine e-mail newsletters, intranet content, webinars and short videos to meet employees where they are.

Offer decision support. Provide access to benefits counselors, either in person or virtually, to help employees choose plans and understand coverage.

Encourage preventive care. Regular reminders about screenings, vaccinations and annual checkups can reinforce healthy behaviors and reduce long-term costs.

Use data to guide efforts. Review claims trends and employee questions to identify where confusion is highest, then tailor education accordingly.

Build trust and engagement

Employers that invest in health care literacy often become a trusted source of information for their workforce. That trust can increase participation in wellness programs, improve satisfaction with benefits and strengthen retention.

It also aligns with a broader shift in how employees view their benefits. Workers increasingly expect guidance and want help navigating a complex system. Fortunately, employers are well positioned to provide it.

HRAs Can Help Your Staff Pay for Medical Expenses

AS RISING health insurance premiums and out-of-pocket costs for health care are burdening workers, more employers are looking for ways to help their staff put aside money for those expenses.

While health savings accounts have grown in popularity, you can only offer them to employees who are enrolled in high-deductible health plans. Fortunately, there is another option: a health reimbursement arrangement (HRA).

Employers fund these accounts, which reimburse your staff for qualified medical expenses and, in some cases, insurance premiums.

You can claim a tax deduction for the funds you transfer to your employees' HRAs, and the funds they withdraw from the accounts to reimburse for medical-related expenses are generally tax-free.

Unlike HSAs and flexible spending accounts, though, HRAs are solely funded by employers. Also, unlike HSAs, they are not portable if an employee moves to a new employer.

In addition, federal regulations dictate what types of health care expenses HRAs can reimburse, and those rules vary depending on the type of HRA you offer.

Depending on the type of HRA, funds may be used to reimburse:

- Health insurance premiums,
- Vision and dental insurance premiums,
- Coinsurance, copays and out-of-pocket medical outlays, and
- Qualified medical expenses.

How HRAs work

You decide how much you want to fund your employees' HRAs. Under federal regulations, you must fund all like employees' HRAs with the same amount. So, if you have 12 sales reps, each one would have to get an HRA funded with the same amount, but managers and supervisors could receive a different sum.

Employees can only withdraw funds from their account to reimburse for a legitimate expense they have already paid for. Another option is to provide them with an HRA debit card, which they can use to pay for qualified medical expenses.

Once they have depleted the funds in their HRA for the year, they have to pay for medical expenses out of pocket.

Any HRA money that is unspent by year-end may be rolled over to the following year, although an employer may set a maximum rollover limit that can be carried over from one year to the next.

Types of HRAs

There are a number of different HRAs:

Integrated HRA – This type of HRA requires employees to also be covered by a group major medical plan. It generally reimburses out-of-pocket medical expenses.

Dental/vision HRA – This type of HRA limits reimbursements to only dental and/or vision expenses.

Qualified Small Employer Health Reimbursement Arrangement – This type of HRA is only available to employers that have fewer than 50

employees. The maximum annual reimbursement amount is \$5,450 for self-only employees (\$454.16 per month) and \$11,050 for employees with a family (\$920.83 per month).

QSEHRAs are typically used to (legally) allow employers to reimburse their workers for individual health insurance premiums, in addition to other out-of-pocket expenses being reimbursed.

Individual Coverage HRA – This type of HRA is available to employers of all sizes, and employees must be covered by an individual health insurance plan to be eligible.

The primary intent of the ICHRA allows reimbursement of individual health insurance premiums, but other out-of-pocket expenses, such as copays and deductibles, can also be reimbursed.

Employees can use these HRAs to buy their own comprehensive individual health insurance with pretax dollars either on or off the Affordable Care Act's health insurance marketplace.

Excepted Benefit HRA – This HRA will allow for the reimbursement of COBRA premiums, short-term medical plan premiums, dental and vision expenses. The annual reimbursement limit for an EBHRA is \$1,800 (adjusted for inflation).

The takeaway

An HRA is another tool in helping you retain and attract talent.

In fact, you can even pair an HRA with an HSA, as long as the HRA is HSA-qualified.

In these instances, you would need to offer a "limited-purpose HRA" that only reimburses employees for expenses that are exempt from the HSA deductible requirement, including:

- Health insurance premiums,
- Long-term care premiums,
- Dental expenses, and
- Vision expenses.



If you have questions about your coverage or our products, please reach out to me:

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