BENEFITS REPORT

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HEFFERNAN INSURANCE BROKERS

Because You're Different

GROUP HEALTH COVERAGE

EMPLOYERS EXPLORE NEW STRATEGIES AS COSTS RISE

A NUMBER of surveys are predicting another year of steep group health insurance cost increases in 2027, prompting many employers to rethink plan designs, pharmacy benefits and relationships with health care vendors.

The Business Group on Health's "2027 Employer Healthcare Strategy Survey" projects a median 9.2% increase in employer health care costs in 2027, which employers hope to reduce to about 8% through plan changes. Other forecasts are projecting similar premium increase in the coming year.

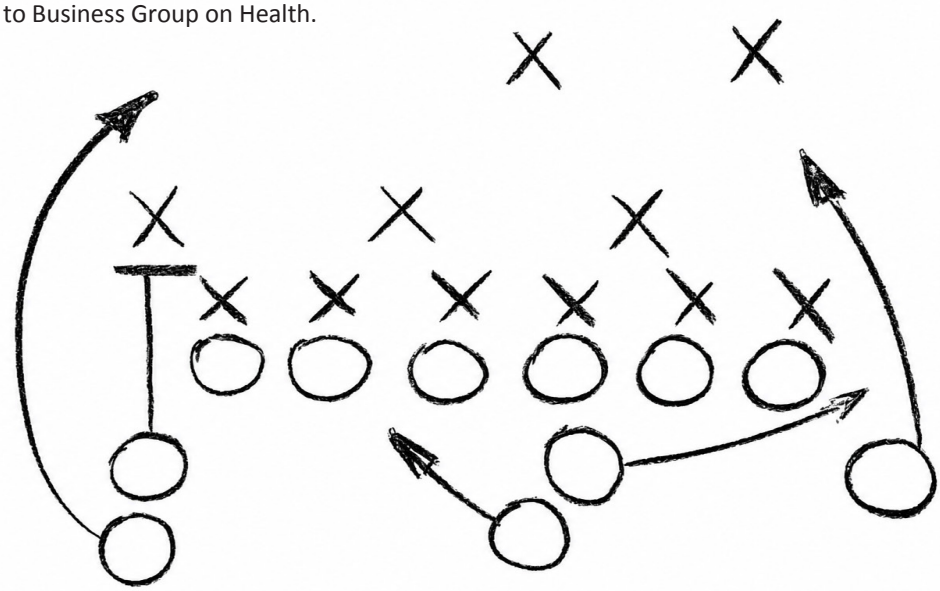
Multiple forces pushing costs higher

Employers are being hit by large claims, expensive prescription drugs and rising costs for treating serious health conditions.

Catastrophic claims: According to a survey by the International Foundation of Employee Benefit Plans (IFEBP), employers cited catastrophic claims more often than any other factor as the primary driver of higher costs. A small number of employees play an outsized role in increasing average claims costs due to lengthy hospital stays, complex cancer treatments, specialty medications or other intensive care that can generate claims reaching hundreds of thousands of dollars or more.

Cancer is a major contributor. In the Business Group on Health survey, 70% of employers ranked cancer as the top condition driving their health care costs, and 92% placed it among their three most expensive conditions. Musculoskeletal conditions ranked second, cited by 68%, followed by cardiovascular conditions at 37%.

Prescription drugs: Pharmacy benefits now account for about one-quarter of employer health care spending, and drug costs are projected to increase 12% in 2026, according to Business Group on Health.



Drug cost concerns for employers

- GLP-1s
- Autoimmune and inflammatory therapies
- Cancer drugs, and
- Cell and gene therapies

Medical care and provider pricing: Employers are also paying more for hospital and physician services.

Business Group on Health points to declining population health, rising provider prices and increased use of expensive therapies as part of the broader cost problem. Employers have also underestimated their health care costs for three consecutive years, illustrating how difficult medical expenses have become to predict.

Cost-control strategies

With costs continuing to climb, employers are increasingly looking beyond simply raising deductibles and shifting more expenses to workers. Strategies include:

Steering workers to high-value providers. Centers of excellence and high-performance networks direct employees to providers with better outcomes and more competitive pricing. Eighty-four percent of Business Group on Health respondents plan to offer at least one center of excellence in 2027.

Reassessing pharmacy benefits. Employers are exploring transparent, pharmacy benefit managers that provide

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ACA COMPLIANCE

GROUP HEALTH PLAN AFFORDABILITY LEVEL RISES FOR 2027

THE IRS has increased the group health plan affordability threshold, which determines whether an employer's lowest-premium health plan complies with Affordable Care Act rules, for plan years beginning in 2027.

The threshold has been set at 10.22% of an employee's household income, up from 9.96% in 2026. The higher threshold will give employers more leeway in determining employees' share of health insurance premiums. It also marks the first time the threshold has exceeded 10%.

Under the ACA, "applicable large employers" — those with 50 or more full-time or full-time-equivalent employees — must offer their workers at least one health plan that is considered affordable based on a percentage of the lowest-paid employee's household income. Employers may face penalties for noncompliance.

For 2027, coverage is considered affordable if the lowest-paid employee's required contribution for self-only coverage under the employer's lowest-cost plan providing minimum value does not exceed 10.22% of their household income.

The affordability test applies only to the employee's cost for self-only coverage, not to the premium for family coverage. If an employer offers multiple health plans, the test is based on the lowest-cost option that provides minimum value.

Calculating plan affordability

Employers can rely on one or more safe harbors when determining if coverage is affordable:

- The employee's most recent W-2 wages.
- The employee's rate of pay, which is the hourly wage rate multiplied by 130 hours per month.
- The federal poverty level.

Penalties

Failure to provide affordable coverage may result in a penalty of $5,670 per affected full-time employee in 2027, up from $5,010 in 2026. The penalty may apply when an employee is offered unaffordable coverage and receives a premium tax credit for Marketplace coverage.

A separate Employer Shared Responsibility Payment may apply if an employer fails to offer minimum essential coverage to at least 95% of its full-time employees and their dependents and at least one full-time employee receives a premium tax credit for Marketplace coverage.

The separate penalty will rise to $3,780 per employee in 2027 from $3,340 in 2026. It is generally calculated using the employer's total number of full-time employees minus 30.

Both penalties are indexed to inflation and calculated monthly.

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Employers May Eliminate Underutilized Programs

greater visibility into drug pricing and rebates. They are also tightening utilization controls on costly drugs, including GLP-1s, and encouraging lower-cost biosimilars when clinically appropriate.

Demanding more from vendors. Employers are scrutinizing wellness, digital health and other benefit programs for measurable results. In 2027, 58% of Business Group on Health respondents plan to replace underperforming vendors and eliminate underutilized programs. Others are increasing the portion of vendor fees tied to outcomes.

Improving employee navigation. Providing employees with cost and quality information before they schedule care may help them find higher-quality, lower-cost providers. Employers may also consider reducing cost-sharing for high-value preventive and chronic-condition care.

Digging into claims data. Claims audits, utilization reviews and predictive analytics can help identify billing problems, high-cost conditions and opportunities for earlier intervention.

OPEN ENROLLMENT PREP

PAY ATTENTION TO HEALTH PLAN NOTIFICATION DEADLINES

AS YEAR-END annual open enrollment approaches for many group health plans, plan sponsors also have to be mindful of their obligations under the law to distribute health plan notifications.

The Affordable Care Act and other laws require that employers furnish certain forms and documents to employees annually. To help your organization remain compliant, we've compiled this list of health and wellness plan notices that employers need to provide annually, in addition to a few that we recommend you include in your benefits communications.

Most of the documents must be distributed during open enrollment. Here's the list.

Summary of Benefits and Coverage

The SBC gives employees a standardized, easy-to-compare summary of a health plan's benefits, deductibles, copayments, coinsurance, exclusions and coverage limitations. It is required for most group health plans, including self-insured plans.

When it must be distributed: With open enrollment materials when employees have an opportunity to elect or change coverage.

Medicare Part D Creditable Coverage Notice

Employers offering prescription drug coverage must notify Medicare-eligible individuals whether their coverage is "creditable" under Medicare rules. Creditable coverage is expected to pay at least as much as the standard Medicare Part D coverage.

While there is no direct penalty to employers for failing to send the notice, a delay can lead to higher costs for staff who later enroll in Medicare Part D without having maintained creditable coverage. Because employers typically do not know which workers are eligible for Medicare, sending this notice to all employees is considered best practice. You can find model notices here.

When it must be distributed: By Oct. 15 each year.

Grandfathered Plan Notice

This document outlines ACA protections for non-grandfathered plans, ensuring participants understand their coverage rights.

When it must be distributed: This notice must be distributed whenever a summary of benefits, description of coverage or enrollment material is provided to participants and beneficiaries.

Children's Health Insurance Program Notice

This document alerts employees to the availability of premium assistance programs through their state of residence. This notice should be sent to all employees, regardless of location, to avoid the burden of tracking residency status. Failure to provide the CHIP notice can result in fines of up to $137 per employee per day.

When it must be distributed: Although it doesn't have a fixed deadline, many employers include it in their annual open enrollment materials to ensure consistent delivery.

The Women's Health and Cancer Rights Act Notice

This federally mandated disclosure informs group health plan participants and beneficiaries of their rights to post-mastectomy breast reconstruction benefits. It must be sent to all employee participants and covered beneficiaries in your health plan.

When it must be distributed: Annually, typically included with open enrollment materials.

ICHRA Notice

Employers offering an Individual Coverage Health Reimbursement Arrangement must give eligible employees a written notice explaining the arrangement and important consequences of accepting it. Among other things, the notice helps employees understand how the ICHRA interacts with individual health insurance coverage and eligibility for premium tax credits through the ACA Marketplace.

When it must be distributed: Generally, at least 90 calendar days before the beginning of each plan year. Employees who become eligible later, such as certain new hires, generally must receive the notice no later than the date the ICHRA can first take effect for them.

VOLUNTARY BENEFITS

ACCIDENT INSURANCE CAN SAVE YOUR WORKERS FROM RUIN

EVEN IF you are providing your staff with health benefits, they could be left under great financial pressure if one of them has a major accident off the job that leaves them debilitated and unable to work.

Millions of working Americans struggle with managing out-of-pocket costs for non-medical and medical expenses after suffering an unexpected event such as an accident.

If you are already offering your employees health insurance coverage, you can help fill the gap by also offering voluntary accident insurance, which can pay for:

- Lost wages,
- Deductibles and other expenses not covered by insurance,
- Transportation to and from hospitals and doctors' appointments, and
- Home modifications.

Many Americans are ill-prepared financially

According to a survey by Prudential Insurance Co.:

- Two-thirds of Americans say it would be very or somewhat difficult to meet their current financial obligations if their next paycheck were delayed for just one week.
- Half of all households say they have less than $10,000 in liquid assets available for use in an emergency.

Why your employees need coverage

- Health insurance only covers a portion of expenses, and only after the employee has paid their deductible and copay.
- Employees sometimes have to pay out of pocket for medicines, medical equipment and visits to out-of-network physicians.
- Employees have to pay out of pocket for travel to appointments, home accommodations, caregiving and housekeeping if they need help after an accident.
- Lost wages are a sometimes overlooked cost of illness or injury. This can be an issue not only for the employees directly impacted by illness or injury, but also for family members.

Types of accident insurance

Traditional treatment-based plans. These pay benefits based on the occurrence of an accidental injury and the type of treatment or procedure required to treat an injury.
The injured individual will often submit a separate claim for each service they receive related to the accident. For example, if they were in a car accident in which they broke both legs, they would file individual claims for:

- Costs not covered by health insurance for each service to treat the injury.
- The cost of paying for transportation to doctors' visits and physical therapy sessions.
- Each time a home caregiver visits them to provide care.

Incident-based plans. These pay benefits based on the incident and type of injury. This can simplify the claims process by reducing the number of claims that must be submitted.
In the case of the car accident victim with broken legs above, they would likely be required to submit evidence only for the fractures and for their hospital stay to be reimbursed.

Benefits to the employer

A more robust benefits package – Offering accident insurance paid for by employees allows you to provide a more robust benefits package that can improve employees' satisfaction with their jobs.

A smoother transition to high-deductible health plans – Employers replacing traditional medical insurance with an HDHP may find the transition more readily accepted by employees if it is accompanied by an offer of a voluntary accident insurance plan.

Potential for improved productivity – Employees under financial pressure may be less productive than those who are not, and knowing they have accident insurance can put their fears to rest.

Low cost and administrative burden – Most employers offer accident insurance that is paid for by the employee, meaning there is little or no cost to the organization.

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

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