MY BENEFIT ADVISOR

2025: Second Quarter

Compliance Digest

Compliance Bulletins Released April to June

2025 Compliance Bulletins: Second Quarter

April

May

June

Proposed HHS Rule: Considerations for Plan Sponsors

Issued date: 04/02/25

On March 10, 2025, the Department of Health and Human Services ("HHS") released the Patient Protection and Affordable Care Act; Marketplace Integrity and Affordability Proposed Rule ("Rule"). While much of the Rule is focused on individual and small group Marketplaces, a few key changes may indirectly impact employer sponsored plans.

Although the Rule is still in the proposed stage and subject to change, employers should take note of the following key provisions that could affect benefits administration and employee decision-making for plan year 2026.

Key Proposed Changes for 2026

Shortened ACA Marketplace Open Enrollment Period

Historically, the annual open enrollment period ("OE") for the ACA Marketplace plans runs from November 1 through January 15. The proposed rules suggest shortening the OE for 2026, which would run from November 1 through December 15, 2025 (this is for policies available on and off the Marketplace). It is important to note that a shortened OE window may impact employers offering individual coverage health reimbursement arrangements ("ICHRAs") effective January 1, 2026. If finalized "as is," employers offering ICHRAs should be strategic with their OE periods where employees will have a shorter window to select individual coverage from the Marketplace for 2026.

Changes to Essential Health Benefits Coverage for Sex-Trait Modification Services

The Rule proposes removing the current requirement that non-grandfathered individual and small group market plans subject to essential health benefits ("EHBs") must include sex-trait modification services as part of the EHBs. The Rule does not provide a definition for "sex-trait modification."

The Rule does not prohibit employer sponsored plans from voluntarily covering these services, nor does it prevent states from requiring coverage under state mandated benefit rules. Currently, five states (California, Colorado, New Mexico, Vermont and Washington) include some level of sex-trait modification coverage in their EHB benchmark plans. Forty states exclude this coverage under their current EHB benchmark plans and six states do not explicitly include or exclude such coverage.

Employers sponsoring fully insured small group plans should review state specific requirements as state mandates will still apply. While large group insured plans and self-funded plans are not required to cover EHBs, to the extent the plan provides coverage for EHB the plan is prohibited from imposing lifetime and annual dollar limits on EHBs. In addition, any cost-sharing for EHBs provided in-network must accumulate to the annual out-of-pocket maximum.

Cost-Sharing & Affordability Adjustments

The Rule suggests an alternative calculation method for the 2026 out of pocket maximums ("OOPMs") and cost sharing. OOPMs apply to non-grandfathered health plans, including employer sponsored plans, and represent the maximum amounts an enrollee must pay for covered EHBs in-network in a given plan year before the plan covers 100% of eligible expenses. Under existing ACA requirements, OOPMs are indexed annually using the premium adjustment percentage ("PAP") which reflects the growth of private health insurance premiums.

In October 2024, HHS announced the OOPM for plan years beginning on or after January 1, 2025 as:

- $10,150 for self-only coverage; and
- $20,300 for coverage other than self-only.

Under the modification proposed by this rule, the 2026 OOPM would be higher than previously anticipated. Specifically, as proposed the OOPM would increase to:

- $10,600 for self-only coverage; and
- $21,200 for coverage other than self-only.

These proposed adjustments to the OOPMs could affect employer plan designs for 2026.

Employer Action

The Rule is currently proposed guidance that still needs to be finalized. Employers should await further guidance.

Reminder: San Francisco HCSO Reporting Due May 2, 2025

Issued date: 04/04/25

As a reminder, employers covered under the San Francisco Health Care Security Ordinance ("HCSO") need to submit the 2024 Employer Annual Reporting Form by May 2, 2025. The form is completed and submitted online at www.sf.gov/submit-employer-annual-reporting-form-olse, beginning April 1, 2025.

It is important to note that this annual reporting includes the reporting requirement associated with San Francisco's Fair Chance Ordinance ("FCO"), also due May 2, 2025. Details related to the FCO are not addressed in this summary; visit the FCO website of the San Francisco Office of Labor Standards Enforcement ("OLSE") for more information.

Employer Annual Reporting Form

Under the HCSO, covered employers must make minimum health care expenditures for each hour worked by covered employees in San Francisco.

Covered employers must also submit an online Employer Annual Reporting Form each year that summarizes how they complied with the HCSO.

The Form is normally due on April 30th of the following year, but the OLSE has announced that the deadline to submit the 2024 Form has been extended to May 2, 2025. According to FAQs emailed from the OLSE, no submission will be accepted after that date. The penalty for failing to timely submit the Employer Annual Reporting Form is $500 per quarter.

An employer that was not covered by the HCSO and/or the FCO in any quarter of calendar year 2024 does not need to submit the Form. To determine whether the Form is required, an employer will answer the short survey on the first page of the online Form. Employers that were not covered by the HCSO or the FCO in 2024 will be directed to a webpage indicating that they do not need to submit the Form, and no further action is required. Covered employers will be directed to the appropriate online Form.

For employers who wish to preview the Form before completing it online, the OLSE has posted a sample of the 2024 Form and instructions on its website: media.api.sf.gov/documents/ARF_PDF_Preview.pdf

HCSO Notice for Employees

If they haven't already, covered employers should make sure to post the official 2025 HCSO Notice in a conspicuous place at any employer workplace or job site where covered employees work. The Notice should also be mailed or emailed to employees who do not work at an employer workplace or job site, such as employees working from home. The Notice is available in several languages at www.sf.gov/sites/default/files/2024-11/2025%20HCSO%20poster%20_%20Nov2024.pdf.

Ohio Legislature Passes Madeline's Law Covering Hearing Instruments

Issued date: 04/08/25

On January 2, 2025, Ohio governor Mike DeWine signed H.B. 315 into law. Madeline's Law was included as a part of this larger omnibus bill. This law became effective April 3, 2025 and health plans will be required to provide coverage for hearing instruments. The plan participant must be verified as deaf or hearing impaired by a licensed audiologist, a licensed hearing aid dealer or fitter, or an otolaryngologist.

Briefly, the requirements are:

- coverage must be provided for one hearing aid per hearing-impaired ear up to $2,500 every 4 years
- applies to any participant under the age of 22
- the hearing instruments must be considered medically appropriate for the covered participant
- the benefit does not appear to be subject to a deductible
- coverage must include the hearing instrument as well as any related services although batteries and cords are not included

This coverage will unlikely materially impact rates. This requirement does not apply to self-funded ERISA group health plans.

Employer Action

Large employers with fully insured group health plans in Ohio should anticipate receiving updated guidance and changes to plans from their carriers.

Alaska's New Paid Sick Leave Law

Issued date: 04/16/25

Alaska's Ballot Measure 1 was passed in the 2024 general election. In addition to changes to Alaska's state minimum wage and a limitation on employee mandatory meetings, Ballot Measure 1 adds a new paid sick leave requirement for all employers effective July 1, 2025. Regulations are expected in the spring of 2025.

Ballot Measure 1

Ballot Measure 1 was a voter initiative that was passed in November 2024. Among other things, the law requires:

- All Alaska employers to provide paid sick leave to all Alaska employees, including overtime exempt (salaried) and part time employees (unless the employee is otherwise exempt)
- Sick leave to accrue at a minimum of one hour of sick leave for every 30 hours worked
    - Large employers (15+ employees) must allow employees to use up to 56 hours of sick leave per year
    - Small employers must allow employees to use up to 40 hours of sick leave per year
- Sick leave can be used for injury, illness, to care for a family member, or to receive care or help for issues related to domestic violence, sexual assault, or stalking
- Employers to provide written notice by the later of July 31, 2025, or an employee's date of hire, informing them that beginning July 1, 2025:
    - employees are entitled to paid sick leave;
    - the amount of paid sick leave;

- the terms of its use guaranteed under the statute; and
- that retaliation against employees who request or use paid sick leave is prohibited.

Employees can use leave as it is accrued. While the law requires a minimum number of hours that must be available for use per year (i.e., 40 or 56) the law does not appear to allow accrued, unused leave to be forfeited. However, employers are not required to pay out accrued unused sick leave. Additionally, an employee with unused accrued sick leave that is terminated must have the sick leave balance reinstated if rehired within six months.

Regulations expected in Spring 2025 should provide additional guidance related to counting employees to determine employer size and the notice requirement. Until that guidance is available, Alaska has provided a helpful FAQ for employers (see Resources below).

Existing Policies

Employers are not required to change existing policies that meet the requirements of Ballot Measure 1. However, it is important to note that employers are not permitted to:

- Deny the use of sick leave;
- Penalize an employee for using sick leave;
- Require an employee to arrange coverage for their missed shift;
- Require proof of illness for paid sick leave that is three days or less; or
- Require the employee to share the nature or detail of the illness.

Given the prohibition on denial of sick leave or penalty for an employee that uses paid sick leave, employers should ensure alignment with their other workplace and time and attendance policies. For example:

- An attendance policy that tracks absences for purposes of performance management may not include leaves that are covered by Ballot Measure 1.
- A policy that requires a doctor's note for an absence of more than three days should be updated to reflect the permitted format under Ballot Measure 1.

Employer Action

Employers with employees in Alaska should confirm their HR or payroll system is prepared to begin tracking the required paid sick leave accrual based on employer size. Employers should work with their employment counsel to confirm that leave and related policies, such as time and attendance or sick leave policies, comply with the requirements of Ballot Measure 1. Policies should be updated in the event any gaps are found.

Employers should also review additional guidance, such as the expected regulations, when issued.

Virginia Implements Guidance for Excepted Benefits Policies

Issued date: 04/25/25

The Virginia Bureau of Insurance (the “Bureau”) recently released guidance, Wellness Benefits in Excepted Benefits Policies Guidance (the “guidance”), relating to excepted benefits policies written in Virginia. The new guidance clarifies previous regulations issued by the Bureau, which prohibit certain wellness benefits from being attached to coverage not included in the traditional health care plan.

Effective July 1, 2025, carriers must cease issuing any insurance policies previously approved that are not compliant with the new guidance.

Background

Prior to this newly issued guidance, the Bureau allowed a wide variety of benefits (including wellness benefits), to be included in certain accident and sickness policies, including excepted benefits policies. After analyzing the 2023 regulations, the Bureau concluded that the inclusion of wellness benefits that do not meet the definition of, or standards for, the various types of excepted benefits policies takes the policy outside of the scope of an excepted benefits policy. Consequently, the Bureau will no longer be approving such policies.

Excepted Benefits Rules

Excepted benefits policies issued in Virginia must meet specific requirements to be considered “excepted” from state and federal laws that apply to health benefit plans. Including certain benefits in the policy that take the policy outside of the scope of these specific requirements will disqualify excepted benefits policies from being “excepted” and will not be approved upon filing.

The guidance outlines the only acceptable combinations of accident and sickness excepted benefits that will be approved. No other combinations of excepted benefits may be filed under a single policy unless approved in advance by the Bureau.

Further, wellness benefits that are compliant with the guidance may be embedded in the body of a policy or included via a rider. The guidance outlines specific rules for the types of excepted benefits as follows:

- **Accident:** Wellness benefits cannot be included in Accident Only policies. Benefits added must conform to Accident Only coverage requirements.
- **Specified Disease:** Any wellness benefit included in a Specified Disease policy must be related to the disease for which coverage is being provided. For example, in a cancer-only policy, a wellness benefit that has nothing to do with cancer would be impermissible.
- **Hospital or other Fixed Indemnity:** Wellness benefits are not allowable in group hospital or fixed indemnity policies.
- **Disability Income:** Wellness benefits are not allowed in a disability income policy.
- **Limited Scope:** Routine dental, hearing, or vision exams that are specifically covered in limited scope dental, hearing, or vision polices are allowable.

Scope of Guidance

Compliance with the guidance is a requirement for all carriers who market, sell, issue, or renew forms on or after July 1, 2025. A policy or certificate is exempt from this guidance to the extent it is issued prior to the effective date of the guidance, and the policy or certificate prohibits unilateral benefit revisions by the carrier. Further, all policy forms and rates currently under review or submitted for review will not be approved unless they comply with all requirements of the guidance. Rates associated with these policy forms may require revision to ensure that premiums remain reasonable in relation to the benefits provided.

Carriers are encouraged to review policies and rates for new business and renew policies and certificates well in advance of the deadline, as they may be subject to knowing and willful violations of the Virginia Code if not in compliance.

Employer Action

Employers offering affected coverage may hear from their insurers about required changes to their coverage. The employer and/or the insurer should communicate any policy changes to participants.

Massachusetts Enacts Enhanced PBM Law

Issued date: 04/30/25

Massachusetts recently enacted a new law ("the Act") which further regulates Pharmacy Benefit Managers ("PBMs") and pharmaceutical manufacturers doing business in the state. Key provisions of the Act include consumer cost-sharing limitations, mandatory PBM licensing and regulation, and PBM and pharmaceutical manufacturer detailed data reporting, enhanced transparency, and increased oversight. Prior to the issuance of regulations, it appears the direct impact to employer plans is not significant.

Cost Sharing Limitations

The Act requires health plans to identify and offer, without cost-sharing (including copays and deductibles), one generic drug used to treat diabetes, asthma, and the two most prevalent heart conditions among its enrollees. These cost sharing limitations do not apply to self-funded plans. In addition, health plans must identify and offer one brand name drug for the above conditions and cap cost-sharing at $25 for a 30-day supply. Health plans may not change the selection of drugs more than annually and must make public the drugs selected. The cost sharing limitations are effective July 1, 2025.

PBM Licensing and Regulation

PBMs must obtain a license from the Massachusetts Division of Insurance ("DOI") to do business in the state. A PBM license is valid for a three-year period, is renewable for additional three-year periods, and requires a $25,000 application and renewal fee. The Act establishes a $5,000 per day penalty for an individual or business that operates an unlicensed PBM. Further, the Act establishes a penalty of no less than $5,000 for each violation of other Massachusetts PBM laws.

The Act requires licensed PBMs to notify health plans in writing of any activity, policy, practice contract or arrangement of the PBM that directly or indirectly presents any conflict of interest with the PBM's relationship with or obligation to the health plan client. A PBM may not make payments to a pharmacy benefit consultant or broker whose services were obtained by a health benefit plan sponsor to work on the pharmacy benefit bidding or contracting process if the payment constitutes a conflict of interest. The DOI will decide what payments constitute a conflict of interest.

The Act requires the DOI to implement licensing regulations by October 1, 2025, and requires all PBMs operating in Massachusetts to be licensed by January 1, 2026.

Data Reporting, Transparency and Oversight

The Act requires PBMs and pharmaceutical manufacturers to submit detailed cost and pricing data to the Center for Health Information and Analysis ("CHIA") on an annual basis. CHIA will be required to implement regulations to ensure the uniform reporting of information from PBMs to allow CHIA to analyze:

- year-over-year changes in wholesale acquisition cost;
- year-over-year trends in formulary, maximum allowable cost lists and cost-sharing design, including the establishment and management of specialty product lists;
- aggregate information regarding discounts, utilization limits, rebates, administrative fees charged to pharmaceutical manufacturing companies and other financial incentives or concessions related to pharmaceutical products or formulary programs; and
- trends in estimated aggregate drug rebates and other aggregate drug price reductions from PBMs to health plans.

The data CHIA obtains will generally not be publicly available; however, CHIA will analyze the data it collects for inclusion in its annual health care costs trends report.

The Act also requires PBMs and pharmaceutical manufacturers to participate in certain state hearings and creates an office of pharmaceutical policy and analysis to review data and provide oversight of the entities.

Employer Action

It seems that the Act will have a minimal direct impact on employer health plans. However, there appears to be extraterritorial requirements on HMOs and certain other types of health plans. It is also likely that the costs associated with the burden placed on PBMs will be passed on to employer plans. We will continue to monitor this issue as more information and regulations become available.

Medicare Part D Creditable Coverage Determination Update

Issued date: 05/01/25

The Centers for Medicare and Medicaid Services (“CMS”) recently released final instructions addressing the Medicare Part D prescription drug benefit redesign changes effective beginning in 2026. The instructions:

- Revise the existing Simplified Method for determining the creditable (or non-creditable) status of prescription drug coverage provided under an employer-sponsored group health plan
- Allow group health plans to use the existing Simplified Method or the Revised Simplified Method to determine creditable status of prescription drug coverage in 2026.

Background

Employers sponsoring group health plans with prescription drug benefits are required to notify both CMS and Medicare Part D-eligible individuals as to whether the prescription drug coverage provided is “creditable” or “non-creditable.”

It is important to note that, generally, a Medicare Part D eligible individual is:

- Enrolled in Medicare Part A or Part B; and
- Resides in a service area of a Part D plan.

This may include active employees, COBRA qualified beneficiaries, retirees, and spouses and other dependents of the employee who are enrolled in Medicare and are covered by the plan.

Prescription drug coverage is considered “creditable” if the actuarial value of the coverage provided equals or exceeds the value of standard prescription drug coverage provided under Medicare Part D. Coverage that is not as good as Medicare Part D is considered “non-creditable.”

An employer with a fully insured prescription drug plan can usually rely on the carrier to disclose whether the coverage is creditable or non-creditable.

For an employer with a self-funded plan (or a fully insured plan for which the carrier has not made a creditable coverage determination), CMS rules provide two methods to determine creditable coverage:

- Simplified Method (based on plan design features)
- Actuarial Determination (based on an analysis of claims information)

As previously reported, the Inflation Reduction Act of 2022 ("IRA") made improvements to Medicare Part D prescription drug benefits, beginning in 2025.

CMS acknowledged that due to these improvements, some group health plans offering prescription drug benefits that met Part D creditable coverage requirements in the past might no longer meet those requirements for plan years beginning in 2025. However, CMS still permitted group health plans to use the existing Simplified Method to determine creditable (or non-creditable) status of prescription drug coverage in 2025.

What's New?

On April 7, 2025, CMS released its Final CY 2026 Part D Redesign Program Instructions ("2026 Final Instructions"). The provisions relating to creditable coverage are summarized below.

Revised Simplified Method

The 2026 Final Instructions revised the parameters of the Simplified Method to better reflect actuarial equivalence with the enhanced Part D benefits for 2026.

Under the Revised Simplified Method, prescription drug coverage will be deemed to have an actuarial value that equals or exceeds the actuarial value of standard Part D coverage if it meets all of the following standards:

- Provides reasonable coverage for brand name and generic prescription drugs and biological products;
- Provides reasonable access to retail pharmacies; and
- Is designed to pay on average at least 72% of participants' prescription drug expenses

The Revised Simplified Method's changes to the existing Simplified Method include:

- Adding coverage of biological products
- Eliminating requirements related to annual and lifetime benefit maximums
- Eliminating requirements related to an annual deductible
- Increasing the payment threshold from 60% to 72%

High-Deductible Health Plans

The 2026 Final Instructions point out that although plans with high annual deductibles might appear less likely to meet the requirement to pay at least 72% of prescription drug expenses under the Revised Simplified Method, this risk can be mitigated through other aspects of benefit design, such as:

- Not applying a deductible to preventive medications
- A reasonable and supportable allocation of the deductible attributable to prescription drug expenses
- Offering lower cost sharing than standard Part D coverage once the deductible is met

Creditable Coverage Determinations for 2025, 2026, and 2027

As mentioned above, CMS is still permitting group health plans to use the existing Simplified Method to determine creditable (or non-creditable) status of prescription drug coverage in **2025**.

For 2026 only, group health plans will be permitted the choice of using the existing Simplified Method or the Revised Simplified Method to determine creditable coverage status (as well as the Actuarial Determination method).

For 2027, CMS has indicated that it does not intend to permit the continued use of the existing Simplified Method. If this position is finalized, group health plans would have to use either the Revised Simplified Method or the Actuarial Determination method to determine creditable coverage status for 2027.

Employer Action

Group health plan sponsors should review the guidance in the 2026 Final Instructions and be aware of their options to determine creditable status of their prescription drug coverage as described above. As they evaluate their benefit design for the upcoming plan year, sponsors will need to:

- Understand whether prescription drug benefits are considered creditable or non-creditable, and
- If there is a change in the creditable status of the prescription drug coverage, consider whether to:
    - Modify prescription drug benefit coverage to maintain creditable status, or
    - Maintain current prescription drug benefits, even if it means becoming non-creditable.

If a prescription drug plan changes creditable status, an updated disclosure to CMS must be provided within 30 days of the change. Notice should also be provided to participants.

Keep in mind, a late enrollment penalty may apply for individuals who do not maintain creditable coverage for a period of 63 days or longer following their initial enrollment period for Medicare Part D.

New Executive Order Addresses Lowering Drug Prices

Issued date: 05/12/25

On April 15, 2025, President Trump issued an Executive Order (EO 14273) directing federal agencies to propose regulations or make recommendations to provide access to prescription drugs at lower costs.

While the bulk of the EO pertains to lowering Medicare drug prices, this summary highlights aspects of the EO that may be relevant to employer-sponsored group health plans and their covered participants.

EO 14273 Directives

Within 90 days of the date of the EO (by July 14, 2025), the relevant agencies shall provide recommendations to the President on how best to advance a more competitive, efficient, transparent, and resilient pharmaceutical supply chain that delivers lower drug prices to consumers.

Within 180 days of the date of the EO (by October 12, 2025):

- The Department of Labor shall propose regulations to improve employer health plan fiduciary transparency into the direct and indirect compensation received by pharmacy benefit managers ("PBMs").
- The Food and Drug Administration shall issue a report providing administrative and legislative recommendations to:
  - Accelerate approval of generics, biosimilars, combination products, and second-in-class brand name medications; and
  - Improve the process through which prescription drugs can be reclassified as over-the-counter medications, including recommendations to optimally identify prescription drugs that can be safely provided to patients over the counter.
- The Department of Health and Human Services, the Department of Justice, the Department of Commerce, and the Federal Trade Commission shall conduct joint public listening sessions and issue a report with recommendations to reduce anti-competitive behavior from pharmaceutical manufacturers.

Employer Action

At this time, there are no immediate action items for employers.

Since the EO has given the relevant agencies their marching orders to develop new regulations and other guidance on these issues, in the next 3-6 months we may see new proposed rules that could impact employer health plans.

We will continue to monitor these developments and provide updates as new information becomes available.

2024 RxDC Reporting Reminder

Issued date: 05/14/25

The Centers for Medicare and Medicaid Services ("CMS") previously released updated Prescription Drugs Data Collection ("RxDC") reporting instructions related to reporting 2024 data; there are no changes between the 2023 and 2024 instructions. The deadline to report 2024 RxDC data to CMS is **June 1, 2025.**

Background

Plan sponsors of group health plans (typically, employers) must submit information annually about prescription drugs and health care spending ("RxDC reporting") to CMS. The next deadline is **June 1, 2025**, for reporting on calendar year 2024. This is a firm deadline date, which falls on a Sunday in 2025.

It is important to note that carriers, pharmacy benefit managers ("PBMs"), and third-party administrators ("TPAs") assisting with the reporting may have earlier deadlines for employers to respond to them with certain data points (e.g., plan name, average monthly premiums).

RxDC reporting consists of uploading to CMS a total of nine spreadsheets, consisting of a plan list (P2 is used for group health plans) and eight data files (D1 through D8), plus a "narrative response." In some situations, a TPA or PBM will not handle the full filing. This often requires the employer to file at least the D1 file, and occasionally the D2 file. A P2 list file must accompany all "D" filings.

HIOS Guidance

The HIOS RxDC User Manual and RxDC HIOS Access Guide were updated in April 2024. If an employer needs to submit one (or more) of the "D" files (e.g., D1) on behalf of the group health plan because a TPA or PBM is not handling the full filing, the employer must sign up for a HIOS account.

Employer Action

Employers should:

- Work with carrier partners, TPAs, PBMs and other vendors, as appropriate, to submit the requisite 2024 data and submit RxDC reporting.
- Understand whether the employer will be responsible for submitting any of the information to HIOS. For example, when an employer offers a self-funded health plan where stop loss insurance is carved out, the employer may be responsible for furnishing stop loss information by filing a P2 and D1 with HIOS.

The instructions are very helpful and answer questions about the filing requirement and provide relevant examples when appropriate.

We will continue to monitor and inform you of any applicable changes.

Another Delay for Maryland's Paid Family and Medical Leave

Issued date: 05/20/25

On April 7, 2025, the Maryland General Assembly passed HB 102 ("the bill") to postpone the implementation of Maryland's Time to Care Act ("FAMLI") by eighteen months. This is the third time that Maryland FAMLI has been delayed. The bill's passage follows the Maryland Department of Labor's ("DOL") proposed delay, announced in February 2025. The delay will become official upon the signature of Governor Wes Moore, which is expected soon.

The new implementation timeline is as follows:

- Payroll deductions for the state plan will begin **January 1, 2027**.
- FAMLI benefits to eligible employees will begin **January 3, 2028**.

It is important to note that payroll deductions were previously set to begin on July 1, 2025, with benefits beginning July 1, 2026.

The DOL is expected to revise their proposed regulations, previously released in November 2024 and January 2025. In their announcement of the proposed delay, the DOL paused all previously communicated regulatory timelines, which included deadlines for applying for a private plan and submissions of wage and hour reports. Presumably, the revised regulations will include updated timelines.

Employer Action

Employers should:

- Adjust their own implementation timeline accordingly.
- Await the publication of revised regulations by the DOL.

2026 Inflation Adjusted Amounts for HSAs, HDHPs, and EBHRAs

Issued date: 05/23/25

The IRS released the inflation adjustments for health savings accounts ("HSAs") and their accompanying HSA-compatible high-deductible health plans ("HSA-compatible HDHPs") effective for calendar year 2026, and the maximum annual amount that may be made available under excepted benefit health reimbursement arrangements ("EBHRAs"). All limits increased from the 2025 amounts.

HSA Annual Contribution Maximum

For calendar year 2026, the maximum HSA contribution amount for an individual with coverage under an HSA-compatible HDHP is:

- $4,400 for self-only coverage (up from $4,300 for 2025)
- $8,750 for coverage other than self-only (up from $8,550 for 2025)

It should be noted that individuals who are age 55 or older and covered by an HSA-compatible HDHP may make an additional HSA catch-up contribution of $1,000 each year until they enroll in Medicare. This catch-up contribution amount has not increased since 2009.

HSA Compatible High-Deductible Health Plan

For calendar year 2026, an HSA-compatible HDHP is a health plan:

- for which the maximum annual out-of-pocket expenses (deductibles, co-payments, and other amounts, but not premiums) do not exceed:
    - $8,500 for self-only coverage (up from $8,300 for 2025)
    - $17,000 for coverage other than self-only (up from $16,600 for 2025), and

- with a minimum annual deductible that is not less than:
    - $1,700 for self-only coverage (up from $1,650 for 2025)
    - $3,400 for coverage other than self-only (up from $3,300 for 2025)

If family HDHP coverage includes an embedded individual deductible, for 2026 that embedded individual deductible cannot be less than $3,400 (the statutory minimum deductible for family HDHP coverage).

Non-calendar year plans: In cases where the HSA-compatible HDHP renewal date is after the beginning of the calendar year (e.g., a fiscal year plan), any required changes to the annual deductible or out-of-pocket maximum may be implemented as of the next renewal date.

Excepted Benefit HRA Adjustment

For plan years beginning in 2026, the maximum amount that may be made newly available for the plan year for an EBHRA is $2,200 (up from $2,150 in 2025).

Enforcement Relief Coming for MHPAEA Final Rule

Issued date: 06/02/25

In recent court filings, the Departments of Health and Human Services ("HHS"), Labor, and the Treasury (collectively, "the Departments") announced they will:

- Revisit the 2024 Mental Health Parity and Addiction Equity Act of 2008 ("MHPAEA") final regulations; and
- Issue, in the near future, non-enforcement guidance as it relates to the provisions of these rules effective for plan years beginning on or after January 1, 2025 and January 1, 2026.

The Departments have since issued a statement announcing enforcement relief.

Background

On September 9, 2024, the Departments released final rules pertaining to the MHPAEA with the aim of ensuring that individuals who seek treatment for mental health ("MH") or substance use disorder ("SUD") reasons do not face greater burdens than they would face when seeking coverage for medical or surgical ("M/S") reasons.

Among other things, the 2024 final rule required:

- Use of a meaningful benefit standard. If a plan provides any benefits for a MH condition or SUD in any benefits classification, it must provide meaningful benefits for that condition or disorder in every classification in which meaningful M/S benefits are provided.
- A two-part test for NQTL application. New standards for evaluating whether a non-quantitative treatment limitation ("NQTLs") may be applied to MH/SUD benefits (the design and application requirements and the relevant data evaluation requirement).
- Additional requirements related to the comparative analysis, including providing a list of all NQTLs to the relevant enforcement agency and, for ERISA plans, a fiduciary certification confirming a prudent process was undertaken to select qualified service providers to perform and document the analyses.

2024 Rules Challenged

On January 17, 2025, the ERISA Industry Committee ("ERIC") filed suit against the Departments arguing that the 2024 rules create an unworkable standard, violate due process, exceed the authority of the Departments and the intent of Congress, and are arbitrary and capricious.

On May 9, 2025, the Departments filed a Motion for Abeyance in the lawsuit. In the filing, the Departments stated that they intend to:

1. Reconsider the 2024 rules, including whether to issue a notice of proposed rulemaking rescinding or modifying the regulations;
2. Issue a non-enforcement policy in the "near future" covering the portions of the 2024 rules that are applicable for plan years beginning on or after January 1, 2025 and January 1, 2026; and
3. Re-examine the Departments' current MHPAEA enforcement program more broadly.

Prior to the filing, the Departments provided ERIC with a copy of the non-enforcement policy that they expect to publicly release memorializing their intention not to enforce the portions of the 2024 rules that are applicable for plan years beginning on or after January 1, 2025 and January 1, 2026. In response, the Court granted a stay in the lawsuit on May 12, 2025.

Departments' Statement

On May 15, 2025, the Departments issued a statement regarding enforcement of the 2024 final MHPAEA rules.

- They will not enforce the 2024 Final Rule or otherwise pursue enforcement actions, based on a failure to comply that occurs prior to a final decision in the litigation, plus an additional 18 months. This enforcement relief applies only with respect to those portions of the 2024 Final Rule that are new in relation to the 2013 Final Rule. The Departments note that MHPAEA's statutory obligations, as amended by the Consolidated Appropriations Act, 2021 ("CAA-21"), remain in effect.
    - As an example, the requirement to perform an NQTL comparative analysis and furnish it upon request from the Departments remains enforceable as this was included in the statute under CAA-21. However, the ERISA fiduciary certification of the analyses (part of the 2024 Final Rule) is not enforceable during this relief period.
- They will undertake a broader reexamination of each department's respective enforcement approach under MHPAEA, including provisions amended by the CAA, 2021.
- Plans and issuers may continue to refer to the 2013 Final Rule and other sub-regulatory guidance issued by the Departments (including FAQ 45, addressing changes to MHPAEA under the CAA-21). However, in their process for reconsidering the 2024 Final Rule, the Departments may make updates to the sub-regulatory guidance implementing MHPAEA.

The Departments' statement acknowledges that they remain committed to ensuring individuals receive protections under the law in a way that is not unduly burdensome to plans and carriers.

Employer Action

With respect to the 2024 Final Rule, the Departments' announcement of non-enforcement relief and plan to revisit the final rule is welcome news as employers and plans were challenged by these complex requirements.

This announcement only applies to the specific provisions of the 2024 Final Rule. Plans and carriers will need to continue to comply with other aspects of MHPAEA including the statute (as amended under CAA-21), 2013 final regulations and relevant guidance.

The Departments may issue further guidance addressing non-enforcement relief and MHPAEA compliance in light of this statement.

Our Compliance Team is monitoring developments and will release an update when the guidance is available.

2025 PCOR Fee Filing Reminder for Self-Insured Plans

Issued date: 06/05/25

The Patient-Centered Outcomes Research ("PCOR") fee filing deadline is **July 31, 2025**, for all self-funded medical plans and some HRAs (including individual coverage HRAs ("ICHRAs")) for plan years (including short plan years) ending in 2024. Carriers are responsible for paying the fee for insured policies.

The plan years and associated PCOR fee amounts due July 31, 2025, are as follows:

Plan Years Ending	Amount of PCOR Fee
January 31, 2024	$3.22/covered life/year
February 29, 2024	$3.22/covered life/year
March 31, 2024	$3.22/covered life/year
April 30, 2024	$3.22/covered life/year
May 31, 2024	$3.22/covered life/year
June 30, 2024	$3.22/covered life/year
July 31, 2024	$3.22/covered life/year
August 31, 2024	$3.22/covered life/year
September 30, 2024	$3.22/covered life/year
October 31, 2024	**$3.47/covered life/year**
November 30, 2024	**$3.47/covered life/year**
December 31, 2024	**$3.47/covered life/year**

Employers with self-funded health plan years ending in 2024 should use the 2nd quarter Form 720 to file and pay the PCOR fee by July 31, 2025. The information is reported in Part II.

IRS Form 720 is a quarterly form that is used to report and pay many different taxes, including fuel and other transportation excise taxes. The IRS has adapted the Form 720 to be used for this annual reporting requirement. Each year, the PCOR section is updated with the fee rates in June for the July 31st due date (the 2nd quarter form).

Please note, Form 720 is a tax form (not an informational return form such as Form 5500), and as such, the employer or an accountant would need to prepare it. Parties other than the plan sponsor, such as third-party administrators, cannot report or pay the fee.

Resources

For a copy of Notice 2024-83, visit https://www.irs.gov/irb/2024-49_IRB#NOT-2024-83

For a copy of the regulations, visit: http://www.gpo.gov/fdsys/pkg/FR-2012-12-06/pdf/2012-29325.pdf

For additional information, please visit the following IRS sites:

- Form 720, Quarterly Federal Excise Tax Return – instructions and forms: https://www.irs.gov/forms-pubs/about-form-720.
- Patient-Centered Outcomes Research Trust Fund Fee, Questions and Answers: https://www.irs.gov/newsroom/patient-centered-outcomes-research-institute-fee
- PCOR Filing Due Dates and Applicable Rates Chart: https://www.irs.gov/affordable-care-act/patient-centered-outreach-research-institute-filing-due-dates-and-applicable-rates

House Passes Reconciliation Package

Issued date: 06/06/25

On May 22, 2025, the House passed a budget reconciliation bill, "One Big, Beautiful Bill Act" (H.R. 1) that advances President Trump's comprehensive tax package.

This bill is not law. The package now moves over to the Senate for consideration. The Senate will likely have amendments or other changes to the bill. It is too early to tell what will be included in the final package.

That said, there are some notable provisions that, if enacted, will impact employer-sponsored health and welfare plans. Notably, there will be additional flexibility and relief for Health Savings Accounts ("HSAs").

It is important to note that this House bill does not include a change in the tax favored treatment of health insurance provided by employers to their employees. Limiting favorable tax treatment was a policy idea that was floated to pay for retaining the tax cuts set to expire at the end of 2025. At this point, the bill does not include such a policy.

The following are some of the provisions included in the reconciliation package that will impact employers sponsoring group health and welfare plans. Keep in mind, this is all subject to change as the bill works its way through Congress. These provisions, if enacted "as is", would-be effective January 1, 2026.

Individual Coverage Health Reimbursement Arrangements

Current law. Under a final regulation, the IRS established Individual Coverage Health Reimbursement Arrangements ("ICHRAs"), which (subject to certain rules) may be used to purchase qualified individual health insurance without violating group health plan requirements.

- **Proposed provisions:**
  - Codifies the final rule and renames the policy from ICHRA to Custom Health Option and Individual Care Expense ("CHOICE") arrangements. (Sec. 110201)
  - Permits employees enrolled in a CHOICE arrangement to use pre-tax salary reduction elections to pay for health plan premiums purchased through the Exchange marketplace. (Sec. 110202)

- Under current law, employers cannot reimburse employees for health plan premiums purchased through an Exchange if any of the premium could be paid through salary reduction.

- Creates a two-year tax credit for small businesses (fewer than 50 employees) offering a CHOICE arrangement for the first time ($100/employee/month in the first year and $50/employee/month in the second year). (Sec. 110203)

Medicare Part A eligible individuals allowed to contribute to an HSA. (Sec. 110204)

Current law. Individuals entitled to Medicare Part A are not eligible to contribute to an HSA, even if they are still enrolled in a qualified high-deductible health plan ("HDHP").

- **Proposed provision.** Working seniors who are eligible for Medicare Part A, but enrolled in an HDHP, may continue to contribute to an HSA.

Direct Primary Care and HSA eligibility. (Sec 110205)

Current law. Certain direct primary care ("DPC") arrangements that furnish medical benefits for free or at a reduced cost before satisfaction of the deductible in an HDHP is generally disqualifying coverage for purposes of HSA eligibility and contributions.

- **Proposed provision.**
    - Individuals with HDHPs may enroll in DPC arrangements that consist solely of primary care services and contribute to their HSA. This will require that the fees for the DPC do not exceed $150/month (or $300/month when more than one individual is covered)
        - Primary care does not include:
            - Anesthesia services,
            - Prescription drugs (except for vaccines),
            - Laboratory service not typically administered in an ambulatory primary care setting.
    - HSA funds may be used to pay for DPC services up to $150/month for individuals or $300/month for family arrangements, adjusted annually for inflation.

Onsite clinics and HSA eligibility. (Sec. 110207)

Current law. Onsite clinics that provide significant medical benefits (more than just preventive care) are generally disqualifying coverage for purposes of HSA eligibility if provided for free or at a reduced cost.

- **Proposed provision**. Allow individuals who utilize free or discounted qualified items and services from an onsite clinic at their worksite to contribute to an HSA.
        - For this purpose, a qualified item or service includes:
            - Physical examination,
            - Immunizations,
            - Non-prescription drugs or biologicals,
            - Treatment for injuries in the course of employment,

- Preventive care for chronic conditions (defined by IRS Notice 2019-45),
- Drug testing,
- Hearing or vision screenings or related services.

Contributions permitted if a spouse has a health FSA. (Sec. 110212)

Current law. Generally, an individual will not be eligible to contribute to an HSA if their spouse is enrolled in a traditional health flexible spending account (health FSA).

- **Proposed provision**. Allow individuals to be eligible for an HSA even if the individual's spouse is enrolled in an FSA.

Increased HSA contributions for certain individuals. (Sec. 110213)

Current law. Maximum HSA contributions are set by statute and indexed for inflation (for 2025, $4,300 for self-only coverage and $8,550 for coverage other than self-only).

- **Proposed provision.** Allow individuals who make less than $75,000/annually (or $150,000/family) to contribute an additional $4,300 (or $8,550 for families) each year as indexed for inflation. Additional amounts are phased out for individuals making $100,000/annually ($200,000 families).

Other proposed HSA related provisions

- **Physical activity, fitness and exercise are treated as amounts paid for medical care. (Sec. 110208)**. Individuals will be allowed to use their HSA for physical fitness memberships and for participation or instruction in physical activity up to $500 per year for an individual ($1,000 per year for a family) with up to one-twelfth of such expenses allowed per month.
    - Under current law, sports and fitness expenses, such as fitness facility membership fees, are not treated as HSA qualified medical expenses.
- **Permit both spouses to make catch-up contributions to the same HSA. (Sec. 110209).** Both spouses may deposit their catch-up contributions into one HSA.
    - Under current law, if both spouses are HSA-eligible and age 55 or older, they must open separate HSA accounts to make their respective "catch-up" contributions (an extra $1,000 annually).
- **Permit health FSA or HRA terminations or conversion to fund an HSA. (Sec. 110210)**. An employee who has not been covered by an HDHP during the 4-year period prior to the new HDHP may, at the employer's discretion, convert health FSA or HRA balances into an HSA contribution upon newly enrolling in an HDHP/HSA plan, subject to certain rules. The conversion amount is limited to the annual health FSA contributions limit ($3,300 in 2025).
    - Under current law, individuals cannot transfer health FSA or HRA balances into an HSA.
- **Special rule for certain medical expenses incurred before establishment of the HSA. (Sec. 110211)**. Allow medical services incurred within 60 days before the HSA is established to be an eligible qualified medical expense.
    - Under current law, HSA funds can only be used for the purchase of a qualified medical expense after the HSA is established.

Other notable provisions

- **Employer payments for student loans (Sec. 110113)**. Make permanent the exclusion from gross income for qualified education loan payments (set to expire after 2025) and index for inflation the maximum exclusion for educational assistance programs (currently fixed at $5,250/year).
- **Permanent termination of qualified bicycle commuting reimbursement exclusion (Sec. 110012)**. This provision will permanently eliminate the qualified bicycle commuting reimbursement exclusion.

Executive Order Targets Prescription Drug Pricing

Issued date: 06/10/25

On May 12, 2025, President Trump issued an Executive Order ("EO") directing federal agencies to take steps to reduce the prices Americans pay for prescription drugs and align them with those paid by other countries.

- It is important to note that an earlier EO (EO 14273) directed federal agencies to propose regulations and make recommendations to improve access to prescription drugs at lower costs. Among other things, it directs the Department of Labor to propose regulations by October 12, 2025, under ERISA §408(b)(2) to improve transparency into the direct and indirect compensation received by Pharmacy Benefit Managers ("PBMs").

Specifically, the EO sets forth the following initiatives:

- **Address Foreign Nations Freeloading on American-Financed Innovation**. The U.S. Trade Representative and Secretary of Commerce are directed to take action to ensure foreign countries are not engaged in practices that purposefully and unfairly undercut market prices and drive price hikes in the United States.
- **Enable Direct-to-Consumer Sales to American Patients at the Most-Favored-Nation Price**. The Department of Health and Human Services ("HHS") is directed to facilitate direct-to-consumer purchasing programs for prescription drug manufacturers to sell their products to American patients at the "Most Favored Nation" ("MFN") price.
- **Establish Most-Favored-Nation Pricing**.
    - Within 30 days (by June 11, 2025) HHS, along with other agencies, shall communicate MFN price targets to pharmaceutical manufacturers to bring prices for American patients in line with comparably developed nations.
    - If significant progress toward MFN pricing is not delivered to the extent consistent with applicable law, then, among other things:
        - HHS shall propose rulemaking to impose MFN pricing; and
        - Relevant agencies may consider other aggressive measures to reduce the cost of prescription drug coverage and end anticompetitive practices.

Employer Action

The EO directs the applicable agencies to take action with respect to the President's policy goals. This will come in the form of regulations and other formal guidance.

Much remains uncertain at this time as to the practical effect this EO will have on the commercial insurance market. For example, it is not clear whether MFN pricing will be available only to Americans with government provided coverage (e.g., Medicare, Medicaid) or if employers will be able to access this pricing on behalf of their group health plan members.

In addition, once guidance is issued, it is likely that the pharmaceutical industry and other stakeholders may seek to challenge any such regulation through litigation.

We will continue to monitor developments and share updates when available.

Reminder – Seattle Ancillary Hotel Business Health Expenditures

Issued date: 06/12/25

The Improving Access to Medical Care for Hotel Employees Ordinance ("the Ordinance") requires covered employers to make healthcare expenditures to or on behalf of covered employees. Covered employers include:

- Employers that own, control or operate a Seattle hotel or motel with 100 or more guest rooms (referred to as a Large Hotel or Covered Hotel); and
- Ancillary hotel business employers with 50 or more employees worldwide.

As previously reported, healthcare expenditures for ancillary hotel businesses that have between 50-250 employees worldwide are required to begin on the later of July 1, 2025, or the earliest annual open enrollment period for health coverage after July 1, 2025.

> Note that this requirement is already in effect for ancillary hotel businesses with more than 250 employees worldwide. Smaller ancillary businesses were given additional time to come into compliance. Ancillary businesses with fewer than 50 employees worldwide do not need to comply.

Covered employers also include ancillary hotel businesses defined as a business with one or more of the following relationships with a Large Hotel:

- Routinely contracts with a hotel to provide services in conjunction with the hotel's purpose;
- Leases or subleases space at the site of the hotel to provide services in conjunction with the hotel's purpose; or
- Provides food and beverages to hotel guests and to the public and has an entrance within the hotel.

For the 2025 calendar year (January 1 to December 31, 2025), the required expenditure rates are:

- $561 per month for an employee with no spouse, domestic partner, or dependents;
- $955 per month for an employee with only dependents;

- $1,124 per month for an employee with only a spouse or domestic partner;
- $1,686 per month for an employee with a spouse or domestic partner and one or more dependents.

  It should be noted that as of the date of publication of this article, the 2026 calendar year expenditures have not been released.

The Seattle Office of Labor Standards ("OLS") has provided FAQs to assist employers with compliance with the Ordinance including counting hours, calculating expenditures for employees, and waivers.

Employer Action

- Ancillary businesses that had relief from this requirement should begin to prepare for the upcoming July 1, 2025 (or first plan year on or after that date) effective date. The OLS FAQs provide helpful information.
- If compliance is required for a plan year beginning in 2025, the 2025 adjusted rates should be used to determine appropriate expenditures.
- Include the adjusted rates of the expenditure as part of the annual notification required to covered employees.
- Monitor OLS FAQs and website for further information.

WA Cares Fund Updates

Issued date: 06/12/25

As previously reported, Washington's Long Term Services and Supports ("LTSS") Trust Program ("the Program"), known as "WA Cares Fund," was amended to add certain individual exemption categories. During the 2025 legislative session, SB 5291 was passed modifying certain requirements and individual exemptions. The Governor signed the bill into law on May 20, 2025.

Background

The WA Cares Fund provides long term care ("LTC") benefits to eligible Washington residents. The Program is funded by a premium assessment of 0.58% of all wages earned by employees in Washington. Premium payments via payroll withholding by employers began July 1, 2023. Certain individuals meeting specific requirements are eligible to apply for an exemption from the Program. Exempted individuals are not required to pay premiums but will never be eligible for benefits.

SB 5291

The LTSS Trust Commission monitors Program implementation and recommends improvements. SB 5291 contained various recommendations of the LTSS Trust Commission:

- **Out-of-state participants**. Out-of-state participants who elected coverage may not withdraw from the Program. However, the Employment Security Department ("ESD") must cancel the out-of-state elective coverage if the participant fails to make required payments or submit required reports;
- **Active-duty service members exemption**. An active-duty service member who is concurrently working off duty civilian employment is automatically exempt from the Program.
- **Temporary employees with a non-immigrant visa exemption**. An employee who holds a nonimmigrant visa for temporary workers, as recognized by federal law, is automatically exempt from the Program, unless the employee notifies the employee's employer that the employee would like to participate.

- **Automatic exemptions discontinued upon:**
  - Out-of-state residents moving to Washington
  - Member of military discharged or separates from service
- **Individuals with a valid "opt out" due to obtaining private LTC insurance.** Individuals will be permitted to opt back into the Program by rescinding the exemption.
- **Supplemental LTC insurance.** New standards and requirements for supplemental private LTC policies designed for coverage after WA Cares benefits are exhausted and that are issued after January 1, 2026.

Employer Action

Employers will need to be aware of which employees will be automatically exempt and ensure no premiums are withheld from those employees' paychecks. Coordination with payroll service providers may be required to determine the best administrative processes for ensuring premiums are not withheld unless permitted.

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