BENEFITS REPORT

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HEFFERNAN INSURANCE BROKERS
Because You're Different

GROUP HEALTH PLANS

'STEALTH' COST DRIVERS EMPLOYERS CAN'T IGNORE

AS EMPLOYERS face rapidly rising health insurance costs for their employees, industry pundits are increasingly urging benefit leaders to confront "stealth" cost drivers that quietly inflate spending year after year.

While headline issues like premium increases draw the most attention, some of the most meaningful opportunities to control costs lie in areas that are often underinvested or poorly integrated into benefit strategies.

Addiction support services

Behavioral health, and particularly substance use disorders, remains one of the most expensive and least efficiently managed areas of employer-sponsored health care.

Untreated mental health and addiction issues contribute to higher medical claims, absenteeism and lost productivity. According to the Center for Prevention and Health Services, untreated mental health concerns can cost a single organization tens of thousands of dollars annually and amount to more than $100 billion nationwide.

Despite those figures, addiction and recovery services have historically received less attention than other wellness initiatives. Inpatient treatment models can be disruptive for employees and expensive for employers, while high relapse rates have made some organizations hesitant to invest more heavily in this space.

Employer actions: As a result, employers are increasingly looking at more structured, accountable recovery programs that focus on ongoing support, medication-assisted treatment and measurable outcomes.

Improving access to specialty care

Employees may technically have coverage, but long wait times for specialists can delay treatment and worsen underlying conditions. Nationally, more than 100 million specialty referrals are issued each year, yet patients in many metropolitan areas wait more than a month to see specialists such as gastroenterologists, dermatologists or cardiologists.

When employees cannot access specialty care in a timely manner, they are more likely to rely on emergency rooms or urgent care, which drives up costs.

Employer actions: Some employers are responding by supplementing traditional plans with specialty telehealth solutions or third-party platforms that shorten wait times and improve care coordination.

Consider surveying employees to identify gaps in access and understand whether additional solutions are warranted.

Accessing analytics to tailor benefits

Because many organizations still design benefits based on assumptions rather than real utilization patterns, only a small share of workers report being truly satisfied with their benefits — suggesting a disconnect between what is offered and what is needed.

Employer actions: Use carrier-provided tools, if available, such as reporting dashboards, health risk assessments or plan modeling software. Review claims data at least quarterly to identify cost trends, any under- or overutilization, emerging risks or cost anomalies.

Understanding which programs are being used, where employees are falling through the cracks and which interventions are producing results allows organizations to refine benefits with greater precision and financial discipline.

The takeaway

Rising health care costs are unlikely to ease in the near term, but employers are not without options. While there are many areas that can be addressed, focusing on emerging cost-containment efforts could be a winning strategy for employers.

ACA ENHANCED SUBSIDIES

EXPIRATION COULD RIPPLE THROUGH GROUP HEALTH PLANS

THE EXPIRATION of enhanced premium subsidies that have helped millions of Americans afford individual health insurance through the Affordable Care Act (ACA) exchanges at the end of 2025 will be felt by employers offering group health plans.

As exchange coverage becomes less affordable for many households, more workers may look to employer-sponsored plans for stability, while employers that fund Individual Coverage Health Reimbursement Arrangements (ICHRA) to help employees buy coverage may need to revisit affordability and contribution strategies because the same employer funds may cover a smaller share of premiums than before when purchasing health insurance on Healthcare.gov and other state-run exchanges.

The temporary subsidy enhancements enacted during the COVID-19 pandemic removed the 400% federal poverty level income cap and increased the value of premium tax credits across income brackets.

As a result, subsidized exchange enrollment nearly doubled between 2020 and 2024. If the enhanced subsidies expire, higher-income households will lose eligibility altogether while those who remain eligible will receive smaller credits and pay more for their share of the premium.

Increasing enrollment pressure

For employers offering traditional group health coverage, one likely consequence is increased enrollment pressure. As individual premiums rise, employees who previously declined employer coverage may opt in during open enrollment.

That could affect plan participation, contribution levels and claims experience particularly if workers with higher health care needs are more motivated to seek employer coverage.

Labor dynamics could also shift. Workers without access to affordable employer-sponsored coverage may be more inclined to change jobs to secure benefits, potentially influencing recruitment and retention in competitive labor markets. At the same time, fewer employees qualifying for exchange subsidies could slightly reduce applicable large employers' exposure to costly ACA "pay or play" penalties, which are triggered when full-time employees receive premium tax credits.

ICHRA effects

The impact may be more immediate for employers offering ICHRAs, which reimburse employees for individual market coverage rather than providing a group plan.

If subsidies shrink and marketplace premiums rise, some ICHRA allowances that were previously affordable may no longer meet regulatory affordability thresholds. Employers may need to increase contribution levels or adjust benchmark assumptions to remain compliant.

Industry experts have also warned that abrupt shifts in individual market enrollment could create volatility. A contraction in exchange enrollment — particularly if healthier individuals drop coverage — could put upward pressure on premiums, further complicating affordability for both employees and employers relying on individual-market plans.

At the same time, the uncertainty may accelerate interest in alternative benefit strategies. Employers facing steep group plan renewals may explore ICHRAs to shift risk to the broader individual market, though that strategy becomes more complex if exchange affordability deteriorates.

What employers should consider

Now that the enhanced subsidies have expired, employers may want to:

- Review group health plan affordability and employee contribution structures.
- Reassess ICHRA allowance levels and benchmark plans if applicable.
- Evaluate workforce demographics and possible enrollment shifts for 2026.
- Prepare employee communications that explain coverage options and tradeoffs.

IRS COMPLIANCE DEADLINES

GET ACA REPORTING RIGHT AND AVOID FINES

EMPLOYERS FACE a familiar but unforgiving task each winter: reporting their group health coverage details to the IRS. With key Affordable Care Act filing deadlines falling in early 2026, employers who sponsor health insurance for their employees should already be reviewing records, reconciling data and preparing required forms to avoid penalties.

ACA reporting is largely about accuracy and timing, and problems often stem from waiting too long to pull information together. Here's how to get it right and avoid penalties.

The required forms

Form 1095-C – This form must be furnished to each full-time employee, regardless of whether the employee enrolled in coverage. The form reports the health coverage offered, if any, for each month of the year.
Due date: Employers must furnish this form to employees by March 2 this year.
Form 1094-C – This form is filed with the IRS and serves as a summary transmittal of all 1095-C forms. Form 1094-C aggregates employer-level data, including employee counts and whether the employer is part of an aggregated group.
IRS due date: Employers must file paper Forms 1094-C and 1095-C with the IRS on or before March 2, and electronically on or before March 31.

Who must report and why

Under the ACA, any employer that sponsors a group health plan must provide forms to their employees and the IRS.

They must also provide them to any employee who was either a full-time employee for any month in the applicable year or who was covered under the group health plan.

Applicable large employers (i.e., generally, those with 50 or more full-time employees) must report whether they offered minimum essential coverage to full-time employees and whether that coverage met affordability and minimum value standards. The IRS uses this information to determine ALE compliance with the law.

Prepare

The most common ACA reporting issues trace back to incomplete or inconsistent data. Employers can reduce risk by preparing well in advance:

- Confirm 2025 full-time and full-time equivalent counts to ensure ALE status was correctly determined.
- Review payroll, time-tracking and benefits systems to ensure hours worked, eligibility and coverage offers align.
- Verify employee names and Social Security numbers.
- Confirm monthly employee contributions for the lowest-cost, self-only plan that provides minimum value.
- Review affordability calculations using the 2026 affordability threshold of 9.96%.

Note: Hybrid and remote work arrangements can complicate efforts to track employee hours and determine eligibility. Make sure your system accurately captures hours worked regardless of the employee's location.

Potential penalties for noncompliance

Late, incomplete or incorrect filings can trigger penalties under Internal Revenue Code Sections 6721 and 6722 for failure to file correct information returns and failure to furnish correct payee statements.

Penalties generally apply per form and can add up quickly.

The largest fines

Employers can be exposed to employer shared-responsibility assessments if at least one full-time employee receives a premium tax credit through a marketplace. For 2026:

- The penalty is $3,340 per full-time employee, excluding the first 30 employees, if coverage was not offered to at least 95% of full-time employees and dependents.
- The penalty is $5,010 per affected employee if coverage was offered but was unaffordable or failed to meet minimum value, and the employee received a premium tax credit.

Bottom line

ACA reporting is not just a new year task. Employers that reconcile data throughout the year, confirm affordability calculations and submit forms before deadlines are far less likely to face penalties or IRS follow-up.

Preparation should be well underway in January. Waiting until February often leaves too little time to fix errors before the March filing deadlines arrive.

HEALTH INSURANCE NAVIGATION

SEVEN TIPS TO HELP YOUR STAFF AVOID HIGH MEDICAL BILLS

WHEN PEOPLE sign up for a new health insurance plan, be that an employer-sponsored plan or one purchased on the Affordable Care Act (ACA) exchange, they can often be confused about when coverage starts, what is covered and whether they have to share in the costs of a medical procedure.

The Kaiser Family Foundation recently compiled a list of seven takeaways from stories about people who ended up paying large out-of-pocket expenses for medical care. Health plan enrollees should read the following to learn how they can better use their plan and avoid financial blowback.

1. Most insurance coverage doesn't start immediately

Many new plans come with waiting periods, so it's important to maintain continuous coverage until a new plan kicks in.

One exception: An employee can opt into a COBRA policy or purchase a plan on the ACA marketplace (healthcare.gov or a state-run plan in certain states) within 60 days of losing their job-based coverage. With COBRA, once you pay, the coverage applies retroactively, even for care received while you were temporarily uninsured.

They will also qualify for a special enrollment period on the ACA marketplace to get coverage for the rest of the year. Coverage can start the first day of the month after someone loses their employer-sponsored coverage.

2. Check coverage before checking in

Some plans come with unexpected restrictions, potentially affecting coverage for care ranging from contraception to immunizations and cancer screenings.

Enrollees should call their insurer — or, for job-based insurance, their human resources department or retiree benefits office — and ask whether there are exclusions for the care they need, including per-day or per-policy-period caps, and what they can expect to pay out-of-pocket.

3. 'Covered' does not mean insurance will pay

Carefully read the fine print on network gap exceptions, prior authorizations and other insurance approvals. The terms may be limited to certain doctors, services and dates.

Also, while the service may be covered, sometimes it won't be until the deductible or out-of-pocket maximum is met.

4. Get estimates for nonemergency procedures

Before scheduling a nonemergency procedure, an enrollee may be able to shop around among different providers that offer the procedure. Request estimates in writing and if an enrollee objects to the price, they should negotiate before undergoing care.

5. Location matters

Prices can vary depending on where a patient receives care and where tests are performed. If a patient needs blood work, they should ask their doctor to send the requisition to an in-network lab.

A doctor's office connected to a health system, for instance, may send samples to a hospital lab, which can mean higher charges if it's not in-network.

6. When admitted, contact the billing office early

When an enrollee or a loved one has been hospitalized, it can help to speak to a billing representative if possible. Questions to ask:

- Has the patient been fully admitted or are they being kept under observation status?
- Has the care been determined to be "medically necessary?"
- If a transfer to another facility is recommended, is the ambulance service in-network or is it possible to choose one that is?

7. Ask for a discount

Medical charges are almost always higher than what insurers would pay, and providers expect them to negotiate lower rates. Health plan enrollees can also negotiate.

Uninsured or underinsured patients may be eligible for self-pay or charity care discounts.

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

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