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BENEFITS REPORT

HEFFERNAN INSURANCE BROKERS
Because You're Different

SEASONAL RISK

LIMITING YOUR LIABILITY DURING THE HOLIDAYS

WITH HOLIDAY festivities underway, make sure to make safety a priority whether you're just decorating the office or throwing a holiday/year-end party for your staff.

While you obviously want your staff to relax and have fun, you also want to make sure they get home safely and that nobody gets hurt or sick at your your holiday party.

Due to their infrequent nature, the liability risks of company-sponsored holiday events are often overlooked.

To ensure the health and well-being of all who attend, it is important to be aware of any potential liability concerns that your company may face if the event doesn't go exactly as planned.

Holiday party safety considerations

- If you are holding a party offsite, inspect the venue first to make sure it meets your safety standards. Keep an eye out for easy-access exits, emergency lighting, and flooring that might cause slips and falls.
- If storms are looming on the date of your party, consider the effects that weather may have on safe travel to and from the event.
- Do you need security?
- Limit alcohol consumption.
- If party-goers are leaving at night, make sure nobody has to walk out alone in the dark to their car for safety reasons.
- Ensure safe food handling, like keeping hot foods warm and covered and not leaving perishable food out for too long to reduce the chance of foodborne illness.
- Have a plan in case someone is injured or needs medical assistance. Know where the closest hospital is and identify staff who know how to use a defibrillator or can perform CPR.

Reducing liability risk

Remind your employees that rules against harassment, discrimination and conduct apply at the event. Monitor behavior and take prompt action if any activity or behavior exceeds acceptable bounds.

Make the event optional and let your team know that it won't reflect poorly on their performance evaluation, advancement potential or job security if they don't attend. Emphasize this in invitations and announcements.

Take complaints that stem from the party seriously. As you would with any other incident, document, investigate and take appropriate action.

Liquor liability

Some companies have recognized the liability exposure and have chosen to hold alcohol-free holiday events. If alcohol is served, limit your exposure by:

- Holding the event at an off-site location and hire professional bartenders who have their own insurance and are certified for alcohol service. Speak with the vendor to determine what protocols it uses to keep from serving minors and others who are visibly intoxicated.
- Provide an array of choices of non-alcoholic beverages.
- Don't have an open bar. Instead, hand out a set number of drink tickets to control consumption (two is usually a standard amount).
- Stop serving alcohol at least an hour before the event ends.
- Provide transportation that may include free cab or Uber rides.

A word about insurance

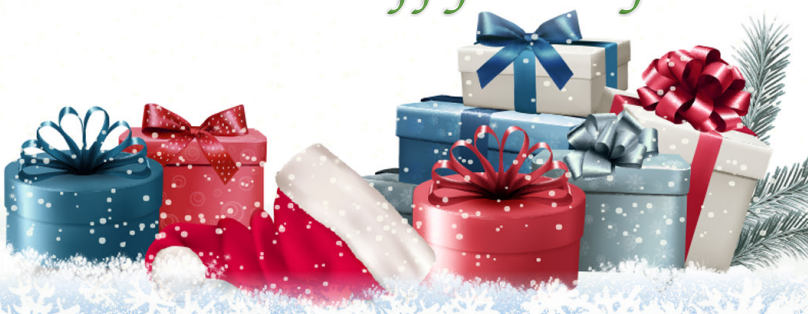
Make sure that any vendors you use carry insurance. Insist on seeing the certificates of insurance with sufficient coverage and liability limits for:

- Catering and bartending firms,
- Facilities, and
- Entertainers.

When reviewing rental contracts, be sure to note any hold harmless or indemnity agreements that could release the vendor from liability and instead hold your company responsible for losses from situations over which you have no control.

Also, talk to us to make sure that your own insurance policies cover any mishaps that may occur at your company event.

Heffernan Insurance Brokers Wishes You a Happy Holiday!



MISSING DOCTORS

ADDRESSING 'GHOST NETWORK' ISSUES IN YOUR HEALTH PLANS

FOR YOUR group health plan enrollees, finding a doctor who accepts their plan should be straightforward since each plan typically has a network of physicians available for enrollees.

However, enrollees regularly learn that a doctor who is clearly listed in their health plan's provider list is no longer in their insurance company's network, which can result in delayed or denied care as well as higher out-of-pocket costs. Welcome to the problem of health plan "ghost networks," or "ghost providers," which are usually the result of outdated provider lists.

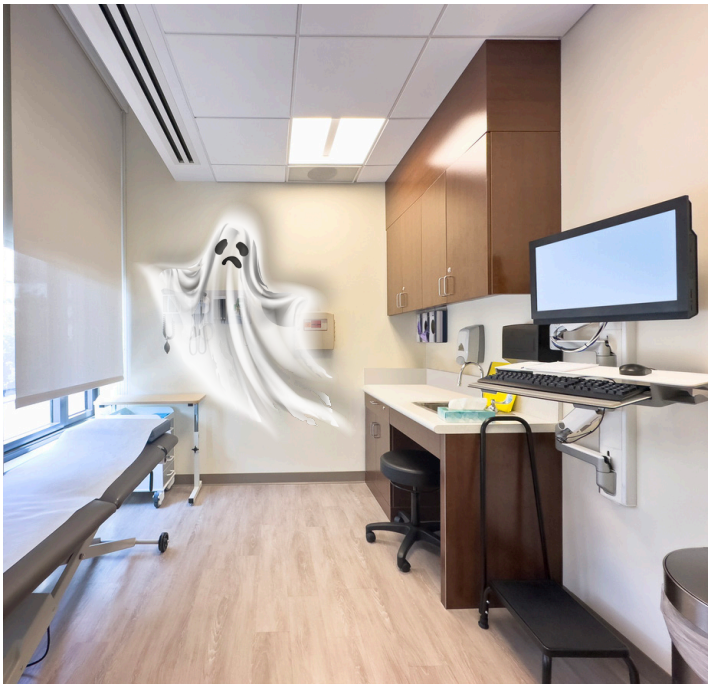
This problem can result in employee resentment about their group health plan and saddle them with higher costs if they are forced to go out of network to seek care. Here's what your employees need to know if they encounter a ghost provider and are unable to access a certain medical service.

What are ghost networks?

A ghost network or ghost provider occurs when a health plan lists health care providers in its directory who are not actually available to enrollees.

Why the problem persists

- The provider has retired or has relocated without their listings being updated.
- The provider has stopped accepting your health plan.
- The provider has reached patient capacity and are not taking new appointments.
- The provider has outdated contact information that prevents enrollees from reaching them.



Many insurer health plan directories are outdated. A 2023 report from the Office of Inspector General found that despite a Centers for Medicare & Medicaid Services rule requiring insurers to update their directories every 90 days, errors persisted.

Some incorrect listings had remained on the network list for over a year.

The fallout

Health plan enrollees who rely on inaccurate provider directories may experience:

- **Delays in care:** Finding an in-network provider can take weeks or even months, potentially delaying necessary medical treatment.
- **Unexpected costs:** Beneficiaries who unknowingly visit an out-of-network provider may face high out-of-pocket expenses or denied claims.
- **Frustration and confusion:** Patients may have to call multiple providers, only to be told that the doctor they are trying to see does not accept their plan.

What you can do to help your staff

To help your staff avoid ghost networks, train them about the importance of verifying information provided by their insurance company. This includes checking the provider's acceptance of new patients, their willingness to see you and ensuring they are truly in-network for your specific plan.

They can do this by contacting the provider directly and verifying their network status and patient acceptance.

Before seeing a new doctor or specialist and to ensure that they are not charged for going out of network, health plan enrollees can start by verifying provider information by:

- **Accessing the provider portal:** Use the insurer's website to access their provider portal and search for specific providers they are interested in.
- **Directly contacting the insurer:** Contact the provider directly (phone, e-mail or online contact form) to confirm their willingness to accept new patients and their in-network status for your plan.
- **Consulting the provider directory:** Double-check the accuracy of the insurer's provider directory by verifying information like office locations, phone numbers and acceptance of new patients.

If a health plan enrollee is confronted with an inaccurate listing, they can:

- Inform the insurer and request that it be corrected.
- File a grievance. If an enrollee is unable to make an appointment with a doctor listed as an in-network provider, they can ask the insurance company to help them schedule an appointment or file a grievance.

STREAMLINING CARE DELIVERY

HEALTH INSURERS SLOWLY CUT PRIOR AUTHORIZATIONS

HEALTH INSURERS pledged in June to overhaul their processes as part of a Trump administration initiative to reduce the volume of prior authorization requirements and modernize how requests are handled.

Many insurers targeted Jan. 1, 2026, for measurable reductions but how far have they gotten? While carriers say they are making progress, provider groups such as the American Medical Association contend that little has changed for patients and clinicians on the ground.

This tension matters to employers and HR executives who sponsor group health plans because prior authorization rules influence employee access to care, administrative costs and satisfaction with their health benefits.

Why prior authorization became a flash point

Prior authorization requires clinicians to secure insurer signoff before performing procedures, prescribing certain medications or ordering tests.

Plans say it helps control unnecessary or low-value care. Providers argue that approvals can take hours or days, even for routine services, leading to delayed diagnoses or treatment.

The June 2025 pledge aimed to blunt these concerns and respond to growing state and federal pressure to simplify the process. Most major insurers pledged to:

- Cut the number of medical services needing prior authorization, particularly common procedures like colonoscopies and cataract surgeries, by Jan. 1, 2026.
- Honor existing prior authorizations for 90 days when a patient changes insurers mid-treatment.
- Offer clearer explanations for denials and ensure all denials receive a medical review.

What the largest insurers are doing

UnitedHealthcare — The company dropped prior authorization requirements for 231 procedures in December 2025, including nuclear medicine studies, certain obstetrical ultrasounds and electrocardiography procedures. It previously reduced approval requirements for services with consistently high adherence to evidence-based guidelines.

Cigna — Cigna has eliminated prior authorization for nearly 100 services and added real-time status tools and expanded patient support teams that help members navigate approvals.

Humana — The insurer says it eliminated about one-third of outpatient prior authorizations, including for colonoscopies and certain imaging studies. It has committed to issuing decisions within one business day for at least 95% of complete electronic requests starting Jan. 1, 2026, and is working to automate approvals for most routine requests.

Aetna — Aetna is in the process of automating one in four PA approvals for near-instant decisions and using AI tools to help members navigate the system. It has started bundling multiple prior authorization requests for cancer imaging into single submissions and has expanded bundling to musculoskeletal services, certain surgeries, medications and related care.

Blue Cross Blue Shield plans — The association says BCBS plans around the country are reducing requirements and preparing January 2026 workflow changes. More detailed reporting is expected in spring 2026 as part of an industrywide dashboard.

State policy activity accelerates

States have become increasingly aggressive in regulating prior authorization. Some have implemented programs that exempt high-performing physicians from prior authorization requirements.

Others mandate shorter decision timelines, including 24-hour urgent reviews and 72-hour expedited reviews. Some states have started requiring denials to be reviewed by clinical peers or physicians with specialty expertise.

Takeaway

Health insurers have pledged meaningful reductions in prior authorization, and the industry is watching to see what kind of changes they implement in 2026. The end result should hopefully improve the health care experience for your employees, particularly those who have ongoing health issues that are expensive to treat.

BUSINES GROUP ON HEALTH REPORT

HEALTH BENEFIT TRENDS TO WATCH IN 2026

EMPLOYERS ARE heading into what may be one of the most challenging years for managing group health costs.

The Business Group on Health's (BGH) new "Trends to Watch in 2026" report outlines developments that will shape next year's benefits environment. Rising medical and pharmacy spending, a rapidly changing policy landscape and increased pressure for innovation may pressure employers to revisit long-standing strategies and consider new ones.

Below are six trends the report predicts will affect health plans.

1. Affordability pressures intensify

Employers project a median 9% increase in health care costs for 2026, dropping to 7.6% after plan design adjustments. These increases follow two years of costs that ran higher than expected.

Chronic conditions, an aging workforce, higher medical and pharmacy prices and ongoing system fragmentation all contribute to the strain. As a result, employers may need to weigh short-term mitigation tactics against longer-term structural changes, including program reductions or redesigned plan approaches.

2. Emphasis on preventive care and primary care

With chronic disease remaining the top cost driver, employers are expected to "get back to basics." That means:

- Increasing focus on preventive care, evidence-based screenings and stronger primary care engagement.
- Reassessing well-being and chronic-condition programs to ensure they produce measurable results.
- Incentives or alternative plan designs that encourage screenings, primary care use or condition management may become more common.

3. Pharmacy costs will continue to weigh

Drug spending is one of the fastest-growing costs, driven by GLP-1 drugs, gene and cell therapies and broader price inflation. Existing mitigation strategies are losing effectiveness, prompting employers to re-examine pharmacy benefit manager relationships, transparency, contracting terms and utilization controls.

The rise of direct-to-consumer cash prices adds another layer of complexity, as employees may seek lower-cost options outside the plan. Employers will need a clear stance on whether to support or discourage such use.

4. Streamlining and tightening vendor partnerships

As a result of years of adding new programs, many employers now face fragmented, duplicative services and inconsistent data integration.

The report predicts that in 2026 employers will subject vendors to greater scrutiny and focus on measurable outcomes. Vendors will be expected to improve data sharing, coordinate care with other partners and demonstrate value.

5. Faster adoption of alternative plan models

To manage rising costs, employers will continue to explore new plan structures.

Options such as copay-based designs, virtual-first plans, primary care-centered models and network-less structures are gaining traction.

6. Shifting policy landscape adds uncertainty

PBM reforms, updated preventive care guidelines and new chronic-disease coverage policies may influence employer plan design. Potential ACA subsidy expirations and ongoing Medicaid eligibility changes could increase reliance on employer coverage.

With the 2026 midterm elections approaching, legislative action may slow while regulatory activity increases. Employers will need to monitor these developments closely to anticipate compliance obligations and communicate changes to employees.

Takeaway

If the BGH report is accurate, many employers will be looking for ways to cut costs, boost vendor accountability and explore new plan structures.

If you are interested in alternative plan models, we can help you compare them with preferred provider organization, health maintenance organization and high-deductible health plan options.

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

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