BENEFITS REPORT

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HEFFERNAN INSURANCE BROKERS

Because You're Different

UNINTENDED CONSEQUENCES

NO SURPRISES ACT FAILING, DRIVING HEALTH PLAN COSTS

A COALITION of more than 60 employer groups, insurers, patient advocacy organizations and labor groups is urging the federal government to crack down on what they say is widespread abuse of the arbitration process created under the No Surprises Act.

In a Feb. 24 letter to the U.S. Departments of Treasury, Labor and Health and Human Services (HHS), the organizations asked the Trump administration to tighten oversight of the law's independent dispute resolution system. The groups argue that the process, which was designed to settle payment disputes between patients and insurers and out-of-network medical providers, is being manipulated in ways that increase health care costs.

A study cited in the letter found that the IDR process generated at least $5 billion in wasteful spending between 2022 and 2024, including administrative fees and arbitration awards that far exceed typical market rates.

How the No Surprises Act works

The No Surprises Act took effect in 2022 and was designed to protect patients from unexpected medical bills, such as if they unknowingly received care from out-of-network providers (for example, an out-of-network anesthesiologist at an in-network hospital).

The law prohibits providers from billing patients for these unexpected charges. Instead, insurers and providers must negotiate payment for the service. If they cannot reach an agreement, either side can initiate the IDR arbitration process.

Federal regulators originally estimated that about 17,000 disputes would enter arbitration each year. Instead, more than 3.3 million disputes were filed between mid-2022 and May 2025, according to a study published in *Health Affairs*.

A new cost driver

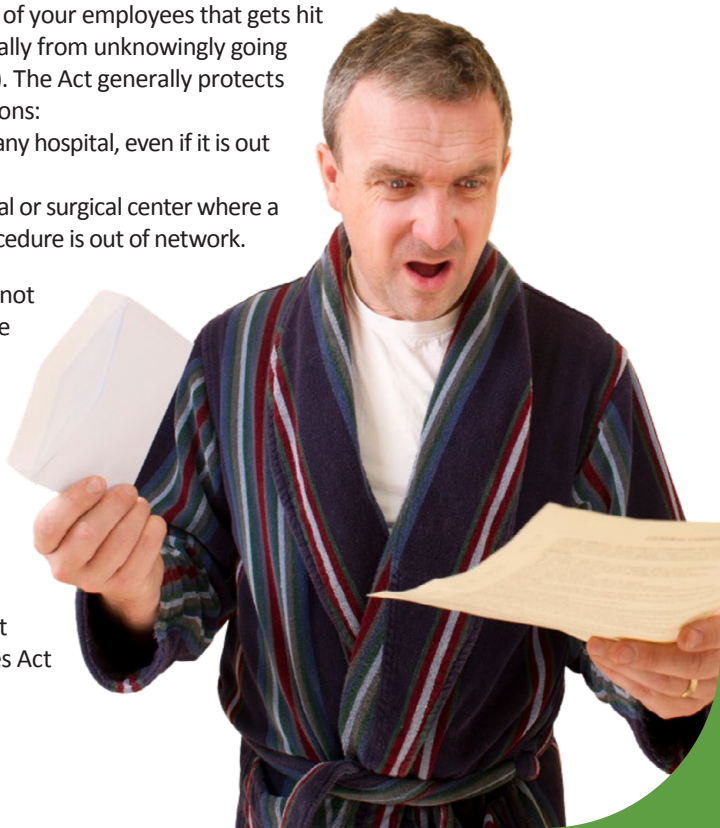
The HHS, issued a report in 2026 that found the Act is driving up costs for health plans, payers and patients. It found that:

- About 85% of the disputes in 2023 involved participants in health plans sponsored by private employers.
- IDR reviewers took an average of 91 days to handle disputes, and some took more than 300 days to close some disputes.
- The reviews cost an average of $445 each.
- The reviewers sided with providers in hospital care cases 80% of the time.
- When reviewers sided with providers, they awarded much higher payment rates. For example: For colonoscopy anesthesia, health insurers paid providers an average of $300 in 2023. When an IDR reviewer handled a dispute involving the procedure, it awarded an average of $1,252.

Your employees

The Act's provisions affects any of your employees that gets hit with a surprise medical bill (usually from unknowingly going to an out-of-network providers). The Act generally protects patients in two common situations:

- Emergency care received at any hospital, even if it is out of network.
- Care at an in-network hospital or surgical center where a specialist involved in the procedure is out of network.



In these cases, the provider cannot bill the patient for the difference between what the insurer pays and the provider's full charge. The patient should only be responsible for the normal in-network cost sharing, such as deductibles or coinsurance.

If a patient believes they were incorrectly billed for a surprise charge, they can file a complaint through the federal No Surprises Act help system.

RETAINING TALENT

A MULTI-GENERATIONAL APPROACH TO EMPLOYEE BENEFITS

OPEN ENROLLMENT season can feel like a familiar ritual: publish the guide, send a few e-mails, hold one webinar and hope employees make good choices. But when employers take a one-size-fits-all approach to benefits design and communication, they often leave participation, satisfaction and retention on the table.

The modern workforce spans four generations, each shaped by different life stages, financial pressures and comfort levels with technology. That means the same benefits message and enrollment experience will land differently depending on who is receiving it.

Benefits are complex, personal and often tied to major life decisions. When communications are too generic or the enrollment process feels frustrating, employees may tune out, postpone decisions or default to last year's elections even when their needs have changed.

Baby boomers

Boomers are often focused on retirement readiness, health care coverage and protecting income:

- Offer live Q&A sessions and phone-based support.
- Provide clear comparisons of plan costs, networks and coverage.
- Highlight catch-up retirement contributions and step-by-step retirement planning resources.
- Pair choices (Medicare coordination, supplemental products and long-term care options) with one-on-one counseling.

Generation X

Gen X employees often juggle competing responsibilities, including kids and aging parents. Communicate by:

- Using concise e-mails and one-page summaries that link to more details as needed.
- Offering self-serve decision tools for health plans, FSAs and disability coverage.
- Emphasizing financial protection benefits (life, disability and critical illness) in plain language.
- Providing flexible office hours for short calls, not long meetings.

Millennials

Millennials commonly look for flexibility and benefits that support evolving family and financial needs. They are comfortable with digital enrollment but still want clarity and proof of value.

- Build mobile-friendly enrollment processes with short videos and brief explainers.
- Spotlight flexibility-related benefits such as remote options, caregiving support and paid leave when applicable.
- Promote financial wellness resources, student loan support or budgeting tools if offered.
- Tie benefits to career growth, such as tuition support, certification reimbursement, mentorship and internal mobility.

Generation Z

- Gen Zers prefer technology-driven portals and information in short, visual formats. They tend to prioritize mental well-being and want.
- Use text message-style reminders, in-app nudges or chat-based help if possible.
- Provide bite-size content like short videos, FAQs and simple "what it covers" flyers.
- Make mental health benefits easy to find and use, including EAP access and digital options.
- Offer guided enrollment portals for those new to employee benefits, including definitions and examples.

Execution

A workable multigenerational strategy does not require building four separate benefits programs. Start by updating how workers access, understand and use existing benefits.

- **Survey and listen:** Ask employees what they use, what confuses them and how they prefer to receive information.
- **Offer "digital plus human":** Keep digital enrollment simple but back it up with real-time support for complex questions.
- **Measure what matters:** Track participation by benefit type, access methods, call center volume and common questions. Then refine communications year-round.
- **Segment by life stage, not just age:** Family status, health needs and financial stress often predict benefit priorities better than age alone.

When employees can engage with benefits in ways that fit them best, enrollment tends to rise, confusion drops and benefits become a more visible driver of satisfaction and retention.

BEST PRACTICES

THE IMPORTANCE OF RECONCILING YOUR EMPLOYEE BENEFITS

EMPLOYEE BENEFITS are one of the largest and most complex expenses many employers manage — and they also include strict fiduciary obligations.

Yet many organizations assume that once open enrollment ends and payroll deductions are set, everything will continue to run smoothly. In reality, enrollment changes, life events, terminations, plan switches and billing delays routinely create discrepancies that can quietly cost both employers and employees money.

Regular reconciliation protects budgets by preventing "premium leakage" — paying for coverage that no longer applies or deducting insufficient amounts from employee paychecks. It can also help mitigate potential legal issues and reduce the risk of employee dissatisfaction when errors surface months later and large corrections are required.

That's why it's important for employers to conduct regular reconciliations of their benefits offerings.

The reconciliation process

Gather information — Reconciliation begins with assembling accurate, matching data for the same coverage period. Employers typically need carrier invoices, payroll deduction reports and enrollment records from their HR or benefits administration system.

Compare enrollment and invoices – Employers should compare the list of employees and dependents on carrier invoices with internal enrollment records. This step helps identify common issues such as terminated employees still being billed, active employees missing from invoices or dependents incorrectly listed. It also confirms that employees are enrolled in the correct plans.

Verify payroll deduction amounts – Next, payroll deductions should be reviewed in comparison against plan rates and contribution structures.

This includes checking employee-only versus family tiers, employer subsidies and any midyear changes triggered by qualifying life events. Even small per pay period errors can add up over time if left uncorrected.

Investigate issues – Discrepancies are common and do not necessarily indicate a system failure. New hires may not yet appear on invoices, plan changes may not have been processed in time or terminations may have missed the carrier cutoff date.

Each issue should be investigated, corrected and communicated to the appropriate party — whether that is payroll, HR, the employee and/or the carrier.

Document findings and resolutions – Finally, employers should document findings and resolutions. This may involve adjusting future payroll deductions, requesting invoice credits or corrections from carriers or updating enrollment records.

Clear documentation creates an audit trail and helps prevent recurring errors.

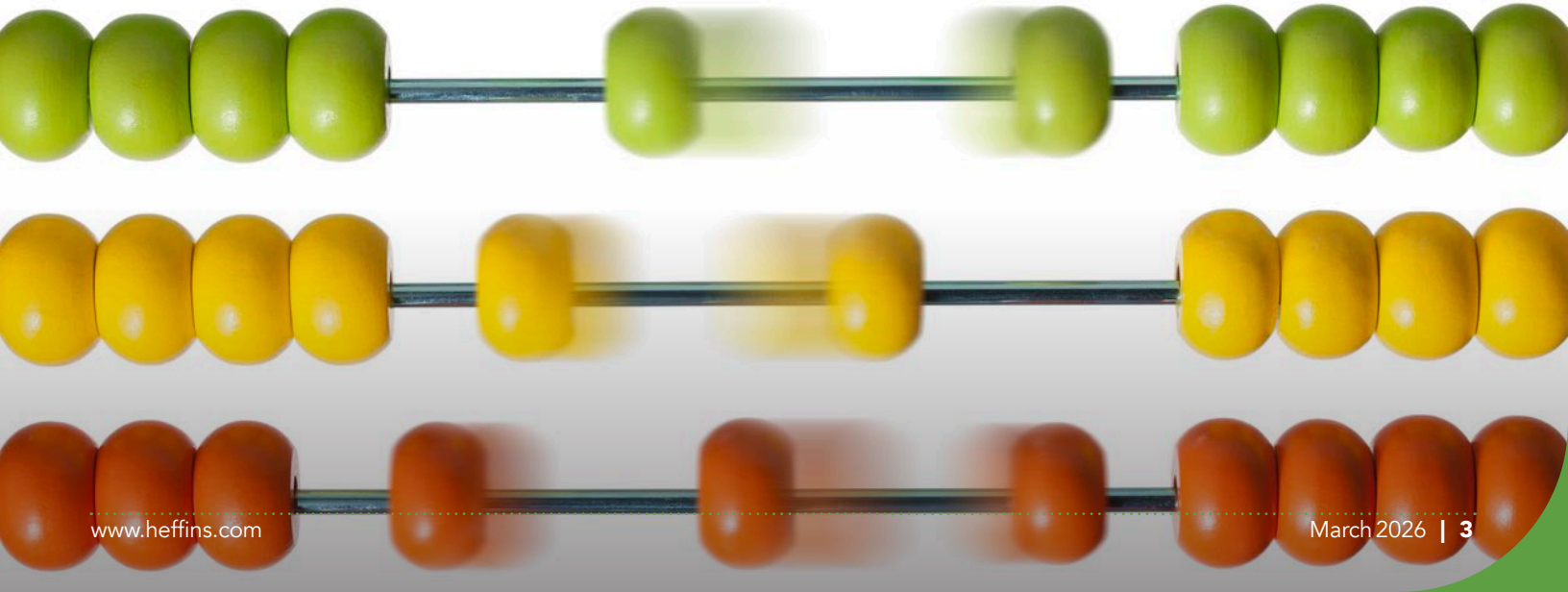
Best practices for employers

Conduct regular audits — Monthly reconciliation is widely considered a best practice, especially for medical, dental and vision plans.

Use automation wisely — Many employers now use payroll or benefits administration tools that automate comparisons between enrollment, deductions and invoices, reducing manual work and improving accuracy.

Consider third-party support — There are vendors that specialize in benefits reconciliation and invoice auditing. These services can be valuable for organizations with multiple carriers, frequent employee changes or limited internal resources.

Include COBRA and other benefits — Reconciliation should extend beyond active employee plans. Employers should also confirm that COBRA participants are billed correctly and that voluntary and ancillary benefits are handled with the same discipline.



HEALTH CARE INFLATION

NEW LAW AIMS TO REIN IN PBMS, REDUCE COSTS

THE FEDERAL spending package that President Trump signed into law Feb. 3 includes provisions aimed at reining in pharmacy benefit manager tactics that have drawn fire from employers, insurers and lawmakers for allegedly driving up costs.

The changes in the Consolidated Appropriations Act of 2026 are designed to ensure that manufacturer rebates and other drug-price concessions flow back to plans and self-insured employers, while giving plan fiduciaries better data to evaluate whether PBM contracts are truly lowering costs.

The goal is for health plans to pass those funds back to their employer customers in the form of lower premiums as they have in West Virginia after similar legislation took effect there, according to studies.

PBMs contract with drugmakers, pharmacies and payers, and handle formularies, pharmacy networks and claims processing while negotiating rebates and discounts with manufacturers … all in the state go. Critics across the political spectrum argue that PBMs' incentives can push plans toward higher list-price drugs with bigger rebates, which PBMs have been accused of pocketing. But that also means that employers and employees pay more overall, especially when cost sharing is tied to list price.

Skeptics of the legislation worry that PBMs will adjust to the legislation by replacing lost rebate-related revenue with administrative fees or other contract mechanics

Reforms that matter most to employers

Rebate and discount pass-throughs — The law requires PBMs to pass through 100% of manufacturer rebates, fees, discounts and other remuneration (excluding "bona fide service fees") to ERISA-covered group health plans or plan sponsors.

Practically, it targets business models where PBMs retain a share of rebates or embed revenue in "spread pricing."

The pass-through requirement will apply to PBM contracts that are entered into, renewed or extended for plan years beginning on or after Aug. 3, 2028. For many calendar-year plans, that effectively means Jan. 1, 2029.

Transparency and reporting — PBMs will have to provide detailed reporting to group health plans at least twice per year, with an option for quarterly reporting if the plan requests it.

Reports are expected to include information that helps sponsors understand drug spend and PBM revenue sources such as rebates, fees and spread pricing, plus data tied to formulary decisions. Civil penalties can apply for failures to disclose and for knowingly providing false information.

What's in it for employers

A key reason employers and other payers are hopeful is the experience in West Virginia, where state officials reported that a rebate pass-through approach was associated with materially smaller group premium increases in the state's 2026 small-group and large-group filings.

For example, for 2026, the rebate pass-through mandate cut the average group health plan rate increase to 12.6%, from 19.5%, according to data calculated by the insurers and published in a report compiled by the West Virginia Offices of the Insurance Commissioner. The pass-through mandate caused one insurer to cut its large-group rates by 3%, rather than increasing its premiums by 5%.

That said, state results can be hard to generalize because plan design, market competition and underlying claims trends differ.

For employers that purchase group health insurance, the new PBM rules could eventually help reduce prescription drug costs by ensuring that rebates and discounts negotiated by PBMs flow back to health plans instead of being retained by intermediaries.

However, because the reforms do not take effect for several years and PBMs may adjust their pricing models, employers should not expect immediate savings. Employers should also work with us to monitor how your carriers incorporate the new requirements into future pharmacy benefit arrangements.

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

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