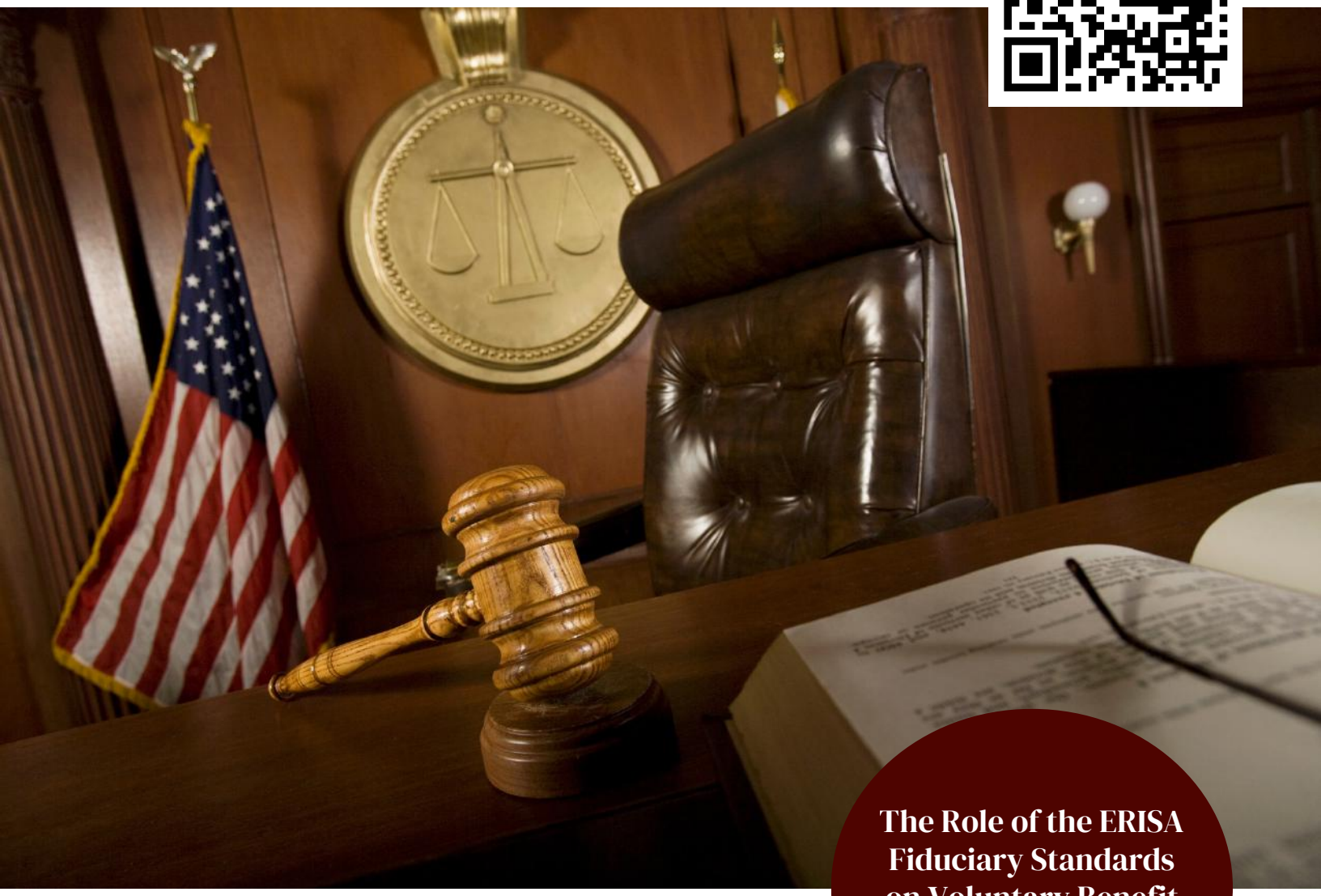
January 2026

Voluntary Benefits Voice

MAGAZINE



The Role of the ERISA Fiduciary Standards on Voluntary Benefit Plans, Programs, and Arrangements

Turning Up the Heat: New State Scrutiny Over Loss Ratios Means Added "Fiduciary Responsibility" Pressures for Plans and Brokers

2026 Outlook: Advisory Board Perspectives on the Future of Voluntary Benefits

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FEATURED ARTICLES

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EASTBRIDGE
COUNSEL TO THE VOLUNTARY INDUSTRY
PART OF NMG CONSULTING

Benefits Outside The Box

PES BENEFITS

Virtual Care as a Fiduciary Advantage

Let’s Get It Started

From The Editor...

Cheers to 2026.

Here we are January 2026 with new goals in hand. Phones are ringing, emails and texts are flowing, LinkedIn activity is back at full strength, flights are booked, and calendars are quickly filling with meeting invites. It is the season to recap the year behind us and begin mapping the route ahead.

Of course, promises will be signed, sealed, and delivered. And yes, some will fail before they ever lift off the ground if history stays its course. Questions will be asked some precisely, others, unfortunately, a bit "grey." Mergers and acquisitions will continue, as change remains the only constant in a thriving marketplace that benefits all stakeholders. New vendors will enter with energy, passion, and bold resolve, while some existing players will exit, leaving behind unanswered questions.

For those who believe in self-reflection, the question remains: will you plan your work and work your plan, or will you pivot at the first sign of challenge?

As we collaboratively paint our individual canvases in 2026, we will undoubtedly be influenced by visible trends already shaping our industry: benefit cost pressures, Rx trend rates, life-stage support strategies, and the accelerating influence of technology. These forces will surely play a role when we look back on this year in January 2027.

Yet when asked the age-old question "What keeps you up at night?" what drivers are not yet visible? What emerging risks could materially impact on how we protect our valued clients so their employees can rest easily each night? Will the catalyst be a mid-term election outcome in a key swing state? New legislation stemming from voluntary benefit litigation? Evolving carrier revenue models tied to cost-containment strategies?

As always, we remain ready to listen, discuss, evaluate, pivot, and proceed committed to moving our marketplace onward and upward.

In this month's issue, you will hear from our Voluntary Advantage Advisory Board as they share their perspectives on what 2026 may bring. Their passion and insights continue to help us play a small but meaningful role in shaping and guiding our marketplace to new levels.

Here's to all of you as you transform your blank canvas into the most beautiful and rewarding one yet in 2026. We share an extraordinary opportunity to help secure the financial livelihoods of so many—an impact that will endure for generations, long after we pass the torch to the next wave of voluntary benefit leaders.

Benefits Outside the Box:
Employee Buying Trends For Nontraditional & Noninsurance Benefits

By Eastbridge Consulting Group, Inc.

Open enrollment season recently wrapped up for most stakeholders in the employee benefits industry. The success of this critically important and time-consuming annual event hinges at least in part in a deep understanding of the benefits employees are buying — which benefits are most popular and which "missing" benefits they would most like to have access to. That may be especially true for nontraditional and noninsurance benefits, two categories playing a growing role in employee benefit packages, according to our most recent MarketVision™ — The Employee Viewpoint© report.

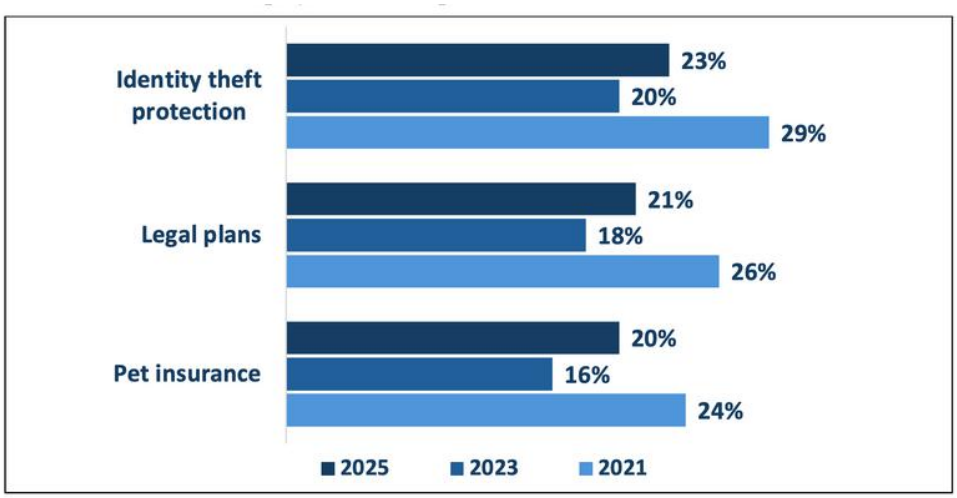
What Employees Are Buying

Not surprisingly, employees are most likely to have core benefits including medical, dental, vision and prescription drug coverage, and many also have mainstream voluntary benefits such as life, disability and accident coverage.

But employees also continue to show significant interest in expanding their protection with other, nontraditional benefits. About one in five employees own identity theft protection (23%), legal plans (21%) or pet insurance (20%). Ownership of these benefits increased last year compared to 2023 but has not quite caught up to the immediate post-pandemic levels of 2021.

Employees also express interest in a wide range of noninsurance benefits. The top three noninsurance benefits employers offer are mental health programs (57%), telemedicine (47%), and financial wellness/planning (41%). Telemedicine and mental health also are the non-insurance benefits employees use most, followed by purchasing programs and financial wellness/planning services.

Employee Ownership of Nontraditional Benefits



Source: Eastbridge 2025 MarketVision™—The Employee Viewpoint© Report

Other non-insurance benefits employers offer that employees buy less frequently include bereavement support, student loan repayment programs, caregiver/family/senior care, estate and will planning services, and genetic testing services.

What Employees Want Access To

Employees also are thinking beyond traditional, mainstream benefits when it comes to the types of coverage they would like their employers to offer in the future. For employees who don't already have these plans, the nontraditional benefits employees say they most want to see on the benefits menu going forward are pet insurance, mental health / counseling and homeowners / auto insurance. Although current buying levels are relatively low, a significant number of employees without access now want their employers to offer caregiver/family/senior care support (33%), estate and will planning services (33%), genetic/DNA testing (29%), bereavement support (28%), purchasing programs (27%) and financial wellness/planning (26%). Millennial and Gen Z employees tend to show the strongest interest in these non-insurance benefits.

What Employees Are Willing to Pay For

Employees often are willing to pay the tab for the benefits they want.

The top voluntary products by percent of ownership include core products such as dental, prescription drug and vision coverage as well as accident plans, but a significant number of employees say they are interested in buying nontraditional benefits on a voluntary basis, including identity theft protection (32%), legal plans (27%) and pet insurance (24%). A little less than half of employees overall own at least one type of voluntary coverage, but a strong majority (71%) of those employees own multiple products. Those who buy voluntary coverage cite the affordable cost, the product meeting their needs, and the convenience of payroll deduction among the most important reasons they choose voluntary benefits.

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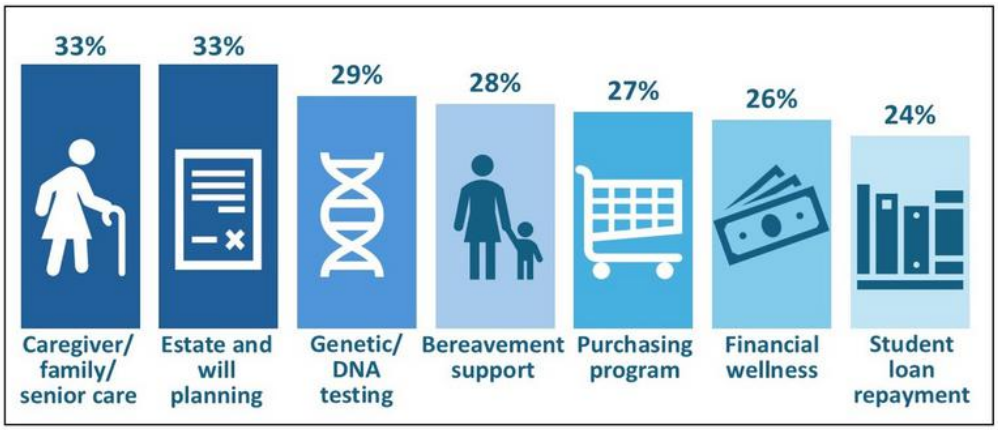
Employee Interest in Nontraditional Benefits Not Currently Offered



Source: Eastbridge 2025 MarketVision™—The Employee Viewpoint© Report

If brokers, carriers and employers aren't already conferring on plans for the next enrollment cycle, they will be soon. These partners can prepare now by taking time to delve into employee buying trends to ensure the success of the next benefits enrollment event.

Eastbridge's "MarketVision™—The Employee Viewpoint" study surveys 2,000 employees every other year to examine their attitudes, opinions and preferences about benefits, including voluntary products. The report covers the types of voluntary benefits employees own, education and enrollment preferences, reasons for purchase, payment preferences, interest in purchasing voluntary products in the future, and the impact of inflation on their current and future voluntary coverage. The reports are available exclusively to members of Eastbridge's Information Partner™ program and survey sponsors. Learn more about this report and the Information Partner™ program on Eastbridge's website.

Danielle Lehman
Senior Consultant

Eastbridge is the source for research, experience, and advice for companies competing in the voluntary space and for those wishing to enter. For over 25 years, they have built the industry's leading data warehouse and industry-specific consulting practice. Today, 20 of the 25 largest voluntary/worksite carriers are both consulting and research clients of Eastbridge.

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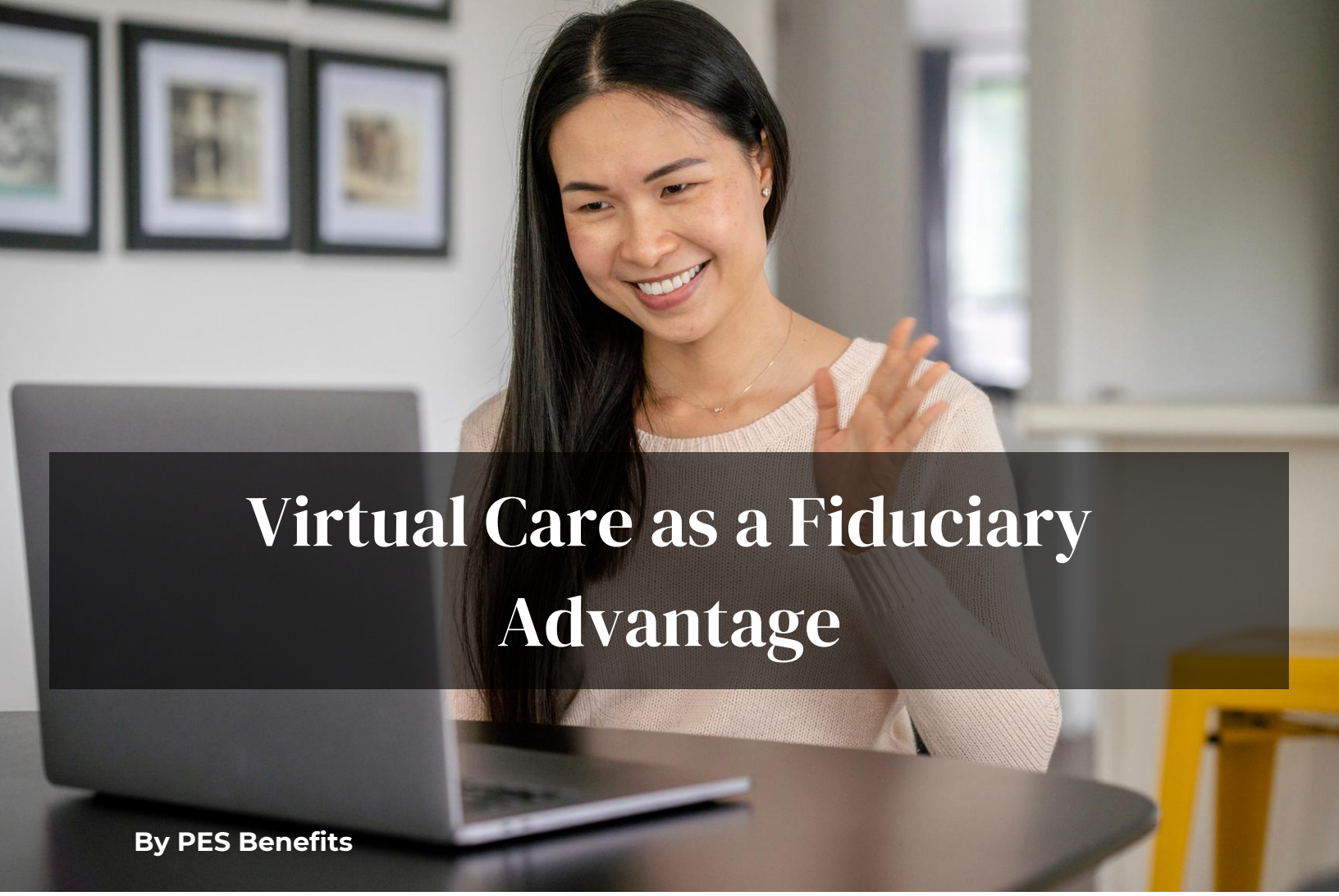

Virtual Care as a Fiduciary Advantage

By PES Benefits

Lower Costs with a Virtual Care Strategy

Employers continue to face mounting financial pressure as healthcare premiums and medical expenses rise year after year. A 2023 article in Healthcare Business Today notes that expanding access to virtual care and wellness solutions can help employers manage healthcare costs while maintaining benefit value and access for employees (Healthcare Business Today, 2023).

Virtual care including primary care, urgent care, behavioral and mental health services, chronic condition management, and follow-up care, offers plan sponsors a practical way to deliver benefits more efficiently. When implemented thoughtfully, these solutions can support both participant outcomes and the fiduciary responsibility to manage plan assets prudently.

Why Virtual Care Aligns with Fiduciary Duty

Virtual care supports cost efficiency while providing access. Virtual visits typically cost less than in-person care, and earlier access to care can reduce the likelihood of high-cost downstream claims such as emergency department visits or hospitalizations. Healthcare Business Today reports that increasing access to virtual care can help lower overall healthcare spending by encouraging preventive and timely treatment while reducing unnecessary utilization (Healthcare Business Today, 2023).

More recent data reinforces this cost advantage. Research highlighted by TechTarget found that employer-sponsored virtual care visits averaged $379.76 per episode, compared with $493.49 for in-person care over a seven-day period.

This represents a 23% lower total cost per episode for virtual care, even when follow-up services were included (TechTarget, 2025). For fiduciaries overseeing health plans, this type of cost differential is meaningful. Reducing per-episode spending helps control claims volatility and supports the obligation to act solely in the interest of plan participants and beneficiaries.

Virtual care also improves access and engagement. Removing barriers such as travel time, scheduling challenges, and provider shortages makes it easier for employees to seek care earlier. Earlier intervention often leads to better outcomes and lower long-term costs. These improvements align with fiduciary goals by promoting participant health while managing plan expenses responsibly (Healthcare Business Today, 2023).

For employers using self-funded or level-funded plan designs, these efficiencies are especially relevant. Lower claims costs driven by appropriate virtual care utilization may contribute to reduced contributions or favorable end-of-year outcomes, reinforcing the financial sustainability of the plan.

What Brokers Should Recommend Now

Brokers advising plan fiduciaries can take several practical steps to support this strategy.

Reviewing current utilization patterns can help identify services where virtual care is an effective alternative, such as non-emergency visits, behavioral health, follow-up care, or chronic condition management. Partnering with high-quality virtual care vendors that can demonstrate utilization, outcomes, and cost metrics is essential. Clear participant communication also matters. Employees need guidance on when virtual care is appropriate and how it can save time and money. Ongoing monitoring of metrics such as cost per visit, avoided emergency care, and overall claims trends helps demonstrate fiduciary diligence and value over time.

Why This Matters Going Into the New Year

As healthcare costs continue to climb, employers will be looking for benefit strategies that balance access, quality, and affordability. Virtual care offers a practical option that supports plan sustainability while meeting participant needs. For brokers, recommending well-structured virtual care solutions is not about adding another benefit. It is about helping clients meet fiduciary obligations in a challenging cost environment and positioning yourself as a thoughtful, informed advisor.

Healthcare Business Today. (2023). Why increasing virtual care is key to decreasing healthcare costs. *https://www.healthcarebusinesstoday.com/why-increasing-virtual-care-is-key-to-decreasing-healthcare-costs/*

TechTarget. (2025). Employer-sponsored telehealth costs 23% less than in-person care. *https://www.techtarget.com/virtualhealthcare/news/366597026/Employer-Sponsored-Telehealth-Cost-23-Less-Than-In-Person-Care*

PES BENEFITS

PES Benefits is dedicated to revolutionizing the employee benefits landscape with cutting-edge technology, administration, education, and virtual care solutions. Since its inception, PES Benefits has focused on simplifying the benefits experience, making it more accessible and meaningful for all involved.

Turning Up the Heat: New State Scrutiny Over Loss Ratios Means Added "Fiduciary Responsibility" Pressures for Plans and Brokers

By Kristi Hardenbergh, FSA, MAAA & Hunter Sexton, JD, MHA

The profitability of supplemental health products has long been one of the industry's defining advantages. As excepted benefits, accident, critical illness, and hospital indemnity plans operate outside many of the loss ratio and rate review requirements applied to major medical coverage. This flexibility has allowed carriers to deliver sustainable margins while expanding product availability and distribution.

But that profitability is drawing new scrutiny. Regulators are increasingly questioning whether current pricing levels in excepted benefit plans reflect fair consumer value and are responding by tightening expectations around loss ratios and experience reporting. The shift signals a new phase for the market, one where carriers will need to balance continued innovation and competitiveness with a heightened focus on demonstrating consumer benefit and transparency.

Simultaneously, plan managers, tasked with making financial decisions in the best interest of plan beneficiaries and policyholders are also on the defensive. Take for example the recent lawsuit filed by law firm Schlichter Bogard which alleges plan administrators breached fiduciary duties by pushing products with low realized losses while simultaneously overcompensating brokers. While this lawsuit is in its nascent stages, and allegations contained therein are just that – allegations, it may serve as the impetus for similar legal actions moving forward.

The National Association of Insurance Commissioners (NAIC) defines a loss ratio generally as "a measure of the relationship between claims and premiums". In the context of pricing and profitability in the supplemental health space, MLR refers to an incurred loss ratio; which is the expected incurred claims, plus any changes of reserves for active claims and claims incurred but not reported (IBNR).

A Shift from Federal to State-Level Oversight

Although federal oversight of excepted benefits has eased under the current administration, state regulators have begun stepping in to fill the gap. Departments of Insurance in several states are now examining supplemental health filings more closely and several are raising minimum loss ratio expectations and tightening reporting requirements for existing business. The message is becoming consistent: carriers with persistently low loss ratios may be required to take corrective action. Moreover, new market entrants are being held to these newly raised MLR standards, undermining long term profitability and compensation assumptions made at the outset of product development.

> **The message is becoming consistent: carriers with persistently low loss ratios may be required to take corrective action.**

Historically, most states have not specified a minimum loss ratio for group supplemental health products. In the absence of prescribed state guidance, the industry often looks to NAIC Model Regulation No. 134, which provides loss ratio standards by renewability clause and a "low average annual premium" formula for a justifiable reduction to those standards. For most supplemental health product filings, where anticipated annual premiums often range in the $200-$500 range, this calculation often yields an implied minimum loss ratio around 50% or lower, and most carriers have priced accordingly. Crucially, plans with claims experience that align NAIC Model Regulation pricing have not been subject to legal scrutiny regarding the discharging of fiduciary duties.

Because the NAIC Model Regulations are not codified law (rather merely recommendations for state legislatures), there have always been states that have their own higher loss ratio standards. New Jersey Maryland, and Washington already require a 75% MLR for group specified disease (critical illness) products. Other states mandate 60–65% for all products. These higher thresholds have always created meaningful challenges for insurers who must then decide whether to reduce commissions, trim expenses, absorb a loss in profitability, or even avoid selling in the state all together.

States Increasing Their Standards

Recently, even states without a strong history of formal loss ratio requirements have begun taking firmer positions. A few examples are:

- **Alabama**: The Department has informally (through objection letters) communicated that 50% is the lowest minimum loss ratio it will accept on new filings. They acknowledge they previously allowed filings with lower loss ratios but have changed their position.
- **West Virginia**: Similarly, beginning this past summer, the Department has taken the position that 55% is the lowest acceptable minimum loss ratio for critical illness products.
- **Virginia**: In August 2024, the Bureau issued a bulletin reminding insurers of anticipated loss ratio standards and encouraging them to review both open and closed blocks of business for compliance. The bulletin noted that the Commission may require corrective actions, including premium refunds, credits, or rate adjustments.

Notably, Alabama and West Virginia have not published formal regulations—these are departmental positions reflected in current filing review practices.

This can be particularly challenging for new market entrants or carriers filing new products. Existing blocks, priced under previously accepted lower loss ratios, seemingly allowed to remain unchanged. New filings, however, must meet the new thresholds, potentially leaving new entrants unable to offer the same commission levels as competitors with legacy products priced at lower MLRs.

Industry Challenges Under Rising MLR Pressure

As loss ratio expectations rise in tandem with rising fiduciary duty legal threats, the industry faces several operational and strategic challenges:

- **Balancing Utilization and Pricing:** Many carriers are already working to increase utilization through claim automation, digital claims submission, and integration with medical data, all aimed at improving consumer experience and ensuring insureds use their coverage. Higher utilization should, in theory, drive higher loss ratios. But if regulators also push for immediate rate reductions based on historic experience, the pendulum could swing too far, too fast, giving rise to serious forecasting and profitability concerns.
- **Uneven Application to New Filings**: When new standards apply only to new filings, the result is an uneven playing field. Established blocks priced to older assumptions retain a competitive advantage in distribution, while innovative new designs are forced to operate under tighter profitability constraints. This dynamic may discourage new entrants and dampen product innovation. Without robust competition on price or innovation, legacy plan administrators may become targets of new legal challenges if sales compensation packages are not adequately adjusted to account for the less competitive market. If there are only a few plans in a market with more favorable MLR targets the selection of a carrier becomes all the more obvious and thus the question becomes: what is the broker truly doing to add commensurate value to the group?
- **Increased Reporting Burden:** States increasing the frequency and granularity of experience reporting means carriers must devote more actuarial and compliance resources to ongoing oversight. For smaller insurers with lean teams, this added administrative cost can be substantial.

Looking Ahead: Industry Response

The industry's best defense may be continued proactive engagement. Carriers should focus on enhancing consumer value: making sure insureds understand their coverage, use their benefits, and see tangible claims outcomes. Demonstrating that these products deliver meaningful financial protection can help regulators view the sector as acting in good faith.

Additionally, transparent communication with regulators, sharing experience data, explaining product features, and documenting steps to improve loss ratios, can help shape future rulemaking. If carriers collectively show that efforts to improve utilization and consumer outcomes are raising MLRs organically, regulators may be less inclined to impose rigid new thresholds.

Carriers should focus on enhancing consumer value: making sure insureds understand their coverage, use their benefits, and see tangible claims outcomes.

Lastly, sales compensation models will be under increased scrutiny. If the belt is tightening on profitability, and there are increased liabilities associated with broker compensation, then adjustments to compensation must be proportional.

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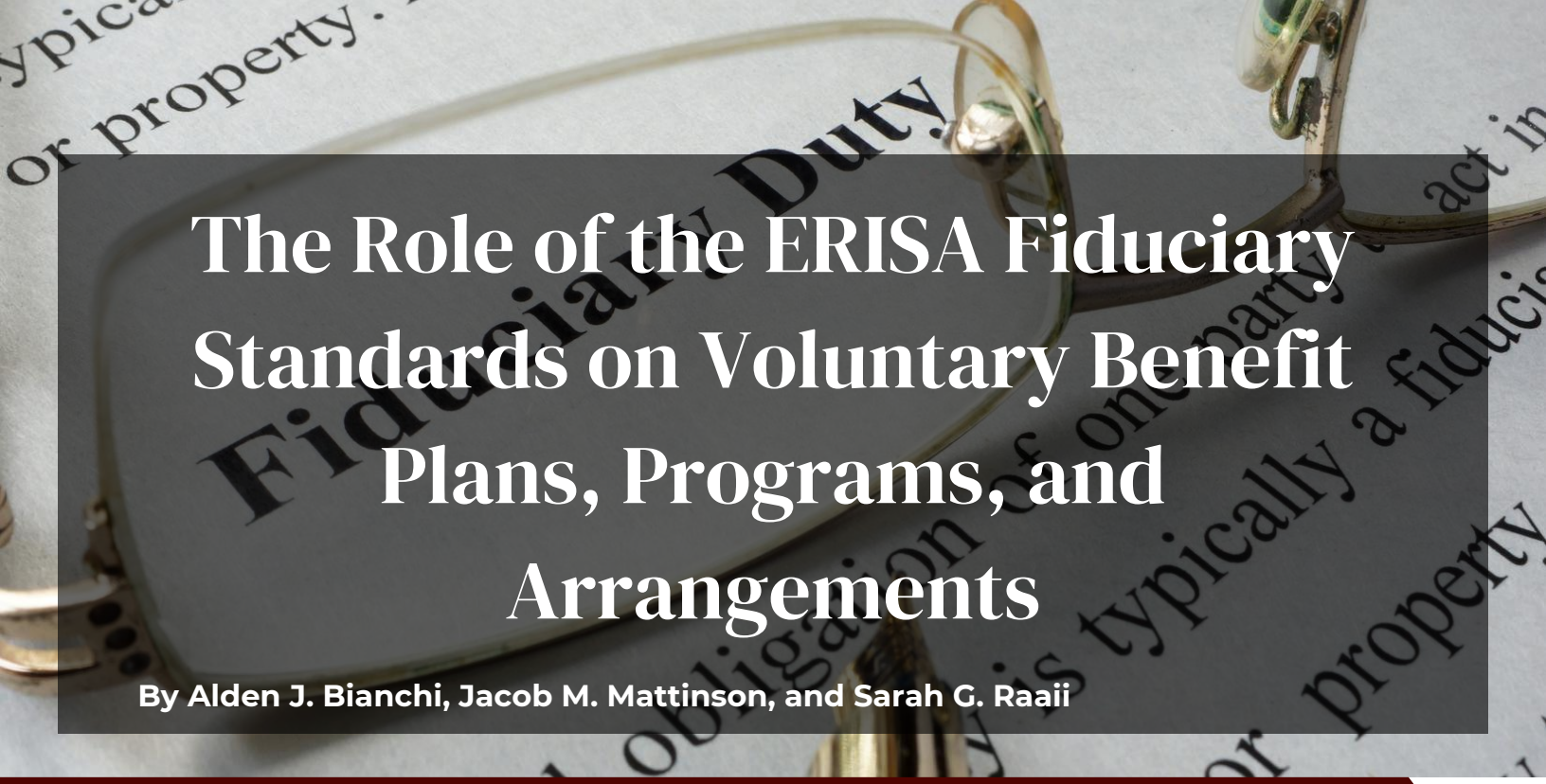
[1] As of Q3 2024 Benefitfocus and VOYA eligible population presented with the decision support option.
[2] Industry Average HSA enrollment reported HealthEquity vs Q4 2023 SAVVI guidance user for Benefitfocus/VOYA 2024.
[3] Calculated using methodology outlined on this SAVVI calculator- https://www.savvifi.com/selectsmart-roi and selecting 10K employees, $70K salary, 40 avg age employee, 30% HDHP usage, 30% guidance utilization, cost $4 PEPY.
[4] CSAT SCORE, 2024 Users, based on aggregated data from SAVVI Financial guidance experiences integrated within the Benefitfocus and myVoyage platforms.



The Role of the ERISA Fiduciary Standards on Voluntary Benefit Plans, Programs, and Arrangements

By Alden J. Bianchi, Jacob M. Mattinson, and Sarah G. Raaii

The Employee Retirement Income Security Act of 1974 (ERISA) is a federal law that sets minimum standards for most voluntarily established retirement and health plans in private industry to provide protection for individuals in these plans. ERISA requires plans to provide participants with plan information including important information about plan features and funding; provides fiduciary responsibilities for those who manage and control plan assets; requires plans to establish a grievance and appeals process for participants to get benefits from their plans; and gives participants the right to sue for benefits and breaches of fiduciary duty.

The term “voluntary benefits” is sometimes used to refer to a broad range of products, including life, disability, critical-illness and accident insurance, and hospital indemnity or other fixed indemnity insurance, as well as pet coverage, ID theft protection, legal services, and financial counseling, among others. Increasingly, however, voluntary benefits refer to fixed indemnity insurance and critical illness insurance. These programs, which were once considered “niche,” have been steadily increasing in popularity. They are now, if not commonplace, well on their way to being so.

Fixed indemnity insurance and critical illness insurance programs maintained by private sector employers generally are regulated as welfare benefit plans under the Employee Retirement Income Security Act of 1974 (ERISA).

Among other things, ERISA establishes reporting and disclosure requirements, imposes fiduciary standards, and creates a robust civil enforcement scheme.

While there is a regulatory exception under ERISA for “voluntary plans,” satisfying the exception is notoriously difficult and often impractical (for the reasons explained below). As a result, employers that offer voluntary fixed indemnity and/or critical illness benefits to employees often are, by default, the ERISA “plan administrator” and thus fiduciaries of their voluntary benefit program. Few employers are aware that this is the case. They instead view their offer of voluntary benefits as a mere accommodation to employees and fail to fulfill their ERISA obligations as a result. This is a mistake.

Overview of the ERISA Fiduciary Standards
ERISA's fiduciary duties fall into four broad categories:

- **Duty of Loyalty:** Fiduciaries must act solely in the interest of plan participants and beneficiaries, with the exclusive purpose of providing benefits and defraying reasonable plan expenses.
- **Duty of Prudence:** Fiduciaries must act with the care, skill, prudence, and diligence that a prudent expert would exercise under similar circumstances.
- **Duty to Diversify Investments:** Relevant primarily for retirement plans, but it underscores the requirement to avoid unnecessary risk.
- **Duty to Follow Plan Documents**: Fiduciaries must adhere to governing plan documents, provided those documents comply with ERISA.

Of these, the duties of loyalty and prudence often pose the greatest challenges. ERISA provides two ways in which an entity or individual can be a fiduciary. Certain key roles are automatically designated as fiduciaries and referred to as "named fiduciaries." These include the "plan administrator," which is the person or entity that is responsible for day-to-day operations. Many employers formally designate a fiduciary committee to fill this role. In the absence of a formal appointment or designation, the employer entity is the plan administrator under ERISA. Some employers are surprised that this means the board of directors (in the case of a corporation), partners (in the case of partnership), or managers (in case of an LLC).

In addition to named fiduciaries, ERISA also recognizes "functional fiduciaries." A person is a functional fiduciary to the extent they exercise discretionary authority or control over plan management or assets or have discretionary responsibility in plan administration. In simple terms, functional fiduciary status is conferred on anyone who acts like a fiduciary.

Thus, HR executives, HR managers, or CFOs, may inadvertently become fiduciaries if they exercise discretion in plan design, vendor selection, or claims oversight.

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ERISA fiduciaries face significant liability exposure. They may be personally liable for losses to a plan resulting from breaches of fiduciary duty, and ignorance of the law is not a defense. Potential consequences may include civil and criminal penalties.

Other Applicable Federal Law

The regulation of employer-sponsored group health plans is governed by a patchwork of overlapping Federal laws. The provisions of the Internal Revenue Code apply to all group health and disability plans (including church plans) but not to governmental plans or health insurance issuers. The Public Health Service Act imposes requirements on health insurance issuers in the individual and group markets and on self-funded non-federal governmental group health plans.

By including parallel amendments to ERISA, the Internal Revenue Code, and the Public Health Service Act, most—but not all—of the Affordable Care Act's insurance market reforms apply to private-sector group health plans (whether sponsored by private sector companies, churches, or instrumentalities of government) and to state-licensed health insurance issuers or carriers.

There is, however, an important exception for certain "excepted benefits" that were first identified in the Health Insurance Portability and Accountability Act (HIPAA) and later carried over into the Affordable Care Act (ACA). As a result, voluntary benefits are not subject to the ACA's insurance market reforms. This is important, since in practice the vast majority of hospital indemnity, fixed indemnity, and critical illness insurance programs could not satisfy those requirements.

The Voluntary Benefits Safe Harbor

There is a narrow "voluntary plan safe harbor" established by regulation under which ERISA does not apply if the plan satisfies all of the following requirements:

- The plan is completely voluntary for employees.
- The plan is 100% employee paid with no employer contributions.
- There is no employer involvement or endorsement of the program.
- The employer receives no compensation (other than reasonable reimbursement for administrative costs).

While seemingly simple, this safe harbor is notoriously difficult to satisfy in practice. Whether ERISA applies is determined based on the facts and circumstances of each case, often informed by DOL Advisory Opinions and case law. For example, salary contributions made on a pre-tax basis through a cafeteria/Section 125 plan are considered employer contributions. In addition, minimal branding of voluntary benefits, such as including an employer's name or logo in marketing materials, may indicate employer involvement or endorsement. The result is that, in most instances, voluntary benefits are ERISA plans, and the ERISA fiduciary standards apply.

Governmental and church plans, while exempt from ERISA altogether, remain subject to applicable state fiduciary and insurance laws, which are often less predictable and more costly.

Application to Employers

Some employers ask why they should care if voluntary benefits are subject to ERISA. As a starting point, many employers never think about ERISA's application until they are sued —and by then it is too late. The application of ERISA can implicate HIPAA, COBRA, reporting requirements, participant disclosures, claims rules, state law preemption, participant requests, and, importantly, fiduciary obligations.

Where the ERISA fiduciary standards do apply to voluntary benefit programs, certain actions are required. First, fiduciaries must ensure vendor contracts are reasonable and transparent. The surest way to create fiduciary exposure is to make available policies with excessive administrative fees. This means employers must understand their vendor's profitability models. Specifically, fiduciaries should question whether the carrier's loss ratio is in line with "market" standards and question whether the commission structure encourages unnecessary rapid policy turnover.

Separately, fiduciaries have an ongoing "duty to monitor," which extends to reviewing claims processing and ensuring employees receive promised benefits. Fiduciaries should continue to evaluate whether costs are reasonable, and whether alternative arrangements could provide better value. Fiduciaries must also communicate accurately and clearly with employees about the nature, cost, and limitations of coverage. Lastly, fiduciaries must scrupulously avoid conflicts of interest, such as selecting a product because of revenue-sharing arrangements.

Best Practices for Fiduciary Governance in Voluntary Benefits

Employers that offer hospital indemnity, fixed indemnity, and/or critical illness insurance under voluntary benefit programs should adopt robust fiduciary governance frameworks. Recommended practices include:

- **Formalize Oversight:** Establish a benefits committee or designate a fiduciary responsible for overseeing voluntary benefits.
- **Document Processes:** Keep written records of decisions regarding vendor selection, fee assessments, and communications.
- **Monitor Vendor Performance:** Regularly review claim payment practices, employee satisfaction, and cost-effectiveness and maintain copies of vendor fee disclosures.
- **Provide Clear Employee Communications:** Ensure that materials avoid misleading language and accurately describe coverage limits and exclusions.
- **Train HR Staff:** Many fiduciary breaches arise from well-meaning HR teams that are unaware of ERISA's reach.
- **Benchmark Costs**: Compare carrier fees and claims ratios against industry standards to satisfy the duty of prudence.

Voluntary benefit programs occupy a complex space in employee benefits law. While often marketed as employee-paid "extras," these programs generally fall within ERISA's scope and subject employers to fiduciary obligations. For plan sponsors, this means implementing structured oversight processes, evaluating vendors rigorously, and ensuring employees receive accurate and transparent communications.

When effectively managed, voluntary benefits can enhance employee well-being, strengthen workplace culture, and provide a competitive edge - without exposing employers to unnecessary fiduciary liability.

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2026 Outlook: Advisory Board Perspectives on the Future of Voluntary Benefits

As the voluntary benefits industry enters 2026, it finds itself at a critical inflection point. Economic pressures, rapid technological advancement, and evolving employee expectations are reshaping how benefits are evaluated, delivered, and experienced. Against this backdrop, organizations across the ecosystem, from carriers and brokers to employers and technology partners, are being challenged to move beyond incremental change and toward more intentional, value-driven strategies.

In this edition of Voluntary Benefits Voice, our Advisory Board shares its perspectives on what lies ahead in 2026.

While viewpoints vary, several themes emerge consistently: the expanding role of artificial intelligence, the growing importance of a differentiated and seamless member experience, and an industry-wide imperative to clearly demonstrate value in an increasingly cost-conscious environment. Together, these insights offer a forward-looking lens into the opportunities and challenges that will define the year ahead - and the actions leaders must consider now to remain relevant, competitive, and impactful.

Here are the board's predictions for 2026...

2026 – The Year of Life-Aware Benefits Personalization and Optimization Delivered by AI

In December 2024, I predicted that 2025 would shift benefits communication from static broadcasts to always-on, personalized AI agents guiding enrollment, explaining benefits, surfacing tailored recommendations, and automating administration. Mercer now calls 2025 "the year of agentic AI," and vendors like Alight Solutions, Alliant, and others are already delivering AI-driven benefits guidance.

Here are my 2026 Projections:

By late 2026, companies will **no longer deploy single benefits agents**, **they'll deploy teams of interoperable AI agents** that coordinate with each other (benefits agent, financial wellness agent, HR policy agent, retirement agent, etc.). These agents will delegate, reason together, and act across systems using agentic orchestration (no need for human intervention). In 2025, agents mostly provided suggestions or explanations. In 2026, they will begin to complete transactions autonomously and in real time.

In 2026, this will be enabled by employers and benefit vendors opening secure, private data channels that allow AI to safely draw on everything known about the employee (payroll, life events, etc.), as well as detect patterns across employee populations. Vendors will be expected to move, where relevant, from static plan designs to ones that enable real-time, life-aware, personalization and optimization. As we get deeper into use of employee data, we can also expect regulators to become far more involved.

Seif Saghri
Founder

Prove It or Lose It

Prove It: Data, Transparency, and ROI Become Non-Negotiable
In 2026, the voluntary benefits conversation will shift decisively from coverage offered to value delivered, providing proof that benefits work! Employers want ROI, brokers want insight, employees want relevance. Data isn't about reporting anymore; it's about decision-making.

All parties will demand clearer answers to fundamental questions: *What value are we getting for our premiums? How are benefits actually being used? And what outcomes are they producing?*

Data will no longer be viewed as back-office reporting. Instead, configurable dashboards, actionable analytics, and transparent performance metrics — including loss ratios and utilization trends — will become central to both sales and retention strategies.

What this means for brokers and carriers:

- Brokers will be expected to translate data into insight and guidance
- Carriers will be evaluated on claims paid
- Organizations that explain impact, not just numbers, will gain trust and preference
- Outcomes matter more than offerings
- Configurable reporting beats static dashboards
- Loss ratios + utilization must tell a clear story

Permanent Life Is Back… and Long-Term Care is Driving It
Permanent life isn't coming back because of death benefits — it's coming back because of living benefits. LTC awareness is personal now, especially for the sandwich generation.

Life insurance is re-emerging as a strategic solution. The gap is no longer theoretical — it's personal, visible, and increasingly urgent, particularly for the sandwich generation balancing caregiving responsibilities across generations.

In 2026, products that combine permanent life with chronic illness or long-term care benefits — and are easy to understand, position, and enroll — will see accelerated adoption. Success will depend not just on product design, but on education strategies that go beyond traditional open enrollment.

What this means for brokers and carriers:

- Brokers will position permanent life as a financial resilience solution, not just insurance.
- Focus will be on the living benefit, not just the death benefit. Financial resilience > death benefit framing for this product.
- Carriers that simplify complex benefits and support off-cycle enrollment will outperform
- Counselor-led off-cycle education and targeted communication will be critical to driving education.

Experience Beats Broad Products: Product Design Shifts to Real World Use
As voluntary benefits mature, differentiation based on rates and standard features alone will continue to erode. In 2026, the market will increasingly reward carriers and brokers who focus on experience-driven product design — using claims and utilization data to align benefits with how employees actually engage with coverage.

Expect continued innovation around inflation protection riders, fewer maximums and exclusions on high-frequency claims, enhanced payouts where benefits are most commonly used, and carry-over or continuity riders. The emphasis will move toward maximizing employee-perceived value rather than theoretical coverage limits.

What this means for brokers and carriers:

- Brokers will need deeper understanding of claims behavior to guide recommendations.
- Carriers that iterate quickly based on real usage data will gain momentum.
- Claims data will drive benefit innovation.
- Experience, simplicity, and relevance will outweigh marginal pricing advantages.

Main Takeaway for 2026
The voluntary benefits market is entering a more mature, accountable phase. Growth in 2026 will favor organizations that:

- Embrace transparency and measurable outcomes
- Address real financial risk gaps with clarity and empathy
- Design, communicate, and deliver benefits around actual employee experience

Brokers and carriers who align around data, simplicity, and value delivery will be best positioned to lead the next chapter of voluntary benefits.

Jennifer Daniel
Aflac

Less Noise, More Impact

Voluntary Benefits Will Continue To Shift From Expansion to Optimization - Employers will be more strategic on adding new voluntary offerings and instead focus more on:

- Participation and perceived value by employee segment
- Reducing redundancy across point solutions and actively reducing the number of disconnected benefit tools
- Ensuring benefits are understood, accessible and actively used

Partners that help simplify portfolios and improve outcomes, not just expand them, will stand out.

Employee Financial Stress Will Drive Benefits Strategy - Ongoing financial pressure on employees will increasingly influence benefit decisions, pushing employers to:

- Balance all benefits more intentionally whether entirely funded by employees or by employers
- Prioritize affordability, predictability, and real-world usability

Benefits that provide protection, guidance, and financial resilience will gain traction, too.

Communication and Education Will Continue To Grow As A Primary Differentiator - Employers will place greater emphasis on:

- Clear, timely, and relevant benefits communication
- Personalized education and decision support
- Technology that enhances understanding, not just enrollment

The ability to translate complexity into clarity will be a key driver of engagement.

Broker Value Will Be Defined By Strategic Impact - Employers will increasingly expect brokers to:

- Align benefits strategy with workforce outcomes
- Coordinate carriers, platforms, and administrative partners
- Serve as strategic advisors across the benefits ecosystem

Transactional approaches will continue to lose ground to consultative, integrated models.

Technology and AI Will Enhance Operations, Not Replace Relationships - Automation and AI will continue to improve efficiency in:

- Enrollment support and decision guidance
- Data analysis and reporting
- Administrative workflows

However, trust, expertise, and human connection will remain essential for navigating complexity and driving meaningful change

What This Means for 2026

The organizations that succeed will focus on simplification, empathetic design, and employee confidence. Less noise, fewer disconnected solutions, and a stronger emphasis on outcomes will define the next phase of benefits strategy

Tim Schnoor
Director, Benefits Consulting Practice - BusinessSolver

Experience, Trust, and the New Standard

As we move into 2026, the workplace and voluntary benefits industry continues to evolve. The change is not driven by a single trend, but by several shifts converging at the same time across experience, technology, and structure.

The client and employee experience will matter more than ever, especially in voluntary benefits. Benefits are no longer evaluated solely on what is offered, but on how they are delivered, understood, and supported. **Experience is becoming a central part of how value is perceived**.

Claims are getting easier. Filing claims is becoming more streamlined, automated, and proactive. Employees are encountering fewer barriers when accessing benefits, and engagement firms, brokers, and employers are increasingly helping employees identify claims, wellness reimbursements, and benefits they may have previously missed.

AI is everywhere, but the AI plus human approach will dominate. Technology enables speed, personalization, and scale. Human interaction remains critical for trust, clarity, and confidence. Together, they are becoming the standard model for education and engagement.

Another notable change is the reevaluation of long-standing carrier relationships. Staying with the same carrier simply because it has always been there is becoming less common. At the same time, many employers are moving away from carrier-driven enrollment platforms toward agnostic benefits administration systems or payroll-based solutions. Employers want **flexibility and portability**, avoiding being locked into a single ecosystem. This shift ultimately benefits employees by creating more continuity, choice, and protection over time.

Voluntary benefits leadership continues to rise in importance. Many national organizations already have dedicated leadership in place, while others are building internal expertise or partnering externally with agnostic voluntary benefits specialists to remain competitive.

Finally, identity theft protection with full restoration is becoming essential. As AI accelerates fraud, data breaches, and identity misuse, individuals are increasingly seeking protection. Employers have a unique opportunity to offer this coverage either as an employer-paid benefit or as an employee option at significantly reduced group rates.

Final thought: Voluntary benefits are not about selling more. They exist to fill gaps, protect families, and reduce financial stress. In 2026, education, transparency, and trust will define leadership.

Jack Holder
EBIS

> **AI is everywhere, but the AI plus human approach will dominate.**

As with many areas of the benefits industry, I anticipate we will see continued cost pressures in 2026 in the supplemental benefits market. Well-intentioned regulatory reforms could have the unintended consequence of reduced employee choice and higher costs, which is contrary to the value supplemental benefits are designed to bring employees. Despite increased competition in the marketplace, stakeholders — carriers, consultants, and captive programs — must navigate difficult trade-offs between claim integration, revenue streams and employee experience.

Here are three trends I think will be important to watch in the voluntary benefit space this year:

1. **Financial pressure and employer risk**: Employers are increasingly facing cost pressures in many areas. As a result of these financial pressures, some employers may be tempted to use employee dollars from supplemental health plans to offset costs associated with additional services like enrollment systems and consulting. Despite these cost pressures, it's important for employers to focus on delivering value for their workforces with quality benefits that meet their needs. Doing so can help with employee morale and retention.

Historically, lower-than-expected claims utilization may have created a pool of excess funds, which could have been redirected to support these additional services. Innovative solutions, such as medical claims integration, help drive higher utilization of benefits and create better employee experiences. But higher utilization may result in a reduced pool of excess funds for other expenses. This can force employers into a difficult position: encourage appropriate levels of claim payments through integration or divert dollars to help relieve financial strain.

2. **Continued and increased regulatory presence**: Regulatory scrutiny of voluntary benefits has intensified. While new regulations are often introduced with the intention of positively impacting the marketplace, these changes can sometimes lead to unintended consequences like reduced employee choice and more limited benefit options, while simultaneously driving up costs. This shift can undermine the original goal of voluntary benefits: to provide meaningful, affordable coverage tailored to employee needs. As the regulatory environment continues to evolve, it is essential to monitor changes closely and for stakeholders to prioritize balanced solutions that help preserve employee value and choice.

3. **Carrier, consultant and captive are in competition**: Carriers, consultants, and captive programs are increasingly competing in the supplemental health marketplace, each leveraging employee dollars in distinct ways. While all parties prioritize employee benefits, the market has evolved. It's not uncommon for secondary objectives, such as maximizing revenue streams or optimizing operational efficiencies, to increasingly influence decision-making.

This shift has led to a crossroads in the industry. The correct use of employee dollars should always be on supporting employees and paying claims at appropriate levels. But the reality is that competing interests can often bring to light difficult decisions and trade-offs that may risk the value and support supplemental health coverage was designed to provide employees.

It's important for stakeholders to understand the factors at play in the supplemental benefits market. In doing so, we can identify challenges and opportunities to create more value for the people who use supplemental benefits.

Paul Hummel
Vice President, Voluntary Benefits Practice Lead - UnitedHealthcare

Headwinds and Opportunity

The outlook for the voluntary benefits industry in 2026 points to a challenging and highly consequential year. Economic, political, and technological forces are converging in ways that will test carriers and distribution partners alike. At the same time, these conditions may create opportunities for those positioned to adapt and lead.

Two primary economic factors are expected to weigh heavily on voluntary benefits sales in 2026. First, a slowing labor market is likely to reduce the number of new entrants into employer-sponsored benefits programs. Sluggish job growth—driven in part by organizations prioritizing efficiency investments such as artificial intelligence—means fewer opportunities for organic new business beyond replacement or takeover cases.

Second, persistent "sticky" inflation continues to erode consumer purchasing power, particularly in non-discretionary spending categories such as housing, energy, food, and healthcare. Employees are facing higher costs at every turn, leaving limited discretionary income for supplemental products. This pressure is amplified by rising major medical premiums, which often hit employees immediately before voluntary benefit enrollment decisions are made—creating an unfavorable mindset for additional purchases.

Political dynamics are expected to further complicate the landscape. Ongoing federal inaction on healthcare reform, including inaction from Congress to extend ACA subsidies, coupled with potential shifts in state-level leadership following the midterm elections, could introduce increased regulatory scrutiny. Historically, Democrat-led states have applied more stringent oversight to voluntary and supplemental benefits, which could result in new compliance challenges and market constraints.

While artificial intelligence is often positioned as a long-term efficiency driver, 2026 may mark a period of recalibration. Capital investment in AI infrastructure is already showing signs of slowing, and broader investor skepticism could impact equity markets and consumer confidence. A cooling of AI enthusiasm—combined with environmental and energy cost concerns tied to data centers—may have downstream effects on employee sentiment, retirement accounts, and overall financial security. These factors can further dampen appetite for voluntary benefits. There will be no major technology advancements in GAI in 2026, though current technologies are likely to continue to incrementally improve. AGI will not be realized in 2026.

Despite these challenges, the voluntary benefits industry enters 2026 with one meaningful advantage: **competition and innovation**. Carriers continue to invest in refreshed and differentiated product offerings, giving brokers a broader and more flexible toolkit to address employee needs—particularly in a high-deductible health plan environment. For brokers, 2026 is likely to be a career-defining year that separates those who rely on favorable market conditions from those who create value through strategy, education, and tailored solutions.

Success will depend on adaptability, thoughtful positioning, and a clear value proposition that resonates with financially strained consumers. Those who rise to the occasion may emerge stronger, more differentiated, and better aligned with the future of employee benefits.

Hunter Sexton, JD, MHA
Sr. Compliance Consultant - **Sydney Consulting Group**

> **If we fail to materially improve the policyholder experience through increased oversight, healthier loss-ratios, and greater operation and financial transparency models, my prediction is simple: Our marketplace will lose its operating independence if we don't take meaningful action as fiduciary and industry stewards.**

2026 – Buckle Up

In January 2025, I made two key predictions about the direction of our marketplace, and both are quickly proving out.

First, I suggested that carrier partners should stop competing in a race to zero and instead begin competing on **fixing a deeply flawed policyholder experience**. That prediction has clearly held. The hottest trend we're hearing from our trading partners today is a renewed and long overdue focus on member experience.

As Co-Founder of Voluntary Advantage and monthly contributor to our monthly Editor's Note, I often wrestle with the balance between advancing a necessary conversation and the concern that I'm not stretching my message base by staying anchored to the same themes: policy holder experience, legislative action and compensation transparency. But a we move into 2026, I'm not pivoting I'm doubling down.

If we fail to materially improve the policyholder experience through increased oversight, healthier loss-ratios, and greater operation and financial transparency models, my prediction is simple: Our marketplace will lose its operating independence if we don't take meaningful action as fiduciary and industry stewards.

To me, 2026 is not about new talking points. It's about finally addressing the ones we've been avoiding.

Trevor Garbers
Voluntary Advantage | SVP Voluntary Benefits HUB International

Voluntary Benefits in an Era of Scrutiny

I anticipate that 2026 will be an important and complex year for the voluntary benefits market. We are likely to see increased activity at both the state and federal levels driven by renewed regulatory interest and potential litigation. These developments, combined with an evolving consumer, may create a challenging sales environment and will force our industry to adapt.

Today's consumer is increasingly fatigued by rising costs across all areas of life. Employees are paying more for health insurance that often delivers diminished perceived value due to high out-of-pocket expenses, limited provider networks, and unexpected medical bills. At the same time, they are facing higher costs of living - escalating taxes, sharply increased homeowners and auto insurance premiums (auto insurance premiums are up 55% on average since February 2020, according to the Bureau of Labor Statistics), and continued inflation in everyday necessities such as groceries. This financial pressure is reshaping how employees evaluate benefits and where they place value.

To succeed in this environment, we must elevate the value we bring to both our clients and most importantly, the end consumer. This includes offering differentiated and innovative solutions that directly address the needs of today's workforce, as well as claims experiences that are seamless, intuitive, and proactive to drive measurable ROI for the member. Equally important will be rethinking how we deliver and engage with our solutions to meet employees where they are.

Advances in data and technology have already introduced meaningful efficiencies into our industry, and in 2026, we must continue to leverage these capabilities to deliver integrated solutions across product, process, and experience. Doing so allows us to support individuals holistically – from health to wealth - throughout their life journey.

In 2026, I will be intentionally reassessing my entire practice to ensure it is aligned with the needs of today's market and positioned to serve the demands of tomorrow.

Heather Garbers
Voluntary Advantage | SVP Voluntary Benefits HUB International

Today's consumer is increasingly fatigued by rising costs across all areas of life.... This financial pressure is reshaping how employees evaluate benefits and where they place value.

Let's Get It Started

By Steve Clabaugh, CLU, ChFC

Relational leaders demonstrate that they care for their team members as much as the organization. As a result, they create, build and lead high-performance teams that consistently achieve excellence.

Over the past few months, we've articulated our belief that the leadership needed to overcome our current cultural challenges is most likely to come from the men and women who are leaders in the workplace. If you have been following those articles, concluding with Dr. Robert Chandler's thoughts in the December issue, I hope you are motivated to want to build and grow a relational leadership culture in your organization.

We all know that getting started is important, and there are any number of quotes by famous personages designed to motivate us in that direction:

"The secret of getting ahead is getting started." - Mark Twain
"You can't build a reputation on what you are going to do." - Henry Ford
"It is not enough to stare up the steps; we must step up the stairs." - Vaclav Havel
"The greatest amount of wasted time is the time not getting started." - Dawson Trotman...

While these are worthy and important quotes, they don't actually answer the most important question which is, how do we get started? As with many things in life the how is much more challenging to answer than the what. So...

How do you get started in building a relational leadership culture in your organization?

On this subject Mark Twain, my favorite author, has another quote that actually provides some meaningful and practical advice.

"The secret of getting started is breaking your complex tasks into small manageable tasks and starting on the first one."

"The secret of getting started is breaking your complex tasks into small manageable tasks and starting on the first one."
Mark Twain

In the spirit of Mr. Twain's advice, we are going to break the process down into practical steps to help you start building a relational leadership culture in your organization in 2026.

Step 1: Be sure you really want a relational leadership culture.

There are many things to like about organizations with a relational leadership culture: open communication; respect for team members regardless of rank; whole team commitment to the company's goals; shared challenges, success and rewards and more. But not every leader and not every organization is prepared or equipped to build and lead this type of culture. It is important to recognize that there is a unique transparency element to relational leadership that can make a certain type of leader uncomfortable. Before you start down the path to a relational leadership culture, make sure you understand what it requires and that you and your organization are willing to pay the price.

I once had the opportunity to work with a family-owned tire and auto service company of more than a dozen stores scattered over a 60-mile radius from the home office. Each of the store managers and assistant managers travelled to the home office for a monthly managers' dinner meeting which was held on the first Thursday of each month. At that meeting the results from the prior month were announced and the top producing stores were recognized. Following the results presentation, one of the owners would give a "motivational speech" to hopefully inspire the managers to greater success for the following month.

Unfortunately, the owners' "pep talk" usually devolved into berating the entire group for not generating higher profits on their volume of business – especially on the auto service part of the business. Instead of leaving the meeting with inspiration and ideas for how to improve the business, they were discouraged and felt their hard work and leadership was unappreciated. This pattern was repeated month after month with neither managers nor owners feeling understood or respected.

We started to address the situation by studying the way the stores operated and soon discovered that the primary reason the auto service business lacked profitability was due to the way they priced the service. Tire sales prices were determined by the home office so the local store could only affect the volume of tires sold, not the profit per tire. Auto service sales (brake jobs, tune-ups, etc.) however, were priced at the store level. The manager would order the needed parts from a local auto parts store, add the prorated labor rate from Chilton's Labor Guide and a few randomly determined dollars for profit which equaled the price charged to the customer. Since managers weren't told what their monthly fixed costs were, they failed to include any allowance for rent, electricity, personnel, marketing, etc. It came as no surprise then that auto service sales weren't generating profits.

We sought to correct the problem by educating each manager on the additional costs for operations and helped them determine a standard mark-up formula for service jobs that reflected the costs at their store. Once the new process was implemented, auto service profits demonstrated an immediate increase in literally every store which should have been a huge positive for managers and owners.

Except it wasn't!

Letting the managers know more of the details about their store made them curious about all the sources of revenue and profits. They wondered if the same process was applied to the price of tires, (which it was), and how did that affect their store's overall profitability? Oh yeah, and what was their store's profitability?

After a few months with the new process, the owners discovered that they really didn't want managers to understand how profitable their store was. Now that managers were aware of how they could influence profitability they wanted to be rewarded financially for their improved results. This was especially true when they found out, from a tire manufacturer's representative, that the company received an end-of-the-year bonus based on the overall number of tires sold during the year with that bonus going straight to the home office and not allocated by store.

Once the managers had a taste for improving their profitability, it was too late for ownership to revert back to the way they had done business for the prior 35 years. To make matters worse for the owners, managers also started coming up with additional new ideas to continue to grow their business.

I hope that most of you, like me, would be thrilled to see such positive results, ongoing motivation and enhanced partnership relationships between the owners and managers. I've been privileged to experience the positive environment that results from a relational leadership culture.

But that is not always the case, so it's a good idea before you start the process to consider all the potential implications and make sure you and your organization are really committed to it.

Next month, we'll address the next step, which is to understand the relational leadership operating principles for your organization.

In the meantime, I hope you will consider participating in our Relational Leadership Experience online program. There is still room available for classes that are starting the last week of this month and those starting in February. Voluntary Advantage members receive an exceptional discount - which includes the full program, all materials and certificate of completion. Your participation will help you find ways to benefit your organization, your career and that of your clients. But if you don't agree, after the first few sessions, we will respectfully refund your fee. There is no risk but there is the potential of great reward.

Welcome to 2026. Best wishes for a productive, exciting and profitable new year.

Steve Clabaugh, CLU, ChFC - started his career in insurance as a Field Agent, moving on to Sales Manager, General Manager, Regional Manager, Vice President, Senior Vice President, and President/CEO. A long time student of professional leadership, Steve created the Relational Leadership program that has been used to train home office, field sales associates, mid-level managers, and senior vice presidents.

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