BENEFITS REPORT

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HEFFERNAN INSURANCE BROKERS

Because You're Different

VOLUNTARY BENEFITS

LAWSUITS ADD FIDUCIARY CONCERNS FOR EMPLOYERS

PLAINTIFFS' ATTORNEYS are breaking new ground by suing employers for allegedly failing in their fiduciary duties to manage their voluntary benefit plans, including accident insurance, critical illness, cancer and hospital indemnity benefits.

These class action lawsuits typically allege that employers exercise sufficient control over these plans to trigger fiduciary duties under the Employee Retirement Income Security Act and that those duties were breached. Once ERISA applies, employers can face claims tied not just to plan design, but to the prudence of benefit selection and monitoring.

If these lawsuits gain traction, they may open a new category of potential liability tied to benefit offerings that many employers have historically overlooked.

At the center of the litigation is the claim that certain voluntary benefit arrangements are not exempt from ERISA, either because they fail to meet the voluntary plan safe harbor or because employers exercise sufficient control to trigger fiduciary duties.

Five areas drawing scrutiny

Four recent class action lawsuits filed against large employers include similar allegations that the employers breached ERISA fiduciary duties by allowing excessive commissions, failing to monitor insurers and brokers and engaging in conflicted arrangements within employer-sponsored voluntary benefits programs.

The companies that were sued

Each of these companies was sued by an employees' union benefit or welfare plan:

- United Airlines
- Laboratory Corporation of America
- Community Health Systems
- Allied Universal

Areas of exposure

Benefits selection processes – Employers are being accused of failing to run competitive requests for proposals or document why certain carriers or products were chosen. A casual selection process that keeps the same plan each year can be portrayed as imprudent once fiduciary standards apply.

Contracts – Vague terms, unclear delegation of responsibilities or contracts that fail to spell out fiduciary status can make it harder for employers to defend their role as plan sponsors.

Broker compensation – Embedded commissions, overrides and incentive payments are a central theme in the lawsuits. Plaintiffs argue that employers failed to monitor compensation levels or allowed conflicted arrangements that inflate employee premiums.

Premium levels – Even when employees pay the full cost, plaintiffs contend that employers must ensure premiums are reasonable relative to the benefits provided.

Insurance product loss ratios – Loss ratios are being used as a proxy for value. Low ratios may be cited as evidence that plans are overpriced.

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HUMAN RESOURCES

MORE EMPLOYERS OFFER CAREGIVER LEAVE AS NEED MOUNTS

A NEW survey found that many employers plan to add or expand caregiver leave over the next two years as they contend with workforce burnout, changing family dynamics and competition for talent.

According to WTW's "2025 Absence, Disability and Medical Leave Survey," caregiver leave is expected to see the fastest growth of any leave benefit over the next two years, even as only a handful of states require it by law. Rather than waiting for mandates, many employers are proactively adding caregiver leave to remain competitive for talent and responsive to employee needs.

The shift comes as caregiving demands intensify across a multigenerational workforce. Many employees are juggling work with caring for children, aging parents or other dependents, often with limited financial or workplace support.

Employers are finding that caregiver leave can help reduce stress and burnout, improve morale and productivity and support retention in a tight labor market where replacing workers is increasingly expensive.

The importance of caregiver leave

Nearly one quarter of U.S. adults are part of the so-called "sandwich generation," caring for both children and aging parents, according to another report. These employees often provide about 20 hours of unpaid care per week and may spend $10,000 to $11,300 a year out of pocket to support family members.

Best practices

When setting up a caregiving leave program, experts recommend:

- Defining caregiving broadly, covering care for children, parents, spouses, domestic partners, and other dependents.
- Coordinating leave with Family Medical Leave Act and state programs to avoid duplication and ensure compliance.
- Setting clear eligibility and documentation standards while keeping the process simple for employees.
- Training managers to handle workload planning and employee conversations consistently.

Although caregiver leave may qualify under the Family and Medical Leave Act (FMLA), it is typically unpaid unless employers offer wage replacement. That financial strain can increase stress and burnout, pushing some caregivers to reduce their hours, change jobs or leave the workforce entirely.

How employers can implement caregiver leave

Employers considering caregiver leave often start by integrating it into their existing leave or paid time off structures.

Common approaches include offering a defined number of paid leave days per year, allowing caregiving use of banked personal time off or layering caregiver leave on top of state paid family leave programs.

The takeaway

From a business standpoint, caregiver leave can help mitigate turnover risk.

As caregiving responsibilities continue to affect a larger share of the workforce, caregiver leave is emerging as a practical, targeted benefit that supports employees while helping employers attract and retain talent in a competitive labor market.

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Work With Us to Evaluate Your Voluntary Benefits

Action items

Employers and HR leaders may want to consider:

- Confirming whether each voluntary benefit arrangement is intended to be ERISA-covered or exempt — and documenting that determination.
- Reviewing contracts to clarify fiduciary roles, responsibilities and delegation.
- Increasing transparency around broker and vendor compensation, including commissions and incentives.
- Benchmarking premiums and insurer loss ratios against the broader market.
- Documenting benefit selection decisions and the rationale behind them.
- Strengthening employee decision support and education to demonstrate a focus on participant outcomes.

If you have voluntary benefits, we can sit down with you to go over your policies and the choices in the marketplace.

GLP-1 DRUGS

EMPLOYERS EXPERIMENT WITH DIRECT-TO-CONSUMER ACCESS

EMPLOYERS GRAPPLING with the cost and complexity of GLP-1 drugs are increasingly testing a workaround: steering certain employees to direct-to-consumer (DTC) arrangements that operate outside the company's health plan.

The shift reflects a growing tension for benefits executives: how to manage soaring GLP-1 demand while preserving affordability, plan sustainability and clinical oversight.

How direct-to-consumer works

Under a DTC model, employees purchase GLP-1 drugs outside the pharmacy benefit on a manufacturer or designated website. Deductibles, out-of-pocket maximums, prior authorization and PBM utilization management requirements do not apply.

While this removes plan-level clinical guardrails, it can materially lower employees' monthly costs. In many cases, cash-pay prices offered by manufacturers or online platforms are lower than what employees would pay through insurance even after discounts and coinsurance.

Instead of covering GLP-1s as a plan benefit, some employers provide fixed monthly stipends — often $100 to $200 — to offset the cost of direct purchases. This allows employers to cap financial exposure while still offering employees access to treatment.

Drug manufacturers are accelerating this shift. Eli Lilly and Novo Nordisk have expanded DTC programs that allow patients to purchase GLP-1 drugs without using insurance, with monthly cash prices below historical list prices.

Beyond consumer programs, both Lilly and Novo Nordisk are piloting direct-to-employer models that bypass traditional PBM structures. In these arrangements, self-insured employers negotiate pricing directly with manufacturers, while third-party administrators handle eligibility screening, prescribing coordination and fulfillment. The goal is to move pricing closer to net cost and reduce employee cost-sharing.

According to the Peterson Health Technology Institute, some employers are evaluating DTC and DTE arrangements because these may offer lower prices than those through traditional pharmacy benefits. They also provide employers with more predictable spending.

However, benefits leaders should view these arrangements as complementary tools rather than replacements for a structured GLP-1 strategy.

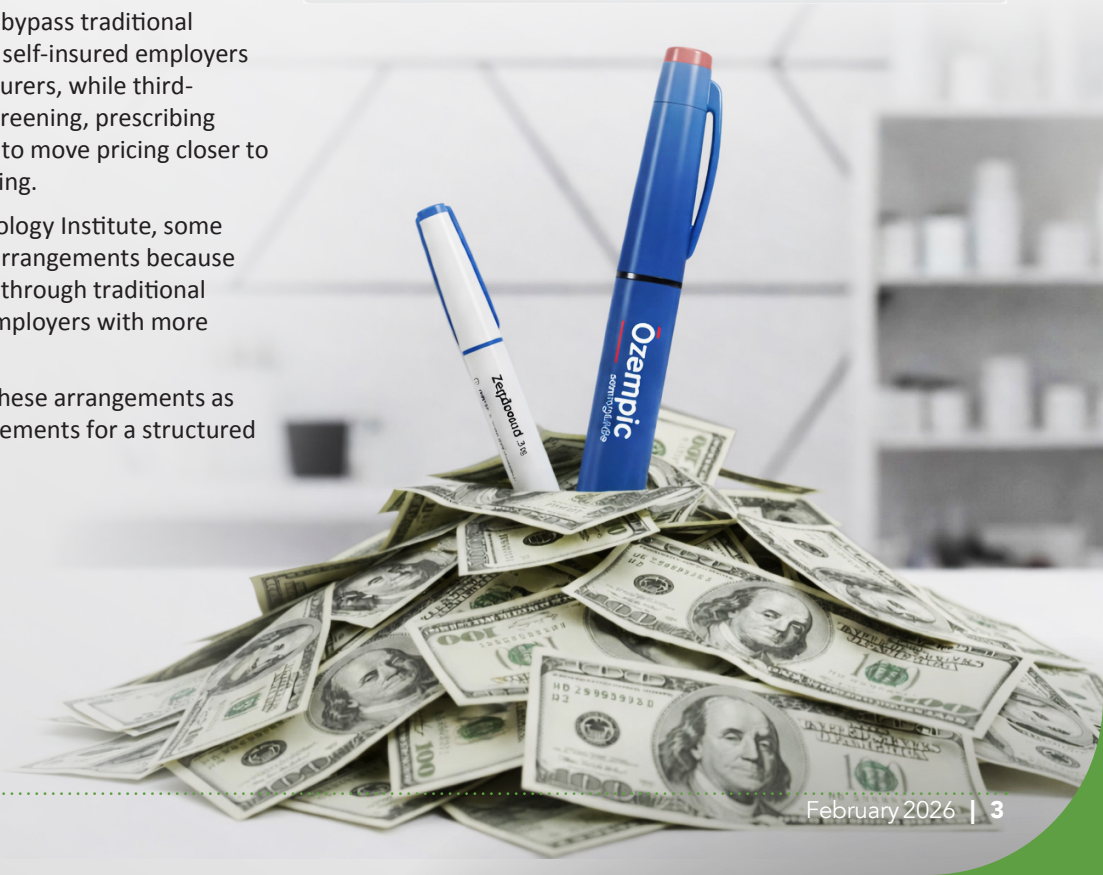
Pros and cons of DTC arrangements

Advantages

- Lower out-of-pocket costs for certain employees.
- Second-chance access for employees who do not qualify under plan rules.
- Predictable employer cost exposure when using fixed stipends or subsidies.
- DTC models typically bypass prior authorization and PBM requirements, reducing friction and administrative delays for employees.

Disadvantages

- Loss of clinical oversight and utilization controls. Off-benefit purchases bypass prior authorization, step therapy and ongoing clinical management built into the plan.
- Employers lose access to claims data needed to track adherence, safety, effectiveness and long-term cost trends.
- Employees may underestimate their total financial exposure, particularly if they later transition back to plan-based coverage.
- Cash-pay prices can make plan coverage appear inefficient or overpriced, even when the pricing structures are not directly comparable.
- Manufacturer DTC pricing reflects market strategy, not negotiated benefit contracts, and can change or be withdrawn with little notice.
- Once established for GLP-1s, employees may expect similar pathways for other high-cost medications.



HEALTH CARE INFLATION

HOW HEALTH INSURERS ARE TRYING TO REIN IN COSTS

BUSINESSES CONTINUE to see higher increases in group health plan premiums due to medical cost inflation, higher utilization and rising drug prices.

As a result, many insurers are pursuing structural changes designed to control long-term costs while improving care quality and the member experience.

Interviews with health plan executives and recent industry reporting point to a common theme: reducing avoidable care, simplifying administration and investing earlier in health to prevent expensive problems later.

Employers and their staff can benefit from these strategies, which are increasingly being built into plan design, provider networks and care management programs that influence both premiums and employees' out-of-pocket costs.

Preventive and personalized care

A central focus for many insurers is expanding preventive care and making it easier for enrollees to engage with their providers. Executives at plans such as Humana and Highmark Wholecare, in a recent roundtable with the news website *Becker's Payer Issues* emphasized coordinated care models that connect primary care, specialists and support services for the patient.

These models rely on data and digital tools to identify care gaps early, such as missed screenings or unmanaged chronic conditions. Members may receive targeted reminders, care manager outreach or digital coaching to stay on track.

Cost containment

Many insurers are expanding value-based payment arrangements that reward providers for keeping patients healthy rather than paying for higher volumes of services. Under these arrangements, insurers and providers share data and align financial incentives around outcomes and the total cost of care.

Plans are also using predictive analytics and artificial intelligence to identify members at higher risk of complications and intervene earlier through care coordination, remote monitoring or alternative sites of care.

Administrative efficiency and transparency

Health plans are investing in modernized claims systems, real-time eligibility and claim validation and more streamlined prior authorization for routine or evidence-based care.

Some plans are reducing or reforming prior authorization requirements where data shows little value, while using technology to make remaining reviews faster and more predictable. Insurers are also working to improve transparency around costs and benefits, helping members better understand service costs and coverage before care is delivered.

For employers, lower administrative costs can help moderate premium growth and reduce HR workload tied to billing disputes and employee questions. Employees may benefit from fewer delays, clearer explanations of benefits and less confusion when accessing care.

What this means for employers and their staff

If these strategies are implemented successfully, both employers and employees stand to benefit through lower premium increases, less expensive claims costs and better health outcomes.

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

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