

# BENEFITS REPORT



*Because You're Different*

## STREAMLINING DELIVERY

# HEALTH INSURERS MAKE PRIOR AUTHORIZATION HEADWAY



HEALTH INSURERS are reporting progress on their voluntary effort to streamline prior authorization. They say they are on track to standardize the process for submitting prior authorization requests for coverage for many common procedures by Jan. 1, 2027.

The push, led by America's Health Insurance Plans and supported by major carriers, aims to standardize how prior authorization requests are submitted and reviewed across commercial plans, Medicare Advantage and Medicaid-managed care. Currently, prior authorization rules are inconsistent, even within a single insurer's operations, and providers have for years bemoaned how authorization delays endanger patients.

Insurers say the goal is to reduce the number of procedures that require prior authorization and to make decisions more quickly on approvals or denials.

Under the initiative, insurers will begin applying common electronic submission standards to frequently reviewed services, such as orthopedic procedures and imaging like CT scans and MRIs, with broader adoption targeted by Jan. 1, 2027.

Other insurers participating in the effort include Elevance Health, Humana, Kaiser Permanente and various Blue Cross and Blue Shield affiliates.

Insurers say standardizing electronic submissions should reduce delays caused by incomplete paperwork and cut down on back-and-forth between providers and health plans.

### Why this matters for employers

For employers that sponsor health plans, prior authorization has been a persistent pain point for their employees. Delays in approvals can disrupt care, affect productivity and lead to employee complaints.

If the changes work as insurers describe, employees could receive faster decisions and face fewer administrative hurdles when seeking care. Employers, however, may need time to assess whether faster approvals will translate into higher utilization and increased claims costs.

*See 'Insurers' on page 2*

## Prior approval status report

Several carriers have disclosed their own progress since they pledged to reform prior approval last year:

- UnitedHealth Group said more than half of its prior authorization volume already follows standardized processes, with a goal of reaching about 70%. The company also said it plans to expand standardization to additional services and reduce the need for repeated requests.
- Cigna reported it has reduced prior authorization volume by about 15% and expects more than 70% of its reviews to fall under the new standards.
- CVS Health, through its Aetna unit, said it has already standardized roughly 88% of its prior authorization volume.
- Across participating insurers, industry groups said prior approval requirements have been reduced by about 11% so far, though reporting methods differ by company.

## HEALTH PLAN DRUG RULES

# BILL WOULD ALLOW ONLINE PURCHASES GO TOWARD DEDUCTIBLES

WORKERS ARE increasingly turning to direct-to-consumer online drug platforms like Amazon Pharmacy, Mark Cuban Cost Plus Drug Company and the government-backed TrumpRx to buy prescription medications at prices that are sometimes far lower than what they would pay through their employer-sponsored health plans.

But in many cases, the money they spend on those drugs does not count toward their health plan deductible or annual out-of-pocket maximum.

A new bill in Congress aims to change that. The Every Dollar Counts Act, introduced by Rep. Greg Murphy (R-North Carolina), would require health insurers to apply out-of-pocket spending on covered prescription drugs toward a patient's deductible and out-of-pocket maximum, regardless of where the drugs were purchased.

Murphy, a physician and longtime critic of insurers and pharmacy benefit managers, said the legislation is designed to remove barriers that can discourage patients from using lower-cost prescription drug options.

Direct-to-consumer drug platforms have gained traction by bypassing some traditional distribution channels and offering discounted pricing, particularly for certain brand-name medications.

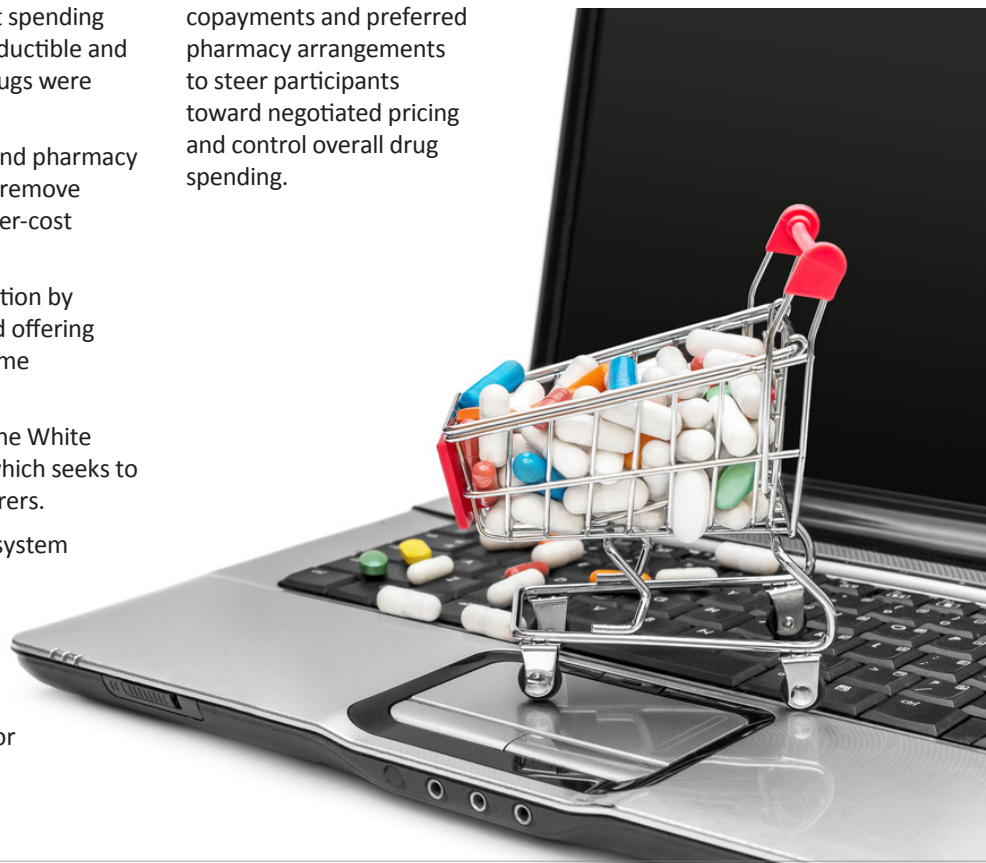
The issue has drawn additional attention following the White House-backed launch of TrumpRx earlier this year, which seeks to negotiate lower drug prices directly with manufacturers.

Supporters of the legislation argue that the current system can effectively force patients to "pay twice." Even if a worker saves money by purchasing a medication through a low-cost online platform, those expenditures often do not help satisfy the plan deductible unless the drug was purchased through a plan-approved pharmacy or pharmacy benefit manager network.

For employers, the proposal highlights a growing tension in prescription drug benefits.

On one hand, allowing employees to use lower-cost purchasing options could reduce out-of-pocket expenses and improve medication adherence. Employees who can afford their medications are more likely to stay on treatment and avoid more costly health complications later.

On the other hand, some employers and health plans may worry that the bill could weaken cost-management strategies tied to network pharmacies, formularies and benefit design. Plans often use deductibles, copayments and preferred pharmacy arrangements to steer participants toward negotiated pricing and control overall drug spending.



*Continued from page 1*

## Most Large Insurers Are Making Incremental Changes

### Limits and ongoing concerns

Despite the reported progress, the initiative has notable gaps. The commitments are voluntary and not all insurers have set clear targets for reducing prior authorization requirements. In addition, reforms largely focus on medical services and do not yet fully address prescription drug approvals, which make up a significant share of requests.

Health plans continue to defend prior authorization as a tool to control unnecessary or overly expensive care. Providers,

meanwhile, argue that requirements are often excessive, slow and inconsistent across insurers. They also note that similar reform efforts dating back years have not fully resolved delays or administrative burdens.

For now, insurers are making incremental improvements like standardized data and reducing the number of procedures that require prior approval. Policymakers and regulators continue to weigh whether more formal rules are needed.

## CHANGING BENEFITS

# HELP OLDER EMPLOYEES NAVIGATE SHIFT TO MEDICARE

FOR MANY workers, retirement marks the first time they must make complex health coverage decisions on their own. After years of relying on employer-sponsored insurance, the transition to Medicare can feel abrupt and confusing, often leaving employees unsure of what to do next.

Employers that step in to guide workers through this transition can improve retirement outcomes, reduce benefit costs and strengthen employee trust. When older employees understand their Medicare options, they are more likely to retire on time, avoid costly mistakes and feel supported by their employer.

### The risks of not helping

Employees approaching retirement often receive little more than COBRA paperwork and general instructions. This lack of guidance can lead to employees making costly errors such as missing key enrollment deadlines.

### Costly penalties for late enrollment

Two of the most common and expensive mistakes involve late enrollment penalties that apply for the rest of an enrollee's life:

**Medicare Part B (medical insurance):** If employees do not enroll when first eligible and lack qualifying coverage, they may face a lifetime premium penalty that increases their monthly cost permanently. The penalty is 10% of the standard premium for every full 12-month period the employee was eligible but didn't enroll or have qualifying coverage.

**Medicare Part D (prescription drug coverage):** Delaying enrollment without creditable drug coverage can trigger a permanent penalty added to premiums. The penalty is 1% of the baseline premium for each month the person didn't have Part D coverage.

Also, some employees remain on employer plans longer than necessary, increasing costs for themselves and the organization.

### How Medicare works with employer coverage

Medicare decisions are not one-size-fits-all. Whether an employee should enroll at age 65 depends largely on their employment status and employer size.

Employees working for companies with 20 or more staff can often delay Part B without penalty if they remain covered under the employer's plan. Those at smaller firms may need to enroll in Medicare at 65, as Medicare typically becomes the primary payer.

Employees must also coordinate coverage if they have a spouse on the plan or contribute to a health savings account, which they must stop prior to Medicare enrollment.

### How employers can support the transition

You don't need to provide individualized advice to help your older workers. You can easily create an education strategy that will go a long way toward improving outcomes. Make sure to:

- **Start early.** Introduce Medicare basics as early as age 60, with more detailed education between ages 62 and 64.
- **Offer workshops and webinars.** Discuss enrollment deadlines, coverage options and how Medicare interacts with employer plans.
- **Provide decision-support tools.** Help employees evaluate whether to stay on the employer plan or transition to Medicare.
- **Send timely reminders.** Notify staff as they approach their initial enrollment window (three months before and after age 65).
- **Connect employees with experts.** Offer access to third-party Medicare advisers for one-on-one guidance.
- **Integrate into offboarding.** Include Medicare education in retirement planning materials and exit communications.

### Benefits to your organization

When older employees understand their Medicare options, they are more likely to retire on time and avoid costly mistakes. With proper guidance, employers can turn a confusing and stressful process into a well-managed transition that benefits everyone involved.



## STUDY FINDINGS

# EMPLOYERS SEE 500% ROI ON MENTAL HEALTH PROGRAMS

AS DEMAND grows for employer-sponsored behavioral health programs, new research suggests well-designed mental health programs can generate measurable financial returns for businesses while improving employee well-being.

Behavioral health services can deliver a projected return on investment of more than 500%, with employers seeing about \$6.07 returned for every \$1 spent, according to an analysis by ComPsych, a company that specializes in organizational mental health and absence management services.

While group health plans are required by law to cover mental health services just as they do physical health services, the shortage of therapists coupled with soaring demand has made it difficult for enrollees to access psychologists on a regular basis. Providing additional behavioral health services can help bridge that gap.

### Where the savings come from

Besides the services offered through group health plans, employers have additional options, including:

- **Employee assistance programs** – Typically provide a set number of free counseling sessions, along with referrals for ongoing care.
- **Tele-counseling and virtual therapy** – Access to licensed therapists via video, phone or messaging.
- **In-person therapy networks** – Expanded provider networks or preferred access to local clinicians.
- **Mental health apps** – Tools focused on stress, anxiety, sleep and mindfulness.
- **Caregiver support** – Help managing elder care, childcare or family responsibilities.
- **Mental health days or expanded leave policies** – Time off specifically for mental well-being.

### How employers benefit

The financial impact is driven by several factors that tie directly to workplace costs:

**Lower medical spending** – Early intervention can reduce emergency room visits, hospitalizations and prescription drug use (this accounts for about one third of ROI).

**Fewer disability claims** – Treating mental health conditions before they escalate can prevent or shorten disability leaves (this accounts for about 15% of ROI).

**Reduced absenteeism** – Employees who receive care are less likely to miss work.

**Improved productivity** – Workers who are mentally well tend to be more focused and engaged on the job (this accounts for about half of ROI).

### Access and engagement remain key

While many employers offer behavioral health benefits, utilization is often lower than expected. Stigma, lack of awareness and limited access can all stand in the way.

Expanding access has become easier in recent years, particularly with the growth of telehealth and digital tools. Many employees now prefer a mix of in-person and virtual care, allowing them to fit treatment into busy schedules.

Employers that see the strongest results tend to focus on more than just offering benefits. They also actively promote them.

### Strengthen behavioral health ROI

To get the most value from behavioral health investments, employers can:

- Promote benefits regularly so employees know what is available.
- Train managers to recognize signs of stress and guide employees to resources.
- Offer a mix of in-person, virtual and self-guided care options.
- Integrate mental health with broader well-being programs, including financial and caregiving support.



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

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