MY BENEFIT ADVISOR

2025 YEAR IN REVIEW

Compliance Digest

COMPLIANCE BULLETINS
RELEASED JANUARY - DECEMBER

2025 Compliance Bulletins

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New Texas Prescription Drug Information Requirement

Issued date: 01/03/25

Beginning with the 2025 policy year, Senate Bill 622 requires Texas carriers to make prescription drug benefit information available upon request to members and providers in real time. The required information includes cost sharing, drug lists, utilization management requirements, and other coverage details. It applies to insured medical plans in Texas and not to self-funded medical or drug programs (other than those offered by professional employer organizations).

Summary:

A carrier must provide information regarding a covered prescription drug to an enrollee or the enrollee's prescribing provider on request. The information provided must include the carrier's drug formulary and, for the prescription drug and any formulary alternative:

1. the enrollee's eligibility;

2. cost-sharing information, including any deductible, copayment, or coinsurance, which must:

    a. be consistent with cost-sharing requirements under the enrollee's plan;

    b. be accurate at the time the cost-sharing information is provided; and

    c. include any variance in cost-sharing based on the patient's preferred dispensing retail or mail-order pharmacy or the prescribing provider; and

3. applicable utilization management requirements.

The carrier must:

1. respond in real time to a request made through a standard Application Programming Interface (API);

2. allow the use of an integrated technology or service as necessary to provide the required information;

3. ensure that the information provided is current no later than one business day after the date a change is made; and

4. provide the information if the request is made using the drug's unique billing code and National Drug Code.

A carrier may not restrict a prescribing provider from communicating to the enrollee information about the cash price of the drug, or any additional information on any lower cost or clinically appropriate alternative drug, whether or not the drug is covered under the enrollee's plan.

This requirement is effective beginning with a policy year beginning on or after January 1, 2025.

Employer Action

Employers with insured medical plans written out of Texas should be aware of the above change. No employer action is required.

New York Issues Guidance on Paid Prenatal Leave

Issued date: 01/06/25

As previously reported, effective January 1, 2025, New York employees will be entitled to 20 hours of paid prenatal leave in a 52-week period to be used for prenatal healthcare service appointments during their pregnancy or related to their pregnancy. New York has published guidance in the form of Frequently Asked Questions ("FAQs") to help employers prepare for the new paid leave requirement.

Highlights from the FAQs are summarized below.

Summary:

Paid Prenatal Leave	Paid prenatal leave is a stand-alone benefit available to employees seeking prenatal healthcare services. An employer cannot require an employee to choose one leave type over another or require an employee to exhaust one type of leave before using paid prenatal leave.
Covered Employers	All private sector New York employers are subject to the paid prenatal leave requirements, regardless of size.
Covered Employees	All employees working for a private sector employer in any occupation are entitled to paid prenatal leave including full-time and part-time employees. This leave is only available to the employee and does not extend to the spouse, partner or other individual.
Amount of the Benefit	Employees are entitled to 20 hours of paid prenatal leave in a 52-week period measured from the first time the employee uses paid prenatal leave. The triggering date is the date that the leave is first recorded on an employee's timesheet.
When Benefits Are Available	Employees are entitled to 20 hours of paid prenatal leave as of their hire date as there is no requirement to work a minimum amount of time before benefits may be taken. This benefit is in addition to any other leave benefits that may be available such as under the New York sick leave provisions.

How Benefits are Taken and Paid	Paid prenatal leave is taken in hourly increments with employees paid their regular rate of pay, or the applicable minimum wage established by the Labor Law, whichever is greater.
Covered Health Care Services	Benefits include health care services received by an employee during their pregnancy or related to such pregnancy, including physical examinations, medical procedures, monitoring and testing, and discussions with a health care provider related to the pregnancy. In addition, leave may be taken for fertility treatment or care appointments, including in vitro fertilization as well as end-of-pregnancy care appointments. The leave does not apply to post-natal or postpartum care.
Employee Notification to the Employer	Employees should request time off in accordance with existing notification/request procedures within their workplaces and are encouraged to provide advance notice of such leave requests, when possible. Employers may not request medical records or ask employees to disclose confidential information about their health condition when requesting paid prenatal leave.
Employer Recordkeeping	Employers are not required to separately identify paid prenatal leave on employee paystubs but are encouraged to keep accurate records.
Retaliation	Employers may not retaliate against employees for requesting paid prenatal leave. Employees may report allegations of retaliation by emailing the Division of Labor Standards.

Employer Action

Employers should review and update leave policies to include the new paid prenatal leave benefit and ensure that eligible employees have access to the paid leave benefit as of January 1, 2025.

California Bans Certain Restrictions for Insured Dental Plans

Issued date: 01/08/25

California has enacted a state insurance law that prohibits fully insured dental plans in California from imposing:

- a *dental waiting period provision* for certain services in a large group dental plan that is fully insured, or
- a *pre-existing condition exclusion provision* in any dental plan that is fully insured.

The new state insurance law, which does not apply to self-funded dental plans, is effective for insurance policies and health maintenance organization ("HMO") dental contracts in California that are issued or renewed on or after January 1, 2025.

Background:

Individuals who have postponed needed dental treatment are considered more likely to purchase dental insurance than healthier individuals with fewer treatment needs. To address this potential for adverse selection, some insurance carriers and HMOs impose waiting periods or pre-existing condition exclusions on the more costly dental services for newly enrolled individuals. Examples of these restrictions include the following:

- A waiting period of 3 to 12 months before the dental plan will pay for fillings, extractions, root canals, and other basic restorative care.
- A waiting period of 3 to 12 months before the dental plan will pay for crowns, dentures, implants, and other major restorative services.
- A pre-existing condition exclusion for teeth that are missing on the first day of coverage.
- A pre-existing condition exclusion for dentures, if the individual received dentures from a different dental plan within a specified time frame.

In some cases, a dental plan may waive the specific services waiting period or pre-existing condition exclusion if the enrolled individual provides proof of continuous dental insurance coverage with a different dental plan immediately prior to coverage with the current dental plan.

New California Dental Insurance Law

On and after January 1, 2025, an insurance carrier or HMO may not issue, amend, renew or offer a dental insurance policy or HMO contract that imposes the following types of restrictions that address adverse selection:

- **A *dental waiting period provision* is prohibited in a large group dental insurance policy or HMO contract.** The term "*dental waiting period provision*" means a provision in the policy or contract that limits coverage for certain services for a specified period following the individual's effective date of coverage. The prohibition applies only to a large group dental plan, which is defined by California as any group plan that is not a small group plan.

- **A *pre-existing condition provision* is prohibited in any dental insurance policy or HMO contract.** The term "*pre-existing condition provision*" means a provision in the policy or contract that excludes or limits coverage for services, charges, or expenses incurred following an individual's effective date of coverage, for a condition for which dental services, diagnosis, care, or treatment was recommended or received before the effective date of coverage. The prohibition applies to both large group and small group dental plans.

Application of New California Insurance Law to Dental Plans

The new California insurance law generally applies to:

- Group dental insurance policies issued or delivered (i.e., sitused) in California;

- Dental HMOs in California;

- Group dental insurance policies issued or delivered (i.e., sitused) outside of California, to the extent that the policy covers California residents, except when:

    - the employer's principal place of business is located outside of California, and

    - a majority of employees are located outside of California.

The new California insurance law does not apply to any dental plan that is self-funded.

Employer Action

As this is an insurance mandate, carriers and HMOs are responsible for compliance. It is likely that dental premiums in the fully insured market will increase.

Employers that want to address adverse selection by continuing to include a *dental waiting period provision* for certain services or a *pre-existing condition provision* in their dental plan may consider replacing their fully insured plan with a plan that is self-funded.

Legislation Reduces Burden of Employer Reporting

Issued date: 01/09/25

Congress passed two bills to reduce the burden of employer reporting related to the Affordable Care Act that President Biden signed into law on December 23, 2024. While small, these bills pack a big punch as they significantly reduce the employer (and carrier) responsibilities for Form 1095-C (and Form 1095-B) reporting.

Paperwork Burden Reduction Act

This Act provides an alternative furnishing method for Forms 1095-C and 1095-B, offering additional flexibility to employers and carriers responsible for sending these Forms to covered individuals.

Currently, most large employers are required to furnish a Form 1095-C to full-time employees. For employers that are self-funded (including level-funded), the employer is required to furnish a Form 1095-C (or Form 1095-B) to any primary insured. In most cases, these Forms are mailed to the home address of the employee or furnished electronically with appropriate notice and consent.

The new law provides that Form 1095-C or Form 1095-B may be furnished to individuals only upon request. In other words, employers are no longer required to furnish these Forms to covered individuals unless the individual requests it.

Employers (or carriers) that take advantage of this relief must:

- Ensure any request for an applicable Form is fulfilled by the later of January 31 or 30 days after the request is made; and
- Provide timely notice of the option. No guidance has been issued on the language for the notice or how it should be displayed or distributed. Employers should await this guidance before relying on this relief.

This law applies to statements with respect to any returns after 2023. This means, employers preparing reporting for calendar year 2024 can take advantage of this relief.

Even though employers relying on this alternative furnishing method are not required to furnish a Form 1095-C to individuals (unless requested), the Forms 1095-C (and 1095-B) must still be completed and timely filed with the IRS along with a Form 1094-C (or Form 1094-B). All Forms 1095-C along with Form 1094-C for calendar year 2024 must be filed electronically with the IRS by March 31, 2025.

California, Massachusetts, New Jersey, Rhode Island and the District of Columbia have individual health insurance mandates with their own requirements for furnishing information regarding health coverage to residents of the state. All of these (except Massachusetts) allow reporting via the federal Forms 1095-C and 1095-B. It is not clear how the states with individual mandate requirements will respond to this federal action, as they do not have a similar "opt-in" provision. Employers who are subject to both state and federal reporting will need to await direction from the state for any further flexibility. Otherwise, they should be prepared to furnish statements to covered individuals as they have in prior years (e.g., by mail).

Massachusetts requires reporting on a separate Form 1099-HC and this requirement is unaffected by the change in federal reporting.

Employer Reporting Improvement Act

This bill:

- Allows a date of birth to be used instead of a tax identification number on the Form 1095-C or 1095-B when the tax identification number is not available. The tax identification number is usually the social security number.
- Codifies that an employer (or carrier) may furnish Form 1095-C (or Form 1095-B) electronically when the individual has consented to electronic delivery.
- Provides at least 90 days (versus 30 days) for an employer to respond to an IRS letter 226-J proposing an assessment under the employer shared responsibility mandate. This provision is effective for assessment proposed in taxable years beginning after 2023.
- Implements a 6-year statute of limitations for shared responsibility penalty assessments. Prior to this law, no statute of limitations applied.

Employer Action

While these two bills provide welcome relief, the timing is not the most favorable.

Employers should:

- With respect to furnishing Forms 1095-C for CY 2024, the due date is **March 3, 2025**. Given the relief afforded in the Paperwork Burden Reduction Act:
    - Consider whether to take advantage of the relief and only furnish the Forms to employees who request them. This will require that appropriate notice is provided to employees. Currently, there is no guidance on how to provide such notice. The IRS will likely issue this guidance, but timing is uncertain.
        - Absent guidance, employers with employees who are residents of a state with an individual mandate may still need to furnish a 1095-C (or 1095-B) to meet state requirements.
    - Given the short time frame before the March 3, 2025 deadline, some employers may consider furnishing the Forms 1095-C as they have in past years (e.g., by mail) and then move to the "opt-in" method for calendar year 2025 reporting (due in 2026).

- Always check the response date on any letter 226-J. While the time frame for a response will be longer – it will not apply until the IRS begins assessing penalties for calendar year 2024. If you receive a letter 226-J with an assessment applicable before 2024 (e.g., 2022), it will be subject to the 30-day response window.

Certain ERISA Deadlines Extended Due to Hurricanes in Southeast

Issued date: 01/14/25

The Departments of Labor and the Treasury issued guidance extending certain deadlines for health and welfare plans due to Hurricanes Helene and Milton. Similarly, the Department of Health and Human Services ("HHS") released a Bulletin to assist individuals and businesses impacted by these storms. Collectively, the Departments provided four pieces of guidance:

1. **EBSA Disaster Relief Notice 2024-01.** Extends the time for plans to provide ERISA-required notifications, such as SPDs, SMMs, and benefit determinations, provided there is a good faith effort to furnish these documents as soon as administratively practicable.
2. **Final Regulations.** Delays or suspends deadlines related to COBRA, HIPAA special enrollment, and claims/appeals, including the deadline for plan administrators to issue COBRA election notices.
3. **FAQs for Participants and Beneficiaries.** Helps participants affected by the hurricanes and tropical storm understand their ERISA rights, essentially reiterating previous guidance.
4. **Insurance Standards Bulletin Series.** Encourages non-federal governmental plans and health insurance issuers to extend participant deadlines and offers non-enforcement relief.

The extensions and suspensions in the Notice and Final Rule apply during the "Disaster Period," with deadlines tolled and resuming after this period ends.

Disaster Periods

- **Florida:**
  - Hurricane Helene: September 23, 2024 – May 1, 2025
  - Hurricane Milton: October 5, 2024 – May 1, 2025
- **Georgia** (Hurricane Helene): September 24, 2024 – May 1, 2025

- **North Carolina, South Carolina, Virginia** (Hurricane Helene and Tropical Storm Helene): September 25, 2024 – May 1, 2025
- **Tennessee** (Tropical Storm Helene): September 26, 2024 – May 1, 2025

The Notice

The Notice, which provides relief, applies to all Title I ERISA disclosures and notifications (except those in the Final Rule) and requires good faith efforts to provide these as soon as administratively practicable. Good faith delivery includes electronic communication methods such as email, text messages, and websites.

The notice provides examples of the type of benefit plan disclosure and notification timing extensions that would apply including:

- Summary Plan Descriptions and Summary of Material Modifications
- Forms 5500 and M-1
- Procedural requirements for plan loans and distributions
- Participant contributions and loan repayments
- Claims and appeal deadlines

The Notice also includes "General ERISA Fiduciary Compliance Guidance," urging plan fiduciaries to prevent benefit loss or undue delay.

Final Regulations

The Final Regulations suspend certain deadlines for health and welfare plan participants during the Disaster Period. These deadlines resume after the Disaster Period ends and apply to all ERISA and Internal Revenue Code plans. HHS encourages non-federal plans and health insurance issuers to extend participant deadlines and provide non-enforcement relief.

Plan Administrator Relief

The 14-day (or 44-day if the employer is the plan administrator) deadline for issuing COBRA election notices is suspended.

Participant Relief

- The following employee notification deadlines are suspended during the Disaster Period:
- HIPAA Special Enrollment Period
- COBRA Qualifying Event and Disability Extension Notices
- COBRA Election
- COBRA Premium Payments
- Benefit Claims and Appeals
- External Review and Perfecting a Request for External Review

Participants must have been in the disaster area or covered by an affected plan at the time of the hurricanes or tropical storm. A plan is directly affected if the employer's principal place of business, the office of the plan or administrator, or the primary recordkeeper's office was in the disaster area.

The companies that are eligible for these rules need to be in a county that is marked as eligible for *individual assistance* (and not only public assistance) through FEMA.

2025 Federal Poverty Guidelines Announced

Issued date: 01/21/25

The Department of Health & Human Services ("HHS") recently announced the 2025 federal poverty guidelines which, among other things, establish the federal poverty line ("FPL") affordability safe harbor for purposes of the Affordable Care Act ("ACA") employer mandate.

For plan years beginning February 1, 2025 or later, the 2025 FPL safe harbor is $117.63/month in the lower 48 states and DC, $146.95/month for Alaska, and $135.22/month for Hawaii.

As a reminder, a plan can use poverty guidelines in effect 6 months before the first day of the plan year for purposes of using the FPL affordability safe harbor.

Because the 2025 guidelines were announced after the start of the calendar year, plans with plan years beginning on January 1, 2025 use $113.20/month for the lower 48 states and DC ($141.38/month for Alaska and $130.11/month for Hawaii), which is 9.02% of the 2024 applicable federal poverty guidelines.

Background

Large employers may be subject to the employer mandate penalty under the ACA if they do not offer affordable, minimum value coverage to all full-time employees, and at least one full-time employee receives a subsidy in the Marketplace.

A large employer's offer of coverage will be considered "affordable" under the FPL safe harbor if the employee's required monthly contribution for the lowest cost self-only coverage that provides minimum value does not exceed 9.5% (as indexed) of a monthly amount determined as the FPL for a single individual for the applicable calendar year, divided by 12. For 2025, this amount is 9.02%.

2025 FPL Affordability Safe Harbor

For FPL affordability safe harbor purposes, the applicable FPL is the FPL for the state in which the employee is employed. The 2025 FPL is $15,650 for a single individual in every state (and Washington D.C.) except Alaska or Hawaii. Thus, if the employee's required monthly contribution for the lowest cost self-only coverage that provides minimum value is $117.63

(9.02% of $15,650/12, rounded down) or less, the employer's offer of coverage meets the FPL affordability safe harbor for a plan year beginning February 1, 2025 or later in the lower 48 states and DC.

FPL Guidelines

The following are the 2025 HHS poverty guidelines:

2025 Poverty Guidelines for the 48 Contiguous States and DC	
Persons in family/household	Poverty guideline
1	$15,650
2	$21,150
3	$26,650
4	$32,150
5	$37,650
6	$43,150
7	$48,650
8	$54,150
For families/households with more than 8 persons, add $5,500 for each additional person.	

2025 Poverty Guidelines for Alaska	
Persons in family/household	Poverty guideline
1	$19,550
2	$26,430
3	$33,310
4	$40,190
5	$47,070
6	$53,950
7	$60,830
8	$67,710
For families/households with more than 8 persons, add $6,880 for each additional person.	

2025 Poverty Guidelines for Hawaii	
Persons in family/household	Poverty guideline
1	$17,990
2	$24,320
3	$30,650
4	$36,980
5	$43,310
6	$49,640
7	$55,970
8	$62,300
For families/households with more than 8 persons, add $6,880 for each additional person.	

Medicare Part D CMS Notification Reminder

Issued date: 01/22/25

Employers sponsoring a group health plan (whether insured or self-insured) need to report information on the creditable (or non-creditable) status of the plan's prescription drug coverage to the Centers for Medicare and Medicaid Services ("CMS").

In order to provide this information, employers must access CMS's online reporting system at: www.cms.gov/Medicare/Prescription-Drug-Coverage/CreditableCoverage/CCDisclosureForm.html

As a reminder, notice must be provided by the following deadlines:

- Within 60 days after the **beginning** date of each plan year;
- Within 30 days after the **termination** of the prescription drug plan; and
- Within 30 days after any **change** in the creditable coverage status of the prescription drug plan.

For example, an employer with a **calendar year plan** (January 1 – December 31, 2025) must complete this reporting **no later than March 1, 2025.**

If there was a change in the creditable coverage status of a prescription drug plan offered by the employer (e.g., from creditable to non-creditable, or vice versa), notice should be provided to CMS within 30 days of the change. For example, if a change occurred in connection with the January 1, 2025 plan year, CMS should be notified by January 31, 2025.

Employer Action

- For **calendar year 2025 plans**, timely complete reporting with CMS. For **non-calendar year plans**, timely complete reporting with CMS following the start of your 2025 plan year.
- You will need to have the following information ready to include when you complete the CMS online reporting:
  - The creditable (or non-creditable) status of prescription drug coverage provided by all plan options available to employees.
  - The date that the annual creditable (or non-creditable) coverage notice was furnished to Part D eligible individuals. You may have included this notice with open enrollment materials or sent it following the start of the plan year.
  - An estimate of the number of Medicare Part D eligible individuals covered under the plan. This does not have to be an exact number.

Additional resources for completing the form are available at:

www.cms.gov/Medicare/Prescription-Drug-Coverage/CreditableCoverage/CCDisclosure.html

Disclosure to CMS Form User Guide with screenshots: www.cms.gov/medicare/prescription-drug-coverage/creditablecoverage/downloads/ccuserguide.pdf

State Health Coverage Reporting Requirements for Calendar Year 2024

Issued date: 01/23/25

Five states (California, Massachusetts, New Jersey, Rhode Island, and Vermont) and the District of Columbia already have individual health insurance mandates with their own requirements for:

- Furnishing information regarding health insurance coverage to residents of the state, and
- Filing that information with certain state agencies.

The Paperwork Burden Reduction Act permits the employer (or carrier) to furnish the federal forms 1095-C (or 1095-B) only upon request when:

- Timely, clear and accessible notice is provided to any individual who would otherwise receive a Form 1095-C (or 1095-B) that they can request a copy of the applicable Form; and
- Upon request, the applicable Form is furnished by the later of January 31 or 30 days after the date of such request.

As described below, satisfying the federal requirements may not satisfy the applicable state obligations. It is important to ensure both federal and state requirements (as applicable) are met. As of the date of this article's publication, the applicable states and District of Columbia have not adopted the federal relief. Absent similar relief at the state level, employers (and carriers) should prepare to furnish Forms 1095-C (or 1095-B) to covered residents as they have in prior years (e.g., by mail).

The following chart summarizes important deadlines related to 2024 state individual mandate reporting.

State	Deadline to Furnish Statements to Employee Residents	Deadline to File Statements with State Agency
California	January 31, 2025. However, no penalty is imposed for failing to furnish by this deadline.	March 31, 2025. No penalties will be assessed if filed by May 31, 2025.
District of Columbia	March 3, 2025	April 30, 2025 (30 days after federal deadline)
Massachusetts	January 31, 2025	January 31, 2025

New Jersey	March 3, 2025	March 31, 2025
Rhode Island	March 3, 2025	March 31, 2025
Vermont	N/A	N/A

It should be noted that the state reporting deadlines are subject to change if the states update their reporting information. This information is current as of the date of publication.

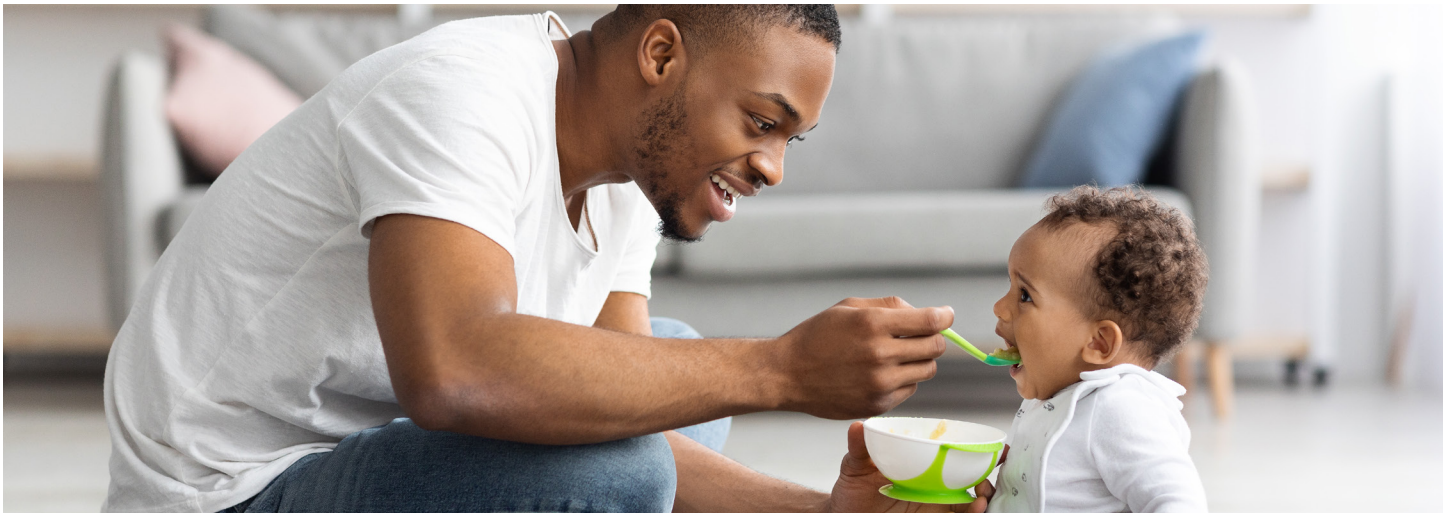
Important issues to consider regarding furnishing and filing state-level health coverage information are as follows:

- **State residents.** Employers with employees and other covered individuals residing in states with health coverage mandates should ensure the state-level health insurance distribution and state-level filing requirements are satisfied. Penalties may arise for late or incorrect filings with the state.
- **Forms.**
  - California, the District of Columbia, New Jersey, and Rhode Island use the federal Forms 1094/1095 (B, C) for the state's individual mandate reporting requirements.
  - Massachusetts requires MA Form 1099-HC to be furnished to Massachusetts residents and filed with the state by January 31. In addition, Massachusetts requires employers with at least 6 employees residing in Massachusetts to file the Health Insurance Responsibility Disclosure ("HIRD") form.
- **Employers with fully insured plans.**
  - Carriers issuing policies in California, Massachusetts, New Jersey, and Rhode Island are generally obligated to issue health coverage statements to plan members residing in the respective state and to file the required health coverage information to that state agency.
  - The District of Columbia requires employers that sponsor a fully insured group health plan with at least 50 full-time employees, including at least one employee who is a resident of the District, to file information returns with the Office of Tax and Revenue ("OTR").
  - It should be noted that a carrier may not automatically furnish a member statement and file with a state agency for plan members residing outside of the policy issue/situs state.
- **Employers with fully insured plans issued out-of-state.** Employers should confirm that the carrier will adhere to the required state distribution and filing obligations for plan members that reside in a state with individual mandate reporting obligations.
- **Employers with self-funded plans.** Employers should confirm with their third-party administrator ("TPA") or ACA form preparation vendor that the required state distribution and filing obligations for plan members that reside in a state with an individual mandate will be satisfied and whether any additional fees will be assessed.

For employers with fully insured plans that are written outside of a state with an individual mandate or a self-funded health plan, if the carrier or TPA will not furnish or file the forms with state residents or the applicable state agency, the employer may be required furnish and/or file. This may require involvement with your payroll provider or other ACA reporting vendor to coordinate.

Employer Action

Employers with employees and/or plan members residing in a state (and/or the District of Columbia) with individual mandate reporting requirements should confirm state reporting requirements with their carrier, TPA or ACA vendor to ensure federal as well as state-level reporting obligations will be met.



Maine Issues Final Paid Family and Medical Leave Regulations

Issued date: 01/29/25

The Maine Department of Labor ("Department") has released final regulations for the Maine Paid Family and Medical Leave ("PFML") program.

Background

On June 11, 2023, Maine Governor Janet Mills signed into law the state's budget bill which established a PFML program. Several rounds of proposed rule making followed. The program provides 12 weeks of wage replacement benefits for employees taking family or medical leave. Contribution withholdings under the state program became effective for all employers on **January 1, 2025**, and claims processing begins **May 1, 2026**. Employers can opt out of the state program and offer a private plan, beginning **April 1, 2025**, if certain conditions are met.

Employer Coverage

All private and public employers who employ one or more employees in Maine are required to provide PFML. The program does not apply to employees of the federal government. Self-employed individuals and tribal governments can opt-in to the program.

Eligibility to Receive Benefits

To receive PFML benefits, a covered individual must work for an employer subject to PFML and:

- Have earned wages paid in the state at least 6 times the State Average Weekly Wage during the first 4 of the last 5 completed calendar quarters immediately preceding the first day of an individual's benefit year.
- Be employed when timely submitting an application for benefits;
- Have not been declared ineligible due to fraud; and

- Satisfy one of the qualifying reasons to take PFML:
    - to bond with the covered individual's child during the first 12 months after the child's birth or the first 12 months after the placement of the child for adoption or foster care with the covered individual;
    - to care for a family member with a serious health condition;
    - to attend to a qualifying exigency (same as per federal FMLA);
    - to care for a family member of the covered individual who is a covered service member;
    - to take safe leave; or
    - any other reason allowed under the state's existing unpaid family leave laws.

Additional provisions regarding eligibility to take leave include:

- The combined medical and family leave may not exceed the 12-week maximum of family and medical leave within a benefit year.
- The 12 weeks of aggregate PFML will be reduced by amounts taken under FMLA or state FMLA in the 12-month period preceding the start of leave, unless the leaves are taken concurrently.

Wage Definition

Wages paid in the state include all forms of compensation for personal services, such as regular salary, tips, commissions, bonuses, and severance pay. It does not cover payments made to independent contractors. For payroll and premium purposes, wages are calculated similarly to how Maine Unemployment wages are determined but applied to a larger base of employees that are not traditionally subject to the Maine Unemployment contributions tax. Wages exclude amounts above the annual base limit set by the U.S. Social Security Administration.

Amount of Benefit

The weekly benefit paid to employees and self-employed individuals on family or medical leave is calculated based on a tiered wage system. The calculation is as follows:

- 90% of Average Weekly Wage up to 50% of the State Average Weekly Wage (Tier 1) plus 66% of Average Weekly Wage in excess of 50% of the State Average Weekly Wage (Tier 2).
- The weekly benefit cannot exceed the State Maximum Weekly Benefit.

Use and Types of Leave

Covered individuals may take up to 12 weeks of approved leave in a variety of ways:

- **Continuous leave** occurs in blocks of consecutive days or weeks.
- **Intermittent leave** provides for varying periods of leave and returning to work throughout a period of approved covered leave time.

- **Reduced schedule leave** reduces an employee's typical number of days per workweek, or hours per workday, on a planned and consistent basis.

Partial weeks or partial days of leave will be prorated against the employee's scheduled workweek.

Premiums

The employer's premium amount and contribution report must be remitted quarterly on or before the last day of the month following the close of the quarter for which premiums have accrued. Beginning **January 1, 2025**, the premium is set at no more than 1% of wages.

- An employer with 15 or more employees may only deduct up to 50% of the required premium from an employee's wages and must remit 100% of the combined premium contribution to the Paid Family and Medical Leave Insurance Fund ("Fund") (i.e., the required premium may be equally shared between the employee and employer).

- An employer with fewer than 15 employees may only deduct up to 50% of the required premium from an employee's wages and must remit 50% of the premium to the Fund as businesses with fewer than 15 employees are exempt from paying into the state plan.

- The PFML program caps the amount of an employee's earnings subject to contributions at the same amount of earnings subject to Social Security taxes.

Employers must determine the number of covered employees for each federal employer identification number ("FEIN") separately. An employer that employs 15 or more covered employees on their payroll in 20 or more calendar workweeks during the 12-month period preceding September 30 of each year will be an employer of 15 or more employees for the following calendar year. This count includes the total number of employees on establishment payrolls employed full or part-time who receive pay for any part of the pay period. Employers will determine their size for each upcoming calendar year as of October 1, 2024 (i.e., effective January 1, 2025) and October 1 of each year thereafter.

The penalty for an employer failing to pay contributions and/or submit wage reports is 1 percent of the employer's total quarterly payroll. Employers will receive a notification if they have failed to pay contributions or submit a wage report and will have time to correct the issue before the penalty is assessed.

Approved Private Plans

Employers may apply for a private plan exemption after **April 1, 2025**. Applications for substantially equivalent private plans (fully insured or self-funded with a surety bond paid to the state) must be submitted online on a form provided by the Department along with an application fee set initially at $250 for review of the application, and an additional $250 administrative reimbursement fee if the application is approved for the substitution. The application fees may be increased by the Department on **January 1, 2026**, or thereafter. An approved private plan is valid for three years.

Employers will generally owe premiums to the state plan until their exemptions are approved. All employers must pay premiums to the state for the first quarter of 2025. The employer is responsible for PFML premiums until the effective date of exemption and premiums owed prior to the effective date of exemption must be remitted to the state and are non-refundable.

Unionized Workforces

Public employers and employees that are subject to a collective bargaining agreement that was in effect on October 25, 2023, are not required to participate in the PFML program until the collective bargaining agreement expires.

Job Protection

Any employee that has been employed with their employer for at least 120 consecutive calendar days is entitled, upon return from leave, to be restored by the employer to the position held by the employee when the leave commenced, or to be restored to an equivalent position with equivalent employment benefits, pay and other terms and conditions of employment.

Tax Issues

The Department has provided the following tax advice in the PFML FAQs on the Department's PFML website. Premiums are calculated on total subject wages, before federal income tax, state income tax, and Social Security and Medicare taxes are deducted. Whether PFML premiums are taxable is reliant on the guidance and processes of the federal Internal Revenue Service. Employers should work closely with their tax professionals on this question. Employee premium contributions should be listed under Box 14 of the W-2 form with the label "MEPFML."

Employer Notifications to Employees

Maine Law requires the Department to issue the workplace notice in English, Spanish, French, Somali and Portuguese and any other language that is the primary language of at least 2,000 residents of the state. Employers must post the workplace notice in English and each language other than English that is the primary language of 3 or more employees of that workplace.

Employers must also provide a written notice to new employees within 30 days of hire that contains the employee's contribution amount and the employees' rights and obligations under the law.

An employer that fails to comply with the poster and employee notice requirements will be liable for a civil penalty of $50 per employee for the first offense and $150 per employee for each subsequent violation.

Employer Action

Employers should review all the available information from the Department, including the final regulations, and continue to work with employment counsel, leave vendors, payroll processors and any other related business advisors to ensure compliance with the PFML program by the requisite dates.

- All employers must be prepared to **withhold** contributions beginning **January 1, 2025**.
- The new Maine PFML Portal ("portal") will be **launching January 6, 2025**.
- All employers will be required to **register** with the Department via the portal to determine their liability for PFML contributions and to designate a third-party payroll or employee leasing company if they wish.
- Employers must **submit premiums and wage reports** quarterly through the portal. The first submission starts **April 1, 2025**, due by **April 30, 2025**.

Fixed Indemnity Notice Invalidated by District Court

Issued date: 01/30/25

On December 4, 2024, the United States District Court for the Eastern District of Texas (the "District Court") vacated the new notice requirement for fixed indemnity insurance coverage issued as a final rule by the Departments of Labor, the Treasury, and Health and Human Services (collectively, "the Departments") on April 3, 2024. The notice requirements were set to take effect for plan years beginning on or after January 1, 2025; however, the District Court held that the Departments exceeded their rulemaking authority with the final rule. Accordingly, employers are not required to include the notice with open enrollment materials as previously required by the final rule.

Background

Under the final rule, for group fixed indemnity coverage to qualify as an excepted benefit, the plan or carrier must prominently display a notice, in at least 14-point font, on the first page of any marketing, application, and enrollment materials provided to participants at or before enrollment and reenrollment. The notice explains that the fixed indemnity policy is not health insurance and outlines the limitations of fixed indemnity insurance in addition to providing resources for more information about how to obtain comprehensive health insurance.

Model notices were provided by the Departments and many plan sponsors had already complied with the rule by including the notice with open enrollment materials for their plan years beginning on or after January 1, 2025.

Lawsuit Challenging Notice Requirement

An insurance company brought a lawsuit in the Eastern District of Texas, Manhattan Life Insurance and Annuity Co, et al v. U.S. Department of Health and Human Services et al., challenging the final rule, specifically asking the court to block the notice requirement as it exceeded the Department's statutory authority.

In a very short decision, the District Court held in favor of the plaintiffs and ruled that the Departments could not enforce the notice requirement, finding that the compelled notice requirement exceeded the statutory authority of the Departments and "was not a logical outgrowth" from the proposed regulations.

Employer Action

The fixed indemnity notice for group coverage no longer applies. Employers and carriers are not required to furnish this notice with enrollment materials for fixed indemnity insurance policies.

DOL Penalties Increase for 2025

Issued date: 02/04/25

The Department of Labor ("DOL") has published the annual adjustments for 2025 that increase certain penalties applicable to employee benefit plans.

Annual Penalty Adjustments for 2025

The following updated penalties are applicable to health and welfare plans subject to ERISA.

Description	2024 Penalty (OLD)	2025 Penalty (NEW)
Failure to file Form 5500	Up to $2,670 per day	Up to $2,739 per day
Failure of a MEWA to file reports (i.e., M-1)	Up to $1,942 per day	Up to $1,992 per day
Failure to provide CHIP Notice	Up to $141 per day per employee	Up to $145 per day per employee
Failure to disclose CHIP/Medicaid coordination to the State	$141 per day per violation (per participant/beneficiary)	$145 per day per violation (per participant/beneficiary)
Failure to provide SBCs	Up to $1,406 per failure	Up to $1,443 per failure
Failure to furnish plan documents (including SPDs/SMMs) to DOL won request	$190 per day $1,906 cap per request	$195 per day $1,956 cap per request
Genetic information failures	$141 per day (per participant/beneficiary)	$145 per day (per participant/beneficiary)
De minimis failures to meet genetic information requirements	$3,550 minimum	$3,642 minimum
Failure to meet genetic information requirements – not *de minimis* failures	$21,310 minimum	$21,864 minimum
Cap on unintentional failures to meet genetic information requirements	$710,310 maximum	$728,764 maximum

Employer Action

Private employers, including non-profits, should ensure employees receive required notices timely (SBC, CHIP, SPD, etc.) to prevent civil penalty assessments. In addition, employers should ensure Form 5500s are properly and timely filed, if applicable. Finally, employers facing document requests from EBSA should ensure documents are provided timely, as requested.

IRS Issues Guidance on State Paid Family and Medical Leave Tax Treatment

Issued date: 02/04/25

The IRS recently issued Revenue Ruling 2025-04 (the "Revenue Ruling") explaining the tax treatment of contributions and benefits related to state paid family and medical leave laws ("PFML"). The welcomed guidance provides clarity related to the federal income tax treatment of contributions, including employee deductions, and benefits for state sponsored PFML plans, as well as providing transitional relief for reporting obligations. Tax treatment for state income tax purposes is not within the scope of this guidance.

Background

In recent years, many states have enacted and continue to enact paid family and/or medical leave laws that require employees to contribute to state funds to be eligible for partial wage replacement benefits in the event of leave for certain family or medical reasons. This includes California, Colorado, Connecticut, Delaware (2025), Washington D.C., Illinois, Maine (2025), Maryland (2025), Massachusetts, Minnesota (2026), Nevada, New Hampshire (voluntary), New Jersey, New York, Oregon, Rhode Island, Vermont (voluntary), and Washington.

Some states allow employers to sponsor private benefit programs to provide the benefits required by these laws. As state PFML laws have been enacted, there have been questions about the federal income tax treatment of the contributions and benefits. The IRS has not been clear as to whether employers were required to treat the employee contributions that were deducted as pre-tax or post-tax deductions on employee pay statements and W-2s.

Revenue Ruling

The guidance details the tax treatment and reporting requirements for:

- Employee contributions;
- Employer contributions;

- Medical leave benefits; and
- Family leave benefits.

The following guidance applies to contributions paid to state PFML programs and benefits paid from state PFML programs only.

Employers will need to consult with service providers, counsel, or tax professionals to determine how this guidance informs their treatment of contributions and benefits related to employer sponsored PFML programs (sometimes called "voluntary plans").

Employee Contributions

According to the guidance, similar to mandatory state disability benefit program contributions that are considered income taxes, employee deductions for contributions for state PFML programs are tax deductible for federal income tax purposes. Accordingly, the PFML contribution paid by an employee via payroll deduction is deductible by the employee on their individual income tax return subject to the rules in the Code. However, amounts withheld from an employee's paycheck to pay a state income tax are includible in the employee's federal gross income. Therefore, the employee's PFML contribution is included in the gross wages of the employee as reported on Form W-2. Employers will need to ensure that employee contributions for the state program are properly detailed on wage statements and included in gross wages.

Any amount of required PFML contribution paid on an employee's behalf by the employer should be imputed as income to the employee.

Employer Contributions

Required employer contributions to state PFML programs for the employer's share of PFML premiums are considered excise taxes paid or accrued in carrying on its trade or business that are deductible at the federal level and no part of the required employer contribution is reported as income for the employee.

However, any payments of employee contributions paid by an employer for an employee's required contribution to a state PFML program would be considered income to the employee and should be imputed as income to the employee and reported as such. The employee may be able to deduct this amount as a state income tax on their federal individual income tax return subject to the SALT (state and local tax) limitation. Also, any amount of PFML contribution paid by the employer on behalf of the employee is deductible as an ordinary and necessary business expense by the employer for employee compensation. Employers will need to ensure that employer contributions paid on behalf of employees for an employee's required contribution to the program are properly imputed as income and reported on Form W-2.

Medical Leave Benefits

Benefits payable to an employee under a state PFML program for reasons of medical leave for the employee's own serious health condition are treated as if received from accident or health insurance and are not reported as income to the employee. However, the amount of medical leave benefits attributable to an employer's contribution for medical leave would be considered income to the employee. Therefore, the amount of medical leave benefits attributable to the employer's contribution would be reported as income to the employee on Form W-2. For example, if an employer pays 40% of the required contribution to the program, then 40% of the medical leave benefits received by an employee would be reportable as income to the employee.

Medical leave benefits attributable to amounts paid on behalf of an employee by the employer for the employee's required contribution to the program would not be included in the medical leave benefits reported as income to the employee as the contribution amounts should already be included in the reported income to the employee. In other words, medical leave benefits attributable to employer pick-up payments for an employee's required contribution to the program are not included in the amount of medical leave benefits reported as income to the employee since the contributions have already been imputed as income to the employee when they were contributed.

Amounts received by employees for medical leave benefits that are reportable as income are subject to all required employment taxes and reporting.

Family Leave Benefits

Benefits payable to an employee under a state PFML program for reasons of family leave are considered income to the employee because they are unrelated to the employee's own health condition and cannot be treated as being received through accident or health insurance. However, family leave benefits are not taxed as wages and should be reported to the IRS and the employee using Form 1099.

Transition Relief

Calendar Year 2025 will be a transition period for enforcement of the requirements in the Revenue Ruling.
For Medical Leave benefits paid to an individual in 2025 attributable to employer contributions:

- neither a state nor an employer is required to follow the income tax withholding and reporting requirements applicable to third-party sick pay;
- neither a state nor an employer will be liable for penalties for failure to file or furnish a correct payee statement;
- neither a state nor an employer is required to withhold and pay associated taxes and will not be liable for any associated penalties.

For employee pick-up payments paid on behalf of an employee in 2025 for the employee's required contribution to a state program:

- employers are not required to treat any pick-up payments as wages for federal income tax purposes.

Employer Action

Employers will want to ensure that their payroll systems correctly identify taxable income for employees related to employer and employee required contributions to state PFML programs. Additionally, employers may want to discuss the deductibility of employer contributions as a business expense or excise tax with their own accounting or tax professional.

Employers that sponsor their own PFML plans (e.g., a voluntary plan) will need to discuss this guidance with any service providers or carriers and likely their own counsel to determine how to treat and report employee and employer contributions and benefits paid under their employer sponsored plans.

Lastly, nothing in the guidance explains how a state program will provide information to employers regarding the amount of benefits paid to an employee that may be subject to payroll taxes. Employers will need to look to state programs for this information. While the guidance does provide limited transitional relief related to certain medical leave benefits and employer pick-up payments, employers will still need to determine how their state programs will address the guidance prior to 2026.

Update on the Johnson & Johnson ERISA Fiduciary Lawsuit

Issued date: 02/10/25

On January 24, 2025, the U.S. District Court of New Jersey dismissed claims made in a class action lawsuit against Johnson & Johnson ("J&J") regarding management of their prescription drug benefits.

In *Lewandowski v. Johnson & Johnson*, the plaintiffs alleged that J&J breached its fiduciary responsibilities under ERISA by mismanaging the prescription drug benefit program, costing employees millions of dollars in the form of higher payments for prescription drugs, higher premiums, deductibles, coinsurance and copays and lower wages and limited wage growth. In addition, the plaintiffs alleged J&J failed to furnish requested plan documents as required by ERISA.

In response, J&J filed a motion to dismiss the lawsuit. The court ruled in J&J's favor regarding the plaintiff's two fiduciary breach claims, finding the plaintiff lacked Article III standing to bring the lawsuit. To establish standing under Article III, the plaintiff must generally show that they have sustained a concrete injury, the injury was caused by the defendant, and the injury could be fixed by the court.

- **Higher health insurance premiums.** The plaintiff claimed that J&J's breach of fiduciary duty by mismanaging the prescription drug plan caused the plaintiff to pay higher premiums for the group health plan coverage. The court held that the plaintiff's alleged injury, paying more in premiums, was not sufficient to establish standing because the allegation about higher premiums is speculative and "stands on nothing more than supposition."
- **Increased out-of-pocket costs.** The plaintiff also alleged that she paid higher out-of-pocket costs because of the higher prices for prescription drugs in the plan. While the court held that the Plaintiff's allegations that she suffered an injury are traceable to the employer's alleged fiduciary violation, the injury alone is not sufficient to establish standing. The plaintiff also needed to show that the injury would likely be redressed by judicial relief. This requires a "substantial likelihood" that the injury can be remedied by a court's decision. The court ruled that the injury was not redressable by court action. Specifically, it appears that plaintiff satisfied her out-of-pocket maximum so a court's decision in her favor would not reimburse her the costs for her prescription drug costs.
    - "In straightforward terms, a favorable decision would not be able to compensate Plaintiff for the money she already paid. Even if Defendants were to reimburse Plaintiff for her out-of-pocket costs on a given drug—that is, the higher

> amount of money she spent as a result of Defendants' breaches—that money would be owed to her insurance carrier to reimburse it for its expenditures on other drugs that same year. In short, there is nothing the Court can do to redress Plaintiff's alleged injury."

It is important to note that the court did not dismiss the Plaintiffs claim that requested plan documents were not timely furnished. This claim is allowed to proceed under the court's decision.

With respect to the above claims, the court is providing the plaintiff with leave to amend the complaint to cure the failures identified by the court as to the issue of standing (they have 30 days to do so). In addition, the plaintiff may seek to file an appeal.

Employer Action

While this decision is a victory for J&J and plan sponsors, the story is not over. Though the court's opinion highlights the challenges for plaintiffs to establish standing to bring these lawsuits against plan sponsors, it does not close the door to other lawsuits alleging fiduciary breach as it comes to plan costs and management of benefits.

Employers should continue to monitor developments in the health and welfare litigation space and continue to review and understand the fiduciary responsibilities with respect to their health and welfare plans, particularly as it comes to monitoring and selecting service providers.

In addition, the decision serves as a reminder for employers to timely respond to requests for ERISA plan documents. Under ERISA, fiduciaries must furnish plan documents within 30 days of a written request of a participant or beneficiary. Penalties of up to $110/day may apply to these failures.

New No Surprises Act and Gag Clause Guidance Issued

Issued date: 02/10/25

On January 14, 2025, the Departments of Labor, Health and Human Services, and the Treasury ("the Departments") issued FAQ Part 69 to clarify:

- Open negotiation and notice and disclosure requirements for plans or issuers, and providers related to the Independent Dispute Resolution ("IDR") process,
- The coordination of the surprise billing rules between plans or issuers, providers, and facilities about the out-of-pocket rate for items or services subject to the No Surprises Act ("NSA") in cases where state law does not provide a method for determining the out-of-pocket rate,
- Plan sponsor responsibilities related to gag clauses included in subordinate agreements, and
- The Gag Clause Prohibition compliance attestation ("GCPCA") requirements when gag clauses remain in provider agreements.

NSA Background

Since its initial passage under the Consolidated Appropriations Act, 2021 (the "CAA"), the NSA provides protections against surprise medical bills for participants, beneficiaries, and enrollees of a group health plan offered by a health insurance issuer with respect to certain out-of-network costs. This is primarily achieved by limiting individual cost-sharing for NSA covered claims to an amount based on the qualified payment amount ("QPA"). However, the method for calculating the QPA has been the subject of litigation. As a result, plans and issuers face significant challenges in calculating QPAs that comply with the NSA.

NSA IDR Process

As part of the NSA, the Departments established a federal Independent Dispute Resolution ("IDR") process for resolving disputes between plans or issuers and providers, facilities, or providers of air ambulance services related to

reimbursement amounts subject to the NSA. The payment determination that results from the IDR process relies heavily on the QPA.

Notably, FAQ 69 addresses the impact of recent litigation on the final rules, including a United States Court of Appeals for the Fifth Circuit opinion, which partially reversed an opinion of the lower district court regarding provisions related to the methodology for calculating QPAs, and affirmed the district court's decision to vacate certain deadline provisions.

Additionally, FAQ 69 addresses several other implementation questions under the NSA including:

- QPA payment calculation for purposes of determining patient cost-sharing,
- Requirements for initial payments or notices of denial of payment and related disclosures when the disclosures are not provided at the same time or in the same format,
- Requirements for the initiation of open negotiation periods and the federal IDR process,
- Requirements for patient cost sharing for OON emergency services and applicable non-emergency items and services,
- Clarification that cost sharing for individuals may not be increased after the IDR process results in a payment determination, and
- Extending enforcement discretion related to QPA calculation for claims before August 1, 2025.

Gag Clause Prohibition Attestation Compliance

As previously reported, group health plans and health insurance issuers ("carriers") are prohibited from entering into an agreement with a health care provider, network or association of networks, third-party administrator ("TPA"), or other service provider offering access to a network that would directly or indirectly restrict the plan or issuer from:

1. Making provider specific cost or quality of care information available to eligible participants, beneficiaries, and enrollees of the plan,
2. Electronically accessing de-identified claims and encounter information upon request, and
3. Sharing such information as described above with a business associate.

These prohibitions are collectively referred to as the "Gag Clause Prohibition," which went into effect on December 27, 2020. Along with this prohibition, plans and issuers must annually submit an attestation of compliance, the GCPCA, with these requirements to the Departments.

The Departments have previously issued guidance on these requirements, including clarification on the meaning of "gag clause" and the attestation process. FAQ 69 continues the trend of answering questions about the prohibition and requirements. This latest FAQ provides the following clarifications:

- Downstream agreements that contain gag clauses violate the Gag Clause Prohibition.
    - For this purpose, a downstream agreement is where the TPA or other service provider that offers access to a network of providers may have separate agreements with entities other than the plan (or carrier) to provide or

administer the plan's (or carrier's) network. Restrictions in those downstream agreements will also constitute a prohibited gag clause if the plan (or carrier) is restricted from providing, electronically accessing or sharing information described in (1).

- Agreements between healthcare providers, networks, TPAs, or other service providers and plans may not restrict de-identified claims data from being shared between the plan and a business associate,

- A limitation on the scope, scale, or frequency of electronic access to de-identified claims and encounter information is a restriction on de-identified claims and encounter information or data that is prohibited by the Gag Clause Prohibition, to the extent the provision places unreasonable limits on the ability of plans and issuers to access such information upon request. The FAQ includes the following examples of some restrictions on an audit or claims review that would be considered an impermissible gag clause:

    - Limiting access to a statistically significant or the "minimum necessary" number of de-identified claims;

    - Limiting the scope of access to the data to specific, narrow purposes (such as limiting access to the context of an audit);

    - Unreasonably limiting the frequency of claims reviews (e.g., no more than once per year);

    - Limiting the number and types of de-identified claims that a plan or issuer may access;

    - Restricting the data elements of a de-identified claim that a plan or issuer may access; and

    - Providing access to de-identified claims data only on the TPA's or service provider's physical premises.

- Plans and issuers that are aware of the presence of a gag clause in their agreements must still submit the annual GCPCA. They may use the GCPCA webform system in the text box labelled "Additional Information" on Step 3 for this purpose. Such additional information includes (but is not limited to):

    - any prohibited gag clauses that a service provider has refused to remove;

    - the name of the TPA or service provider with which the plan or issuer has the agreement containing the prohibited gag clause;

    - conduct by the service provider that shows the service provider interprets the agreement to contain a prohibited gag clause;

    - information on the plan's or issuer's requests that the prohibited gag clause be removed from such agreement; and

    - any other steps the plan or issuer has taken to come into compliance with the provision.

It is important to note that The Departments have indicated that a plan or issuer that submits an attestation of compliance that includes such additional information will be considered to satisfy the requirement to submit a GCPCA, and the Departments will consider good-faith efforts to self-report a prohibited gag clause in any enforcement action.

Employer Action

The requirements of the NSA are handled by carriers and TPAs but typically at an additional cost per claim subject to NSA requirements. Employers sponsoring group health plans may receive communications from carriers or TPAs related to this guidance. Plan sponsors may also want to confirm that their carriers or TPAs are complying with all NSA requirements related to calculation and disclosure of QPAs as it relates to the QPA calculation method.

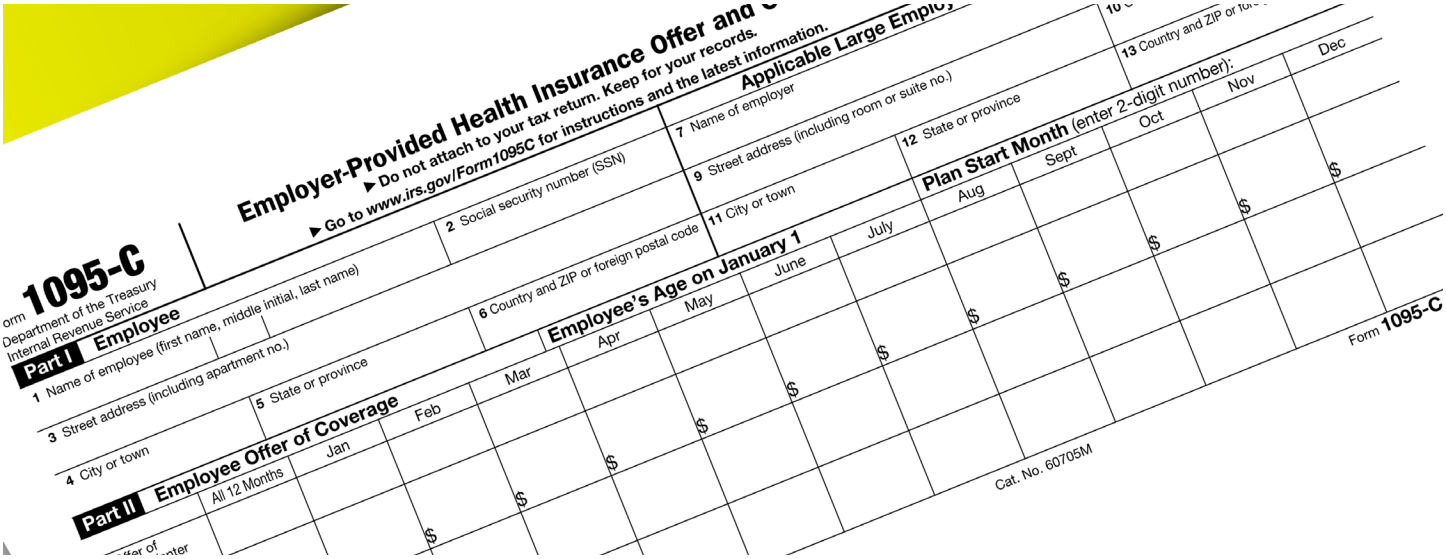
Plan sponsors should also expect to comply with the GCPCA requirements.

- For fully insured plans, most carriers are subject to the gag clause prohibition and will submit the attestation on behalf of the carrier's own responsibility and that of the plan. Employers sponsoring fully insured plans should confirm the carrier will submit the GCPCA and that their contracts are free from prohibited gag clauses.

- For self-funded plans (including level funded), most TPAs and other vendors will not submit the GCPCA on behalf of the plan. This is an employer's responsibility. It will be important to confirm with vendors that there are no gag clauses (including in downstream agreements). As noted in the FAQ, even if there are gag clauses in the agreements, plans must still submit the attestation.

- A limitation on the scope, scale or frequency of electronic access on de-identified claims is a prohibited gag clause as is restricting plans from accessing de-identified claims data. Carriers or TPAs that impose limits or restrictions on accessing de-identified claims data or sharing such data with business associates of the plan have impermissible gag clauses.

We will continue to monitor developments in this area.



New Guidance Provides Additional Details on Form 1095-C Reporting Relief

Issued date: 02/28/25

On February 21, 2025, the Internal Revenue Service ("IRS") released Notice 2025-15 (the "Guidance") providing guidance on an alternative method for furnishing Form 1095-C (and Form 1095-B) to individuals under the Affordable Care Act ("ACA"). The Guidance includes information on how to provide notice that the employer will use this new method for furnishing the applicable form to employees and covered individuals.

Background

Prior to the Paperwork Burden Reduction Act (the "Act"), large employers were required to provide all full-time employees with a Form 1095-C and most employers with a self-funded (or level-funded) plan were required to provide a Form 1095-C or Form 1095-B (the "Forms") to any primary insured. These Forms could be provided to individuals via mail or electronically with appropriate notice and consent.

In December of 2024, the Act was signed into law; it permits employers to provide these Forms only upon request if certain requirements are met, including providing advanced notice to covered individuals.

It is important to note that that the Act **does not** alter an employer's obligation to provide reporting to the IRS. All 2024 Forms must be timely furnished to the IRS by March 31, 2025.

Notice 2025-15

The Guidance describes how an employer may notify full-time employees (and other covered individuals) that it will take advantage of the relief and only furnish the Forms upon request.

- **Content.** The notice to full-time employees and covered individuals should:
  - be written in clear language with font size large enough (or provide other visual cues) to call to the reader's attention that the notice contains important tax information; and
  - contain a statement that individuals have a right to receive a copy of the Forms upon request as well as contact information (e-mail, mailing address, and phone number) and instructions on how to request a copy of the Forms.

- **Timing.** Per the Guidance, notice must be posted by the due date for providing the Forms, including the automatic 30-day extension. This means, for 2024 statements, this notice must be posted by **March 3, 2025**. The notice must also be accessible through October 15 of the following year. In addition, if a Form is requested by a participant, it must be provided by the later of 30 days following the request or January 31 of the following year.
- **Posting the Notice.** The notice may be posted in a location on the employer's website that is reasonably accessible to all individuals. For example, a reporting entity's website provides a clear and conspicuous notice if it includes a statement on the main page – or a link on the main page, reading "Tax Information," to a secondary page that includes a statement in capital letters "IMPORTANT HEALTH COVERAGE TAX DOCUMENTS."

Unfortunately, the Guidance did not include a sample notice. Rather it referred to a notice description found in previously issued regulations.

Employer Action

Employers subject to reporting obligations under the ACA should review their current delivery policies and procedures to determine whether to take advantage of the relief provided by the Act and detailed in the Guidance. Since the IRS had not issued a sample notice, cautious employers may want to furnish the Forms 1095-C (or 1095-B) as they have in past years until the IRS issues further guidance.

Employers who wish to take advantage of this relief should work with any reporting vendors they use for reporting in order to comply with any pre-existing contractual arrangements.

Employers that utilize this new furnishment method must post the notice by **March 3, 2025**.

Employers that are not taking advantage of this alternative method should prepare to furnish Forms 1095-C (or 1095-B) for calendar year 2024 by **March 3, 2025**.

It should be noted that employers that are required to furnish Forms 1095-C (or 1095-B) pursuant to a state individual coverage mandate may still need to furnish these Forms as they have in prior years to covered employees who reside in states with an individual mandate (e.g., California, Washington D.C., New Jersey, and Rhode Island).

Further all 2024 Forms 1095-C must be filed with the IRS electronically along with a Form 1094-C by **March 31, 2025**.

New Executive Order Addresses Price Transparency Rules

Issued date: 03/17/25

On February 25, 2025, President Trump signed an Executive Order (EO 14221), directing federal agencies to update the existing health care price transparency guidance and enforcement efforts.

Background

In 2019, Executive Order 13877 (EO 13877) directed the Departments of Labor, Health and Human Service and the Treasury (collectively, "the Departments") to create regulations for hospitals and health plans to establish price and quality transparency resources.

In response, the Departments issued final transparency rules requiring:

- a price comparison tool with price estimates of all common health care items and services; and
- machine-readable files ("MRF") posted (and timely updated) by hospitals and health plans detailing in-network and out-of-network pricing for medical services and prescription drugs.

It should be noted that for group health plans, the requirement to create and post the MRF for in-network rates and out-of-network allowed amounts went into effect for plan years beginning on and after January 1, 2022 (with enforcement deferred until July 1, 2022 pending guidance). In 2023, the Departments issued guidance announcing their intent to develop and issue technical requirements and an implementation timeline for the prescription drug MRF. To date, this guidance has not been released.

New Price Transparency and Enforcement Guidance

EO 14221 builds on the existing transparency rules and directs the Departments to issue guidance within 90 days (by May 26, 2025). The EO directs the Departments to:

- replace cost estimates with actual prices for health care services and items;

- standardize how hospitals and health plans report pricing data to members; and
- strengthen enforcement policies to ensure compliance with the price transparency requirements.

Employer Action

Currently, there are no immediate action items for employers.

As a reminder, with respect to the transparency requirements currently in effect:

Fully insured plans: Health insurance carriers remain responsible for compliance with transparency requirements. Employers should obtain written confirmation that the carrier posts this information on behalf of the plan.

Self-funded plans: Employers are responsible for ensuring compliance but may contract with third-party administrators (TPAs) and pharmacy benefit managers (PBMs) to fulfill these obligations.

Generally, an employer sponsoring a self-funded plan can satisfy the MRF disclosure requirements by entering into a written agreement under which a TPA posts the MRFs on its public website on behalf of the plan. However, if the TPA fails to do so, the plan is liable. Employers without such a written agreement should post a link to the TPA's MRFs.

When the Departments provide their guidance, employers should reach out to their carriers, TPAs, and PBMs to understand how they plan to comply with the new transparency requirements and whether updates to service agreements may be necessary.

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

Tobacco Surcharges Face Growing Scrutiny in Recent Lawsuits

Issued date: 03/19/25

There has been a recent uptick in class action litigation filed against large group health plan sponsors alleging that the additional insurance premiums levied against tobacco users ("tobacco surcharges") through their wellness programs violate HIPAA nondiscrimination rules.

The litigation reminds employers to carefully review their plan designs for compliance with these rules. Below you will find a summary of the arguments being put forth by the plaintiffs as well as some high-level considerations for employers when implementing tobacco related incentives.

Background

The HIPAA nondiscrimination rules prohibit group health plans from discriminating against plan participants on the basis of a health status-related factor, including tobacco use. There is an exception that allows for the use of incentives or surcharges ("rewards") through a wellness program.

A program that imposes premium surcharges on individuals who use tobacco is considered a health-contingent wellness program and must comply with the following five requirements:

1. There must be an opportunity to qualify for the incentive (or avoid the surcharge) at least once a year.
2. The amount of the reward cannot exceed 50% of the cost of the coverage under the plans.
3. The program must be designed to promote health and prevent disease.
4. The reward must be available to all similarly situated individuals and provide for a reasonable alternative.
5. Plan materials describing the wellness program must include a disclosure of the availability of a reasonable alternative.

The Litigations

While lawsuits challenging tobacco surcharges are not new, the number of suits being filed (and filed as potential class actions) is new. The lawsuits primarily target very large, self-insured health plans such as those sponsored by 7-Eleven; Walmart; XPO, Inc.; Target; Nike; Campbell Soup Company; and Tractor Supply Company. So far, no court has ruled on the merits and only one has been voluntarily dismissed—the plaintiff in Walmart filed a voluntary dismissal back on December 13, 2024. The Department of Labor has also focused on the surcharges, filing an action against Macy's in September 2024.

The plaintiffs allege that plan sponsors are violating their fiduciary duties and violating HIPAA because the wellness program at issue discriminates against them on the health status-related factor of tobacco use. Allegations common within each lawsuit include the plan sponsors' failure to:

- provide a reasonable alternative standard to being tobacco-free;
- disclose the reasonable alternative standard to the surcharge in plan materials discussing the wellness program; and/or
- provide the full reward once a reasonable alternative is satisfied.

While it is still early in the litigation process, it appears that most group health plans are fighting back in these cases. However, at least one plan offered by Bass Pro Groups LLC became the first to file a notice of class action settlement related to their tobacco surcharge lawsuit in the United States District Court for the Western District of Missouri.

It is still too soon to tell the expected outcome from the remaining lawsuits, as none of the other defendants have indicated an interest in settling to date.

Tobacco Surcharges

These lawsuits do not mean that all tobacco surcharges violate the HIPAA nondiscrimination rules. As described earlier, there are five requirements for health contingent plans that must be met.

As reflected in the allegations contained in the lawsuits, employers may not understand or implement the requirements correctly. The following summarizes some common issues employers fail to address in their tobacco-surcharge programs.

- *Reasonable Alternative.* Employers must offer a reasonable alternative to earn the reward without satisfying the health-related standard. In other words, for those who are not "tobacco free" there must be another way they can earn the reward (or avoid the surcharge). This may be through participation in a tobacco cessation program or through a program recommended by their doctor. Often, employers fail to offer another way to earn the reward (or avoid the surcharge).
- *Full reward must be available.* When an individual earns the reward by completing the reasonable alternative standard (e.g., attend a smoking cessation class) the full reward must be made available. The reward cannot be pro-rated for only those months after the individual met the standard. It also cannot be conditioned on the individual being a "non-smoker."
- *Disclosure.* Finally, it's important that plan materials describing the wellness program include language that notifies individuals of the availability of a reasonable alternative standard. Model language is provided by the Department of Labor:
    - Your health plan is committed to helping you achieve your best health. Rewards for participating in a wellness program are available to all employees. If you think you might be unable to meet a standard for a reward under this wellness program, you might qualify for an opportunity to earn the same reward by different means. Contact us at [insert contact information] and we will work with you (and, if you wish, with your doctor) to find a wellness program with the same reward that is right for you in light of your health status.

Employer Action

Employers offering wellness programs with tobacco surcharges should monitor developments as these lawsuits progress. They should also review their program to ensure it meets the requirements under the HIPAA nondiscrimination rules.

Michigan Amends the Earned Sick Time Act and Minimum Wage

Issued date: 03/27/25

The Michigan Legislature recently passed amendments to the Earned Sick Time Act ("ESTA") and the Improved Workforce Opportunity Wage Act ("Wage Act") in response to the Michigan Supreme Court's decision in the *Mothering Justice v. Attorney General*. This means a higher minimum wage and increased sick leave for employees that became immediately effective on February 21, 2025.

Earned Sick Time Act

Michigan employers with at least 1 employee are now required to offer sick leave annually to employees. The only exception is the United States government. Who is considered an employee is broadly defined with only 4 enumerated exceptions. The four exceptions are: (1) an individual employed by the United States government; (2) an unpaid intern or trainee; (3) an individual employed in accordance with the youth employment standards act; and (4) an individual whose arrangement meets requirements enumerated in the act.

Employees accrue 1 hour of leave for every 30 hours worked. Regarding the number of hours of leave able to be accrued, there is a distinction between small employers with 10 or fewer employees and large employers with more than 10 employees. The total number of employees is based upon total employees on payroll and not limited to employees located in Michigan. However, only Michigan employees are entitled to sick leave.

Employer Requirements

Large employers must provide 72 hours of paid sick leave each calendar year. Small employers must offer 40 hours of paid sick leave and are exempt from complying with ESTA until October 1, 2025. Additionally, if a small business did not employ an employee on or before February 1, 2022, then the small employer does not have to begin to provide sick leave or otherwise comply with ESTA until 3 years after the date the first employee was hired.

Regardless of employer size, the employer does have the option of offering more leave. Employees must carry over all accrued but unused sick time; however, an employer is not required to allow the employee to use more than 72 hours (large employers) or 40 hours (small employers) each year. Employers do not have to pay out accrued and unused sick

time upon termination, resignation, retirement, or any other type of separation from employment. An employer can impose a waiting period of 120 days for any new employee hired on or after February 21, 2025, before they are eligible to use accrued time. Employers must maintain records that show the hours worked and sick time taken for each employee for a minimum of 3 years.

If an employer frontloads leave at the beginning of the year, the employer is exempt from: (1) allowing employees to carryover hours to the following year, (2) calculating and tracking an employee's accrual of sick leave, and (3) paying the employee the value of the employee's unused accrued paid earned sick time at the end of the year in which the earned sick time was accrued. Frontloading though does not absolve the employer of maintaining records for 3 years.

Employees are allowed to take sick leave in one-hour increments or "the smallest time increment that the employer uses to account for absences of use of other time."

Part-Time Employees

Regardless of employer size, employers have options regarding compliance for part-time employees. Employers can follow the standard accrual method or use an alternative method to provide the part-time employee at the beginning of the year with sick leave hours available for immediate use if:

- The employer provides this employee with written notice of how many hours the employee is expected to work over the next year when hired;
- The amount of the sick leave provided is, at a minimum, proportional to the earned time the employee would have earned if the employee worked all the hours expected that was detailed in the written notice; and
- If the employee works more hours than detailed in the written notice, the employer must provide the employee the additional sick leave in accordance with the accrual requirements.

Notice Obligations, Documentation & Miscellaneous

Notice obligations vary depending whether the use of sick leave is foreseeable or not. If the need for taking leave is foreseeable, then an employer can require advance notice not to exceed 7 days prior before the date of the leave. If the leave is not foreseeable, the employer can require notice:

- As soon as practicable; or
- In accordance with the employer's policy regarding use of sick time or leave if:
    - On the date of hire, effective date of ESTA or effective date of employer's policy (whichever is latest) the employer provides the employee with a written copy of its policy detailing the procedure for how the employee must provide notice; and
    - The employer's notice requirement allows the employee to provide notice after the employee is aware of the need for the sick time.

An employer may require documentation if sick leave is taken for more than 3 consecutive days, but if they do, the employer will be responsible for any out-of-pocket costs associated with obtaining the documentation. The employee must provide this documentation within 15 days of the employer's request and the employer then has the obligation to keep confidential health information and any information related to domestic violence and sexual assault.

The ESTA also includes anti-retaliation provisions when an employee uses sick leave. Failure to comply with ESTA could result in the Director of Licensing and Regulatory Affairs ("LARA"):

- Imposing civil remedies such as payment of earned sick time, back pay, damages incurred, and reinstatement in the case of job loss
- $1,000 administrative fine with the potential for an additional civil fine up to 8 times the employee's normal hourly wage
- A civil action filed on behalf of the employee

Minimum Wage Law

Beginning February 21, 2025, the legislation created a phased-in approach to minimum wage requirements and adjustments to the tip credit. The tip credit will not be phased out and will diminish by 2% annually until 2031 when the tipped worker's wage would equal 50% of the state's full minimum wage.

Date	Minimum Wage	Tip Credit Rate
February 21, 2025	$12.48	38% of minimum wage
January 1, 2026	$13.73	40% of minimum wage
January 1, 2027	$15.00 plus inflation adjustment	42% of minimum wage
January 1, 2028	Inflation adjusted	44% of minimum wage
January 1, 2029	Inflation adjusted	46% of minimum wage
January 1, 2030	Inflation adjusted	48% of minimum wage
January 1, 2031	Inflation adjusted	50% of minimum wage

Employer Action

Employers should:

- Review sick leave policies to ensure that accrual periods are calculated correctly.
- Ensure that sick leave policies allow employees a minimum of 40 hours (small employers) or 72 hours (large employers) of sick leave annually.
- Prepare written notice of the sick leave policy and distribute the notice in English and, Spanish (MI Licensing and Regulatory Affairs has sample notices posted on their website).
- Amend document retention policies to maintain sick leave records for at least 3 years
- Adjust hourly rates when the State's Treasurer releases the new minimum wage adjusted for inflation.
- Review affordability of plans as an increase in wages may permit an applicable large employer to increase employee contributions for health insurance and still comply with the affordability provisions of the Affordable Care Act.
- Consult with employment counsel if intending to rely upon any exceptions in the ESTA to ensure meeting definitions and other obligations.

Massachusetts Releases 2026 MCC Amounts

Issued date: 03/28/25

The Commonwealth Health Insurance Connector Authority ("Health Connector") recently published Administrative Bulletin 01-25 to provide annual guidance regarding certain provisions of the Minimum Creditable Coverage ("MCC") regulation. Specifically, this Bulletin describes the calculation of the deductible limits and out-of-pocket maximums for 2026 and provides those respective dollar amounts. All limits increased from 2025.

Background

On July 1, 2007, the Massachusetts Health Care Reform Act became effective. A component of this Act included an individual mandate, requiring Massachusetts residents 18 and older to have MCC or pay a penalty on their state income tax return. MCC requirements apply to individuals, not health insurance plans or employers. While employers are not required to provide health plans that meet MCC, their Massachusetts resident employees must enroll in MCC to avoid significant penalties.

Deductible Limits

The 2007 regulations mandated a $2,000/$4,000 deductible limit and a separate prescription deductible limit of up to $250/$500 for in-network covered services. Subsequent regulations required indexing the deductible limits to the annual out-of-pocket maximum ("OOPM") adjustment percentage under federal law, rounded down to the next $50.

Administrative Bulletin 01-25 sets the 2026 maximum MCC deductibles as $3,200/$6,400. If the plan has a separate prescription drug deductible, the amounts cannot exceed $400/$800 and the total maximum deductible applies.

OOPMs

In 2017, the Health Connector published Administrative Bulletin 02-17, tying the indexed OOPMs under MCC to the federally indexed OOPMs that apply to non-grandfathered plans.

For 2026, the OOPMs under MCC will be $10,150/20,300.

Effective Dates

Administrative Bulletin 01-25 takes effect immediately; the changes applicable to employer-sponsored plans will be incorporated with plan years beginning on or after January 1, 2026.

2025 Compliance Bulletins: Quarter Two

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 www.irs.gov/irb/2024-49_IRB#NOT-2024-83

For a copy of the regulations, visit: 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: www.irs.gov/forms-pubs/about-form-720.
- Patient-Centered Outcomes Research Trust Fund Fee, Questions and Answers: www.irs.gov/newsroom/patient-centered-outcomes-research-institute-fee
- PCOR Filing Due Dates and Applicable Rates Chart: 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.

2025 Compliance Bulletins: Quarter Three

July

August

September

Texas Potentially Eases Premium Liability

Issued date: 07/02/25

On May 21, 2025, Senate Bill 1332 ("SB 1332") went into effect. The new legislation gives insurers the discretion to waive premium liability in cases where the employer submits a late termination of eligibility notice, but only if no covered services were used after the employee's eligibility ended.

Background

Texas Senate Bill 51 ("SB 51"), which went into effect in 2006, requires plan sponsors to pay a participant's premiums through the end of the month in which the plan sponsor notifies the carrier that an individual is no longer eligible. However, if an individual ceases to be eligible during the last seven days of a month, the employer must notify the insurer no later than the third day of the following month (not including Saturdays, Sundays, and legal holidays).

This requirement applies to Texas residents covered under insured plans offering the following benefits:

- PPO and HMO medical;
- PPO vision (but not dental); and
- HMO vision and dental (single service).

It is not applicable to self-funded plans.

Missing the deadline results in the employer being charged a full additional month of premiums, even if the employee used no covered services and did not elect COBRA or Texas state continuation. This can be particularly problematic because many employers and insurance carriers now rely on Electronic Data Interchange ("EDI") feeds, which typically transmit weekly. Under SB 51, if a termination of benefits occurs during the last week of the month but the EDI feed does not transmit by the third day of the following month, the employer can be held financially responsible for an entire extra month of premium without recourse. And sometimes there are simply unforeseen administrative errors.

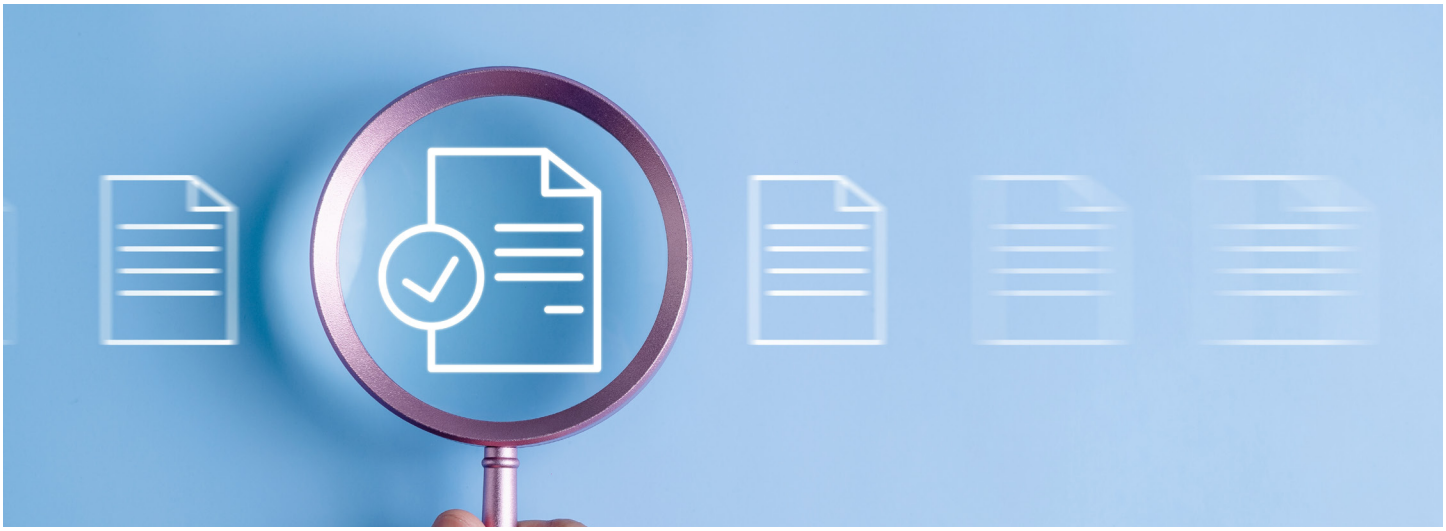
SB1332

The new legislation eases the administrative burden of SB 51 by giving insurers the discretion to waive premium liability in cases where the employer submits a termination of benefits notice late, but only if no covered services were used after the employee's eligibility ended.

While Governor Greg Abbott signed the bill on May 30, 2025, the supermajority passage meant that even if unsigned, the bill automatically became law. Thus, the law became effective in time for retroactive group health plan terminations processed as soon as June 2025 (for terminations in late May 2025).

Employer Action

Coordination with carriers and EDI service providers is still recommended to determine the best administrative processes for ensuring timely notices of termination. While in many cases carriers will be able to waive premiums for months following late-submitted terminations, such waiver is at the discretion of the carrier and employers will still be liable if covered services were used after the employee's eligibility ended.



Proposed Changes to Machine-Readable File Requirement

Issued date: 07/08/25

As previously reported, on February 25, 2025, President Trump signed an Executive Order (EO 14221) directing federal agencies to update the existing health care price transparency guidance and enforcement efforts, including those addressing machine-readable files ("MRFs"). In response, on May 23, 2025, the Departments of Labor, Health and Human Services, and the Treasury (collectively, "the Departments") released some FAQs signaling their improvement of the MRF disclosure process and issued a request for information ("RFI") for how best to report prescription drug information.

Background

Under the Transparency in Coverage ("TiC") final rules, group health plans and health insurance carriers must make public MRFs that disclose:

1. In-network rates;
2. Out-of-network allowed amounts and billed charges; and
3. Negotiated rates and historical net prices for covered prescription drugs.

While (1) and (2) above went into effect on July 1, 2022, the prescription drug MRF was delayed. In FAQ 61, the Departments announced that the enforcement deferral for the prescription drug MRF was rescinded, and that additional guidance would be issued in order for plans and carriers to comply with this requirement.

Improving Efficiency

The latest FAQs indicate that the Departments have identified several areas for strengthening disclosure requirements. The Departments intend to address concerns regarding the MRFs related to accessibility due to file size, data integrity, and a lack of critical context that limits full transparency. The Departments intend to release schema version 2.0, which will implement revised technical requirements for the in-network file and out-of-network allowed amount and billed charges file. In particular, schema version 2.0 will reduce file size by requiring exclusion of duplicative data, reducing unnecessary data

fields, and will include updates to better contextualize the data, making it more meaningful to ultimately achieve greater transparency. The Departments intend to finalize schema version 2.0 on October 1, 2025, with compliance being required by February 2, 2026.

The Departments are also considering rulemaking to further refine and improve upon the MRF requirements.

Prescription Drug Reporting

The RFI is intended to gather input from the public regarding implementation of the machine-readable file disclosure requirements as to prescription drugs in particular. The Departments previously deferred enforcement of this requirement.

Questions concern topics such as how to:

- Identify more meaningful data elements;
- Avoid unnecessary or irrelevant disclosures; and
- Capture rebate amounts.

Employer Action

At this time, there are no immediate action items for employers. As a reminder, with respect to the transparency requirements currently in effect:

- **Fully insured plans:** Health insurance carriers remain responsible for compliance with transparency requirements. Employers should obtain written confirmation that the carrier posts this information on behalf of the plan.
- **Self-funded plans:** Employers are responsible for ensuring compliance but may contract with third-party administrators (TPAs) and pharmacy benefit managers (PBMs) to fulfill these obligations.

It is important to note that generally, an employer sponsoring a self-funded plan can satisfy the MRF disclosure requirements by entering into a written agreement under which a TPA posts the MRFs on its public website on behalf of the plan. However, if the TPA fails to do so, the plan is liable. Employers without such a written agreement should post a link to the TPA's MRFs.

When the Departments provide their guidance, employers should engage with their carriers, TPAs, and PBMs to understand how they plan to comply with the new transparency requirements and whether updates to service agreements may be necessary. We will continue to monitor these developments and provide updates as new information becomes available.

One Big Beautiful Bill Act Signed into Law

Issued date: 07/11/25

On Friday, July 4, 2025, President Trump signed into law the One Big Beautiful Bill Act ("OBBBA"), which encompassed much of the President's desired domestic policies for his term. Importantly for employers, the bill does not alter or eliminate the tax exclusion for employer sponsored health insurance.

There are several provisions in OBBBA that amend the Internal Revenue Code ("the Code") and impact employer sponsored plans.

The following highlights some of the key changes.

Telehealth and Direct Primary Care Are Okay Before the Minimum HDHP Deductible

Most notably, certain types of coverage will no longer preclude individuals enrolled in a qualified high-deductible health plan ("HDHP") from contributing or receiving contributions to a Health Savings Account ("HSA").

Telehealth

For plan years beginning after December 31, 2024, an HDHP will not be disqualified by failing to have a deductible for telehealth and other remote care services. This means that an employer can provide telehealth on a no-cost (or reduced cost) basis for HDHP participants, and the individuals will still be able to make and receive contributions to their respective HSAs.

The retroactive effect of this provision means that if telehealth or other remote care services were provided for free (or at a reduced cost before the deductible) in 2025, that coverage is not considered disqualifying and employers will not need to adjust the tax treatment of any potential employee or employer HSA contributions made earlier this year.

Direct Primary Care

Beginning on January 1, 2026, HDHP participants can make and receive HSA contributions while covered under a direct primary care service arrangement ("DPC"). Previously, free (or reduced cost) DPC services provided before the minimum

HDHP deductible is satisfied would disqualify individuals from making HSA contributions.

To qualify as a DPC, the program must:

- Consist solely of primary care services provided by primary care practitioners, and
- Have a monthly fee of $150 or less for self-only coverage and $300 or less for coverage other than self-only. These amounts will be indexed annually.

For this purpose, the statute states that the following services are specifically excluded from treatment as primary care:

- Any procedures that require the use of anesthesia,
- Prescription drugs (other than vaccines), and
- Lab services that are not typically administered in an ambulatory primary care setting.

Additionally, HSA account holders can pay for a DPC out of their HSA, but only if the arrangement is less than or equal to $150/month for an individual ($300/month for a family) as indexed.

> It is important to note that this change allows for the DPC fees to be reimbursed by an HSA. It does not appear to allow for reimbursement from other types of accounts like a Health Reimbursement Arrangement ("HRA") or a Flexible Spending Account ("FSA"). However, further guidance would be welcome.

Increase to the Dependent Care Account

Previously, Section 129 dependent care assistance programs (also known as "dependent care FSAs" or "DCAPs") were limited to reimbursing up to $5,000 annually ($2,500 if married filing separately) of qualified child and dependent care expenses incurred for the taxpayer to seek employment or work.

For taxable years beginning after December 31, 2025, DCAPs can reimburse up to $7,500 annually ($3,750 if married filing separately). No other amendments were made, so the new maximum is still not indexed for inflation and is subject to meeting certain nondiscrimination requirements provided by the Code.

> Please note that while the increased dollar limit for DCAPs is a welcome development, employers should be mindful that such an increase could impact their nondiscrimination testing results if highly compensated or key employees benefit more from this higher limit.

Permanent Changes to Qualified Education Assistance Plans

Employers may contribute up to a maximum of $5,250 towards educational assistance for an employee in a calendar year and those amounts will be excludable from the individual's taxable income.

An educational assistance program can include payments for expenses incurred by or on behalf of an employee for the education of the employee, as well as payments to the employee or a lender of principal and/or interest on any qualified educational loan incurred by the employee for education of the employee.

The student loan provision was set to expire at the end of 2025, but the provision is now extended permanently.

Additionally, the $5,250 maximum will now be indexed moving forward to account for inflation.

Permanent Changes to Transportation Fringe Benefits

OBBBA permanently eliminates the bicycle commuting reimbursement exclusion.

In addition, the bill adjusts the methodology for calculating inflation when indexing the maximum amount of fringe benefits excludable for parking or public transit.

Extension and Enhancement of the Tax Credit for Paid Family and Medical Leave

OBBBA makes permanent paid family medical leave tax credits under Code § 45S, with three modifications:

- Expands the credit allowing employers to claim the credit for a portion of paid family and medical leave insurance premiums.
- It makes the credit available in all states.

Establishment of Trump Accounts and Employer Contributions

For tax years beginning after December 31, 2025, the law establishes a new type of retirement account called a "Trump Account," which will be treated in a similar manner to Individual Retirement Accounts ("IRAs") but is specifically designed for minors. The accounts are subject to various rules, including:

- The account must be established for the exclusive benefit of an eligible individual under the age of 18 or the individual's children under the age of 18.
- Contributions are limited to up to $5,000 per year (indexed for inflation for years after 2027), and funds must be invested in "eligible investments." Contributions can begin July 4, 2026.
- With limited exceptions, the amounts in the Trump Account must not be distributed before the first day of the year that the beneficiary turns 18.

Employers may contribute up to $2,500 (indexed for inflation for years after 2028) to an employee's Trump Account or that of their dependent(s). Amounts contributed by an employer are excludable from the employee's taxable income provided they are made in accordance with a separate, written plan document and subject to nondiscrimination requirements like those that apply to DCAPs.

Employer Action

Employers should review the benefit related provisions of OBBBA. Employers may want to consider:

- With respect to HDHP/HSA plans, whether to offer:
    - Free or reduced cost telehealth (or other remote care services).
    - A DPC arrangement.
- Increasing the DCAP limit for 2026 to reflect the larger salary reduction of $7,500.
- Whether to take advantage of other tax favored offerings, including:
    - A qualified education assistance program that will permanently include student loan payments; or
    - Contributions to employees' own (or their dependents') Trump Account for future investment (available beginning July 4, 2026).

New York City Issues Guidance for Prenatal Leave

Issued date: 07/16/25

New York became the first state in the nation to enact paid prenatal leave that became effective January 1, 2025. New York employers must provide 20 hours of paid prenatal leave for covered healthcare services in a 52-week period that is measured from the first time the employee uses paid prenatal leave. The New York City ("NYC") Department of Consumer and Worker Protection ("DCWP") amended its interpretive rules for the NYC Earned Safe and Sick Time Act ("ESSTA") to incorporate New York state's prenatal leave guidance.

The NYC amended rules were effective July 2, 2025, and while the rules attempt to align the city's ESSTA with the state's paid prenatal leave guidance, there are some notable differences as summarized below.

	New York State Paid Prenatal Leave	New York City Amendments to DCWP Interpretive Rules
Failure to file Form 5500	Employers may not request medical records or ask employees to disclose confidential information about their health condition when requesting paid prenatal leave	After three consecutive workdays of leave, employers can require employees to submit reasonable documentation to substantiate that paid prenatal leave was used appropriately
Employee Notice Requirements	Employees should request time off in accordance with existing notification/request procedures within their workplaces and are encouraged to provide advance notice of such leave requests, when possible	Employers can require an employee to provide reasonable notice of the need to use safe/ sick time or paid prenatal leave for "foreseeable" absences

Use of Paid Prenatal Leave	Allows employees to take paid prenatal leave in hourly increments	Permits an employer to set a minimum increment of paid prenatal leave at “one hour per day” suggesting that an employer has flexibility to establish a different minimum leave increment
Employer Notice and Recordkeeping Requirements	Employers are not required to separately identify paid prenatal leave on employee paystubs but are encouraged to keep accurate records	Requires employers to report an employee’s available paid prenatal leave balance each pay period in which an employee uses the leave (on the pay statement following the use or other written documentation)

Employer Action

NYC employers should review the paid prenatal leave interpretive rules with counsel to ensure compliance with all relevant guidance. It remains to be seen whether the NYC differences to the state paid prenatal leave provisions are applicable absent amendments to the ESSTA.

Privacy Rule Addressing Reproductive Health Vacated

Issued date: 07/21/25

On June 18, 2025, the amendment to the Health Insurance Portability and Accountability Act ("HIPAA") Privacy Rule concerning reproductive protected health information was vacated.

Background

In April 2024, the Department of Health and Human Services ("HHS") issued a final rule to strengthen the HIPAA Privacy Rule by prohibiting the use or disclosure of protected health information ("PHI") to investigate or prosecute patients, providers, and others involved in the provision of legal reproductive health care, including abortion care ("rPHI"). The rule resulted from concerns that pregnant women who live in a state where elective abortion is illegal seeking an abortion in a state where elective abortion is legal may have their records sought for the purpose of conducting criminal, civil, or administrative investigations following the Supreme Court's overturning of Roe v. Wade in the Dobbs case.

Purl v. HHS

An order out of a federal district court in Texas blocked the final rule on a nationwide basis.

The court ruled against the regulations based on the following:

1. HHS went further than HIPAA allows under standards set forth in the Loper Bright case and cannot restrict state rights to regulate abortion, as granted by the Dobbs decision. This is under the major questions doctrine which indicates that if an agency seeks to decide an issue of major national significance, its action must be supported by clear congressional authorization.
2. Defining "person" as excluding an unborn human conflicts with the Dictionary Act.
3. HIPAA cannot curtail state powers such as the power to create state child abuse and public health reporting laws.

It seems unlikely that HHS, under the current Administration, will appeal the decision.

Result

The Purl order immediately resets the compliance requirements for HIPAA-regulated entities, removing the additional protection HHS imposed on the sharing of rPHI. The general HIPAA Privacy Rule remains in effect. Under the general HIPAA privacy rules, a disclosure of PHI related to abortion without court order is prohibited, but that disclosure related to abortion with a court order does not require authorization.

Further Litigation

Texas has filed a separate lawsuit challenging the 2024 rPHI rule as well as the final 2000 rule, which is pending in federal court in Lubbock. Texas argues that the rule violates the Administrative Procedure Act ("APA") which governs how federal agencies develop and issue regulations. HHS, in a court filing last month, said the Administration is evaluating its position in this case.

Employer Action

Plan Sponsors who amended their HIPAA privacy policies and any other HIPAA-related documents addressing rPHI should remove those references and note that law enforcement is not required to use the model attestation.

California Delays Implementing Mandated Fertility Benefits

Issued date: 07/23/25

The effective date of California Senate Bill 729, which expands fertility coverage for fully insured plans, has been delayed. Originally set to be in effect for contracts issued, amended, or renewed on or after July 1, 2025, the law is now effective for fully insured health policies and HMO contracts **issued, amended, or renewed on or after January 1, 2026.**

Background

California Senate Bill 729 ("SB 729"), signed into law on September 29, 2024, requires large group policies and HMO contracts to cover the diagnosis and treatment of infertility and fertility services, including a maximum of three completed in-vitro fertilization treatments. Small group health insurance policies and HMO contracts are required to offer the employer (or other policyholder) the option to cover these same services but are not mandated to provide this coverage automatically. In California, "small group" is generally defined as a plan covering an employer that employs at least one, but not more than 100, full-time equivalent employees on at least 50% of its working days during the preceding calendar quarter or preceding calendar year, the majority of whom were employed in California.

The new state law applies to every health insurance policy that is issued, amended, or renewed to residents of California, regardless of the situs of the contract. It does not apply to self-funded group health plans or to health insurance policies or HMO contracts maintained by a "religious employer."

The law was originally set to be effective for insurance policies and HMO contracts issued, amended, or renewed on or after July 1, 2025. The new state law does not apply to health plans and policies with CalPERS (the benefit system for state employees) until July 1, 2027.

What's New

Upon signing SB 729, Governor Newsom requested the California Legislature to delay the implementation date from July 1, 2025, to January 1, 2026.

The extension became official on June 30, 2025, when Governor Newsom signed Assembly Bill 116 ("AB 116"), the health omnibus trailer bill, as part of the 2025-2026 state budget. AB 116 included a provision extending the implementation date of SB 729 for both large and small group plans to January 1, 2026. It also gave the Department of Insurance and the Department of Managed Health Care until January 1, 2027, to issue compliance guidance.

The benefit mandate will now take effect for fully insured group health insurance policies and HMO contracts that are **issued, amended, or renewed on or after January 1, 2026.**

Employer Action

Large employers with fully insured plans should be aware of the new fertility requirements that will take effect for plan years beginning on or after January 1, 2026.

Large employers with fully insured policies written outside of California, but providing coverage to California residents, should discuss compliance with the insurance carrier.

Small employers with fully insured plans should determine whether to opt in to the fertility coverage with the first renewal on or after January 1, 2026.

HHS Revises Out-of-Pocket Maximum Limits for 2026

Issued date: 07/28/25

The Department of Health and Human Services ("HHS") released final regulations on the Affordable Care Act ("ACA") Marketplace Integrity and Affordability. While the regulations generally affect Marketplace Coverage, it did include a revision to the out-of-pocket maximum limits for plan years that begin on or after January 1, 2026. This revision is due to an updated methodology to better align with premium trends. The revised limits are as follows:

- $10,600 for self-only coverage (revised from $10,150)
- $21,200 for coverage other than self-only (revised from $20,300).

It is important to note that the out-of-pocket maximum limits for non-grandfathered group medical plans are different (and generally higher) than the out-of-pocket maximum limits required for high-deductible health plans ("HDHPs") that are compatible with health savings account ("HSA") eligibility. For 2026, the out-of-pocket maximum limits for HSA-compatible HDHPs are $8,500 (up from $8,300 for 2025) for self-only coverage and $17,000 (up from $16,600 for 2025) for coverage other than self-only.

In addition, the rule finalized that carriers subject to essential health benefit requirements ("EHBs") (generally non-grandfathered individual and small market group health plans) may not cover specified sex-trait modification procedures
as an EHB. This policy will not prohibit carriers subject to EHB requirements from voluntarily covering specified sex-trait modification procedures, nor will it prohibit states from requiring coverage of such services, subject to the rules related to state-mandated benefits.

Employer Action

- Ensure out-of-pocket maximum limits for 2026 do not exceed the revised maximums.

Deal Reached To Simplify Prior Authorizations

Issued date: 07/30/25

On June 23, 2025, Health and Human Services ("HHS") Secretary Robert F. Kennedy, Jr. and Centers for Medicare & Medicaid Services ("CMS") Administrator Dr. Mehmet Oz met with health insurers to discuss their pledge to streamline and improve the prior authorization processes.

Companies represented at the roundtable included Aetna, Inc., AHIP, Blue Cross Blue Shield Association, CareFirst BlueCross BlueShield, Centene Corporation, The Cigna Group, Elevance Health, GuideWell, Highmark Health, Humana, Inc., Kaiser Permanente, and UnitedHealthcare.

Participating health insurers have pledged to:

- Standardize electronic prior authorization submissions using Fast Healthcare Interoperability Resources (FHIR®)-based application programming interfaces.
- Reduce the volume of medical services subject to prior authorization by January 1, 2026.
- Honor existing authorizations during insurance transitions to ensure continuity of care.
- Enhance transparency and communication around authorization decisions and appeals.
- Expand real-time responses to minimize delays in care with real-time approvals for most requests by 2027.
- Ensure medical professionals review all clinical denials.

For patients, these commitments are intended to result in faster, more direct access to appropriate treatments and medical services with fewer challenges navigating the health system. For providers, these commitments are intended to streamline prior authorization workflows, allowing for a more efficient and transparent process overall, while ensuring evidence-based care for their patients.

Employer Action

This agreement between HHS and insurance companies is a pledge and, at this time, not related to any proposed or final rules around prior authorization processes. It remains to be seen how this will play out in practice, particularly in the commercial market.

No employer action is necessary.

IRS Announces 2026 ACA Affordability Indexed Amount

Issued date: 08/04/25

The IRS recently announced that the Affordable Care Act ("ACA") affordability indexed amount under the Employer Shared Responsibility Payment ("ESRP") requirements will be 9.96% for plan years that begin in 2026. This is a significant increase from the 2025 percentage amount (9.02%), jumping above the original 9.5% threshold.

Background

IRS Revenue Procedure 2025-25 establishes the indexed "required contribution percentage" used to determine whether an individual is eligible for "affordable" employer-sponsored health coverage under Section 36B (related to qualification for premium tax credits when buying ACA Marketplace coverage). However, the IRS explained in IRS Notice 2015-87 that a percentage change under Section 36B will correspond to a similar change for affordability under section 4980H ESRP requirements.

Determining Affordability in 2026

An employer will not be subject to a penalty with respect to an ACA full-time employee ("FTE") if that employee's required contribution for 2026 meets one of the following safe harbors.

1. The W-2 safe harbor.

The employee's monthly contribution amount for the self-only premium of the employer's lowest cost coverage that provides minimum value is affordable if it is equal to or lower than 9.96% of the employee's W-2 wages (as reported on Box 1 of Form W-2). Application is determined after the end of the calendar year and on an employee-by-employee basis. Box 1 reflects compensation subject for federal income taxes, which would exclude amounts such as employee contributions to a 401(k) or 403(b) plan, and towards other benefits through a cafeteria plan.

2. Rate of pay safe harbor.

The employee's monthly contribution amount for the self-only premium of the employer's lowest cost coverage that provides minimum value is affordable if it is equal to or lower than 9.96% of the employee's computed monthly wages. For hourly employees, monthly wages are equal to 130 hours multiplied by their rate of pay. For salaried employees, monthly wages are equal to their monthly salary.

For example, an hourly employee has a $10/hour rate of pay. For a 2026 plan year, coverage is "affordable" for the employee if the employee's cost for self-only coverage does not exceed $129.48/month (($10 x 130 hours) x 0.0996).

3. Federal Poverty Level ("FPL") safe harbor.

Coverage is affordable if it does not exceed 9.96% of the FPL.

For a 2026 calendar year plan, coverage is affordable under the FPL safe harbor if the employee monthly cost for self-only coverage in the lowest cost plan that provides minimum value is not more than $129.89 (48 contiguous states), $162.26 (Alaska), or $149.31 (Hawaii). Note, this amount may increase (or decrease) when the 2026 FPL guidelines are issued.

Employer Action

Employers budgeting and preparing for the 2026 plan year should review these affordability safe harbors when analyzing employee contribution amounts for the coming year.

Update on the End of Indiana's 2025 Legislative Session

Issued date: 08/05/25

As is typical at the end of a legislative session, there was a flurry of activity and passage of multiple bills in Indiana. Two bills touching on benefits have become law; this article summarizes key aspects of each. Overall, the day-to-day impact of these bills to plan sponsors is minimal. However, we anticipate that the bills will allow plan sponsors to:

- Have more options when selecting pharmacy benefit managers ("PBMs"), especially for self-funded plans, and
- Hold PBMs and third-party administrators ("TPAs") more accountable by extending the same fiduciary duties to those entities.

Senate Bill 3 – Now Public Law 69

Effective July 1, 2025, Public Law 69 extends state fiduciary duties to TPAs and PBMs "acting on behalf of a plan sponsor." The law defines plan sponsor as "an employer or organization that offers health insurance coverage to its employees or members through an insurer or a self-funded health benefit plan" and therefore, the law appears to apply to both fully insured and self-funded ERISA plans. The four key fiduciary duties that TPAs and PBMs must follow are:

1. Act with loyalty and care in the best interests of the plan sponsor;
2. Ensure that all fees, costs, and commissions are reasonably and fully disclosed;
3. Avoid self-dealing and conflicts of interest; and
4. Maintain transparency in all financial and contractual arrangements related to the plan sponsor's health insurance coverage, including prescription drug benefits.

Senate Bill 140 – Now Public Law 189

Public Law 189 applies broadly to insurers and pharmacy benefit managers. It sets forth requirements relating to network adequacy, fee/compensation disclosures, cost/reimbursement guidelines, and some contractual limitations. These requirements are effective for any policies or contracts delivered, entered into, renewed, or amended after December 31, 2025.

Network Adequacy

The law mandates that any insurer, PBM, or other administrator of pharmacy benefits "ensure that the network is reasonably adequate and accessible." There are two key requirements to be considered adequate:

1. Offer an adequate number of accessible pharmacies that are not mail-order pharmacies; and
2. Provide convenient access to pharmacies that are not mail-order pharmacies within a reasonable distance of not more than 30 miles from each insured's residence, to the extent that pharmacy or pharmacist services are available.

It is important to note that the distance is based upon the individual employee's address – not the employer's location.

General Restrictions for PBMs

PBMs or TPAs administering pharmacy services are prohibited from engaging in the following behaviors:

- Preventing a pharmacy or pharmacist from selling or providing information about a lower cost alternative;
- Imposing limits, including quantity limits or refill frequency limits, on an insured's access to medication from a pharmacy that is more restrictive than those existing for a pharmacy affiliate;
- Requiring a pharmacy or pharmacist to enter into an additional contract with an affiliate of the insurer, pharmacy benefit manager, or other administrator of pharmacy benefits as a condition of entering into a contract with this insurer, pharmacy benefit manager, or administrator; or
- Requiring a pharmacy or pharmacist to, as a condition of contract, agree to payment rates for any affiliate of the insurer, pharmacy benefit manager, or other administrator of pharmacy benefits that is not a party to the contract.

These restrictions should help expand the inclusion of independent pharmacies as being in-network for plans and thus expand network availability and adequacy to improve participant experience.

Contracting with a Particular PBM or Pharmacy Prohibited for Self-Funded Plans

The law prohibits a TPA from requiring a plan sponsor to:

- Require as a pre-condition or condition of a contract with the TPA that the plan sponsor contract with a particular PBM; or
- Charge a different rate or fee for services if the plan sponsor based upon the plan sponsor's PBM selection.

Employer Action

- Employers should review policies and procedures relating to monitoring of vendors and update any questions relating to:
    - Rates and commissions,
    - Network adequacy, and
    - Conflicts of interest.
- Continue to monitor for further communications from TPAs and PBMs regarding, as applicable, their compensation, rebates, conflicts of interest, and updated contractual terms.

Texas Legislature Extends Period for Newborn Enrollment

Issued date: 08/14/25

On June 20, 2025, Senate Bill 896 ("SB 896") was signed into law. The new legislation extends the automatic period that newborns are covered and gives parents 60 days to request a continuation of that coverage under a Texas medical plan. The legislation applies to plans issued or renewed on or after January 1, 2026.

Background

Under existing law, a Texas plan automatically covers a newborn child of a covered employee beginning on the date of birth and ending on the 32nd day after the date of the child's birth unless, not later than the 31st day after the date of birth, the carrier receives:

1. notice of the birth; and
2. any required additional premium.

This means that a newborn is automatically covered for 31 days with no notice or premium required. To continue coverage past that date, the employee must timely provide notice and any additional premium.

This rule does not apply to self-funded plans other than multiple employer welfare arrangements ("MEWAs").

SB 896

Key points about the new Texas insurance mandate for newborns:

- **Purpose of the law:** The law aims to give parents more time to enroll their newborns and ensures they have continuous coverage.
- **Covered Plans:** The law applies only to:
    - fully insured plans issued in Texas; and

    - MEWAs as to Texas residents only.
- **Extended Enrollment Period:** The law extends the automatic period for newborn enrollment from 31 to 60 days.
- **Notification and Premium Payment:** The carrier must receive notice of the birth and any required additional premium within those 60 days to maintain coverage beyond the 60 days.
- **Effective Date:** The law applies to plans delivered or renewed on or after January 1, 2026.

Employer Action

Carriers are responsible for compliance and must include this mandate in certificates of coverage for plans issued on or after January 1, 2026. Note that they may go further than the law requires, including children other than newborns.

As employees are entitled to rights under this law, plan sponsors are responsible for understanding it and passing on any notice and additional premium from the employee to the carrier. Plan sponsors must also amend their cafeteria plans for this change before it goes into effect (by December 31, 2025, for a 2026 calendar year plan).

New Texas Mandated Benefits for 2026

Issued date: 08/15/25

The Texas legislature wrapped up its 89th legislative session in June, having passed a number of bills related to health insurance. Below are the bills signed into law that relate to employer-sponsored plans. They apply to insured medical plans written out of Texas only and, where applicable, pharmacy benefit managers ("PBMs") operating in Texas, and are effective for health plans delivered or renewed on or after January 1, 2026, unless otherwise noted below.

Summary

Senate Bill 896 – Extends the automatic enrollment period for newborns from 31 to 60 days following birth.

House Bill 388 – Requires the creation and use of a standardized coordination of benefits questionnaire to streamline the billing process, effective February 1, 2026.

House Bill 1052 – Requires health benefit plans to cover telemedicine, teledentistry, and telehealth services provided from locations outside Texas on the same basis as those provided within the state, as long as the patient primarily resides in Texas and the provider is licensed or authorized to provide services in Texas and maintains a physical office in Texas.

House Bill 2254 – Permits preferred and exclusive provider benefit plans to contract with primary care physicians and physician groups on a risk basis, including capitation or other risk-sharing arrangements. Participation in these arrangements is voluntary, and insurers cannot discriminate against physicians or groups who opt out.

House Bill 3057 – Requires health benefit plans that provide coverage for chimeric antigen receptor T-cell therapy (CAR T) to cover medically necessary CAR T therapy when administered by qualified, FDA-certified providers within the plan's network.

House Bill 3233 – Prohibits PBMs from storing or processing patient data for a Texas resident in a location outside of the United States or its territories. Effective for contracts entered into on or after September 1, 2025.

House Bill 3812 – Extends the duration of preauthorization exemptions from six months to one-year, includes additional claims in preauthorization exemption evaluations, and prohibits the physician supervising utilization management at a

health plan from holding an administrative license.

Senate Bill 493 – Prohibits PBMs from including gag clauses in contracts with pharmacies that would prohibit a pharmacist from informing an enrollee of any difference between the patient's out-of-pocket cost for a prescription drug using the PBM benefit and the out-of-pocket price when paying cash. Effective for contracts entered into on or after September 1, 2025.

Senate Bill 527 – Prohibits a health benefit plan covering general anesthesia from excluding medically necessary general anesthesia services relating to dental services for a covered individual, provided that: (1) the individual is younger than 13 years of age and unable to undergo the dental service without general anesthesia due to a documented physical, mental, or medical reason; and (2) a qualified provider of anesthesia services performs the anesthesia.

Senate Bill 815 – Restricts health plans from utilizing artificial intelligence or algorithms for claim denials. However, such systems may still be used for administrative support or fraud detection purposes.

Senate Bill 916 – Extends protections against surprise billing for ground ambulance services in Texas through September 1, 2027. Grants DSHS expanded authority to suspend or revoke the licenses of emergency medical service providers who either intentionally give false information or repeatedly break payment rules with respect to insurance coverage for out-of-network emergency care.

Senate Bill 926 – Permits HMOs and insurers to provide incentives, such as adjusted deductibles, copayments, coinsurance or other cost-sharing mechanisms or to use a tiered network to encourage enrollees or insureds to utilize specific physicians or providers. Prevents plans from using these incentives to limit medically necessary services or provide lower quality of care.

Senate Bill 1236 – Permits pharmacists an opportunity to refuse a proposed modification to a network contract and voids modifications that are not approved and signed by the pharmacist under most circumstances. With some exceptions, under this bill, a health benefit plan could only recoup the dispensing fee and not the cost of the drug or any other cost. Also requires pharmacy benefits to include on the health insurance card a unique identifier that indicates whether the plan is subject to regulation by TDI.

Senate Bill 1257 – Requires plans that have ever provided gender transition coverage to provide broad coverage for adverse consequences, management, reversal or follow up related to gender transition procedure or treatment.

Senate Bill 1332 – Allows health plans to waive premiums when a health plan receives late notification of an employee's departure from a company if the employee did not receive covered services following their departure. It applies to fully insured PPO/EPO and HMO businesses.

Senate Bill 2544 – Out-of-network providers, health benefit plan issuers or administrators may request mandatory mediation for health benefit claims involving out-of-network facilities no later than 180 days after the provider receives an initial payment for the relevant service or supply. Effective June 20, 2025. Currently, there is no deadline.

Employer Action

For the most part, employers with insured medical plans written out of Texas should be aware of the above changes and no employer action is required. However, employers should amend their cafeteria plans for Senate Bill 896 before it goes into effect (by December 31, 2025, for a 2026 calendar year plan).

North Carolina Enacts PBM Law

Issued date: 08/18/25

On July 10, 2025, North Carolina Governor Josh Stein signed the Act Supporting Community Retail Pharmacies and Improving Transparency ("the SCRIPT Act") into law. The SCRIPT Act is the latest in a series of state laws that seek to regulate the business practices of pharmacy benefit managers ("PBMs"). The Act imposes new reporting obligations on PBMs, limits their ability to steer patients to certain pharmacy providers, and requires rebates and discounts to be passed directly to participants. Most SCRIPT Act provisions go into effect October 1, 2025, while others are not effective until 2026 or 2027.

Summary

The pharmacy choice provisions of the Act prohibit PBMs from:

- Prohibiting insured participants from selecting a pharmacy that has agreed to participate in the health plan,
- Denying a pharmacy that has agreed to the terms of reimbursement the opportunity to participate as a contract provider,
- Imposing any cost sharing on any covered benefit that is not equally imposed on contract providers,
- Imposing any monetary incentive that would affect an insured's choice of provider,
- Reducing reimbursement for insured pharmacy services where the participant selects a pharmacy of his or her choice, and
- Requiring participants to purchase pharmacy products through a mail-order pharmacy.

The pharmacy choice provisions apply to insurance contracts entered into on or after October 1, 2025.

Pharmacy Services Administrative Organizations

The SCRIPT Act regulates pharmacy services administrative organizations ("PSAOs"), which are organizations that represent independent pharmacies in negotiations with PBMs and other third-party payers. The Act prohibits PSAOs

from requiring independent pharmacies to buy more expensive drugs from certain wholesalers and to disclose ownership interests to the state. The PSAO provisions are effective for contracts entered into or renewed on or after October 1, 2026.

Reporting Requirements

The Act adopts new reporting requirements for PBMs. Among other things, the Act requires PBMs to report to the Commissioner of Insurance the aggregate amount of rebates paid, amounts retained through spread pricing, the aggregate amount of fees imposed on contracted pharmacies, and the aggregate amount of rebates passed on to the insurer or insured participant. The reporting requirements are effective for contracts entered into on or after October 1, 2025.

Pharmacy Reimbursement Rates

The Act prohibits PBMs from reimbursing pharmacies less than the amount it reimburses its affiliate pharmacies for the same item or service. This provision is effective for pharmacist services dispensed on or after October 1, 2025.

Additionally, PBM contracts may not require independent pharmacies and those in pharmacy deserts to be reimbursed at rates lower than acquisition cost.

PBM Rebates Shared with Consumers

The Act requires that 90% of all rebates received in connection with dispensing a drug be used to offset the patient's cost-sharing. This means that 90% of all rebates will be required to be passed along to consumers at the point of sale. This provision will require insurers to submit an attestation of compliance by January 1 of each year to the Commissioner of Insurance. The consumer rebate provisions apply to prescription drugs purchased on or after January 1, 2027.

Prescription Drug Transparency

For prescription drugs priced at $100 or more for a 30-day supply, the Act requires manufacturers to notify interested parties by January 1 of each year as to price increases of 15% or greater that occurred in the prior calendar year. Drug manufacturers must also notify interested parties of the price of any new prescription within 3 days after it is made available for purchase. The requirement to notify interested parties of cost increases is effective January 1, 2026; the requirement to notify of costs of new drugs is effective immediately.

Applicability

The SCRIPT Act applies to health benefit plans in the state, which means accident and health insurance policies, nonprofit hospital service corporation contracts, health maintenance organizations, multiple employer welfare arrangements, or other benefit arrangements, to the extent permitted under ERISA. While fully insured coverage written in the state will be subject to the new requirements, it is not yet clear which provisions, if any, will apply to self-funded plans.

In 2020, the U.S. Supreme Court held in *Rutledge v. Pharmaceutical Care Management Association* that state PBM laws that merely regulate reimbursements to pharmacies are not preempted by ERISA. However, state laws that regulate the structure of employee health benefit plans will generally be preempted. In 2023, the 10th Circuit Court of Appeals found an Oklahoma law that regulated PBM networks to effectively regulate benefit plan design and was partially preempted by ERISA. In June of 2025, the Supreme Court declined to review the appeal, so the 10th Circuit opinion stands.

To the extent that state laws and regulations are preempted under ERISA, they will not apply to self-funded plans, whether they are established in North Carolina or any other state. Given the evolving ERISA preemption landscape, it is not clear which provisions of the SCRIPT Act will apply to self-funded plans.

Employer Action

Employers who sponsor fully insured plans can expect their insurance carrier to comply with the new requirements and do not need to take any action. Sponsors of self-insured plans should reach out to their TPA or PBM to determine if the North Carolina law requires any benefit design changes.

Departments Extend Enforcement Relief for the No Surprises Act

Issued date: 09/08/25

On July 30, 2025, the Departments of Labor, Health and Human Services, and the Treasury ("the Departments") released FAQ Part 71, which confirms:

- Enforcement relief for following prior guidance related to the Qualified Payment Amount ("QPA") for items and services furnished before February 1, 2026; and
- The changes to the out-of-pocket maximum ("OOPM") limits for plan years beginning on or after January 1, 2026.

Background

The No Surprises Act ("NSA") was part of the Consolidated Appropriations Act, 2021 ("the CAA"). The NSA protects participants, beneficiaries, and enrollees in group health plans and individual health insurance from certain surprise out-of-network services.

As previously reported, the independent dispute resolution ("IDR") process under the NSA has been subject to extensive litigation. Specifically, the presumption in favor of the QPA and the requirement that the IDR entity should choose the payment amount closest to the QPA has been the focus of much of the litigation. As a result of various court decisions, the Departments have released prior guidance indicating that the Departments will exercise enforcement discretion for plans and insurance issuers relying on prior guidance issued in 2021 on how the QPA should be calculated. This prior guidance was effective for items or services furnished prior to August 1, 2025.

What's New?

NSA

As a court decision is still pending on the latest legal challenge to the QPA, the FAQ confirms that plans, issuers, and providers may continue to rely on the older 2021 QPA calculation methodology for items and services furnished before February 1, 2026, without risk of federal enforcement. States are encouraged to adopt a similar approach.

Plans must still provide related QPA disclosures and certify that the QPA was determined in compliance with applicable requirements, even if using the 2021 methodology.

OOPM

In addition, the FAQ restated both the premium adjustment percentage and the OOPM for 2026 plan years. The maximum annual limitation on cost sharing for the 2026 plan year will be $10,600 for self-only coverage, and $21,200 for other than self-only coverage.

Employer Action

Employers should ensure OOPM limits for 2026 do not exceed the maximums. For fully insured plans, carriers are responsible for the IDR process. For self-funded plans, employers should ensure their TPA is supporting compliance with the NSA, including the IDR process.

2025 MLR Rebate Checks to Be Issued Soon to Fully Insured Plans

Issued date: 09/09/25

As a reminder, insurance carriers are required to satisfy certain medical loss ratio ("MLR") thresholds. This generally means that for every dollar of premium a carrier collects with respect to a major medical plan; it should spend 85 cents in the large group market (80 cents in the small group market) on medical care and activities to improve health care quality. If these thresholds are not satisfied, rebates are available to employers in the form of a premium credit or check.

If a rebate is available, carriers are required to distribute MLR checks to employers by September 30, 2025.

Importantly, employers must distribute any amounts attributed to employee contributions to employees and handle the tax consequences (if any).

This does not apply to self-funded plans.

What to Do with this MLR Rebate Check?

The rules around rebates are complex and require careful review with ERISA counsel. Among other things, an employer receiving a rebate as a policy holder will need to determine:

- who receives a rebate (e.g., current participants v. former participants);
- the form of the rebate (e.g., premium reduction v. cash distribution);
- the tax impacts of any such rebate (on both the employer and participants receiving the rebate); and
- what, if any, communication to provide participants regarding the rebate.

The following questions and answers are designed to provide information as to what employer action may be necessary.

What will the rebate amount be?

Carriers determine MLR on a state basis by market segment (individual, small group, or large group). Carriers do not disaggregate by type of plan within these markets (e.g., PPO v. HMO v. HDHP) or by policyholder so the carrier will have to let you know the amount.

A carrier is not required to provide a rebate to an enrollee if the total rebate owed is less than $20 per subscriber ($5.00 when a carrier pays the rebate directly to each subscriber). This rule regarding de minimis amounts only applies to the carrier, not to employers refunding amounts to participants.

Will there be any communication?

Yes.

For each MLR reporting year, at the time any rebate of premium is provided, a carrier must provide the policyholder and each current enrollee who was also enrolled in the MLR reporting year in a form prescribed by HHS.

Employers do not have to notify employees, but they may want to address the notices being distributed by the carriers. Language similar to the following provides a starting point for such a notice:

> Employees should have received a notice of rebate from [carrier]. In short, [Employer] received a rebate check in the amount of $_____. Amounts attributable to participant contributions will be used to [reduce premium amounts] for [currently enrolled employees] in accordance with legal requirements. These amounts will be reflected in the [September ___] paychecks.

What will the form of rebate to the employer be?

Carriers may issue rebates in the form of either a premium credit (i.e., reduction in a premium owed), a lump-sum payment, a lump-sum reimbursement to the account used to pay the premium if an enrollee paid the premium using a credit card or direct debit, or a "premium holiday," if this is permissible under state law.

When will the rebate be issued?

Rebates must be paid by **September 30** each year. A carrier that fails to timely pay any rebate must additionally pay the enrollee interest at the current Federal Reserve Board lending rate or 10% annually, whichever is higher, on the total amount of the rebate, accruing from the date payment was due.

Do employers have to give some or all of the rebate to participants?

Yes, unless they paid 100% for all tiers of coverage.

Carriers will generally send rebate checks to employers and employers must mete out any amounts attributed to employee contributions to employees and handle the tax consequences.

There is no one formula for employers to use, but guidance has been provided to aid employers.

<u>ERISA-covered group health plans</u>

To the extent that rebates are attributable to participant contributions, they constitute plan assets. Plan assets must be handled in accordance with the fiduciary responsibility provisions of Title I of ERISA.

If the employer is the policyholder, determining the plan's portion, if any, may depend on provisions in the plan or the policy or on the manner in which the plan sponsor and the plan participants have shared in the cost of the policy. If the plan

or its trust is the policyholder, in the absence of specific plan or policy language to the contrary, the entire rebate would constitute plan assets, and the policyholder would be required to comply with ERISA's fiduciary provisions in the handling of rebates that it receives.

The HHS regulations and related DOL guidance for ERISA plans leave to the policyholder the decision as to how to use the portion of a rebate that constitutes plan assets, subject to ERISA's general standards of fiduciary conduct. The DOL notes that, in choosing an allocation method, "the plan fiduciary may properly weigh the costs to the plan and the ultimate plan benefit as well as the competing interests of participants or classes of participants provided such method is reasonable, fair and objective." An allocation does not necessarily have to exactly reflect the premium activity of policy subscribers. A plan fiduciary may instead weigh the costs to the plan and the competing interests of participants or classes of participants when fashioning an allocation method, provided the method ultimately proves reasonable, fair, and objective. If the fiduciary finds that the cost of passing through the rebate to former participants would exhaust most of those rebates, the proceeds can likely be allocated to current participants.

Guidance does not address how to handle an MLR rebate where the amount is inconsequential (e.g., a dollar per participant). Taking a cue from DOL Field Assistance Bulletin No. 2006-01, a fiduciary may be able to conclude, after analyzing the relative costs, that no allocation is necessary, when the administrative costs of making correction far exceed the amount of the allocation.

If a plan provides benefits under multiple policies, the fiduciary is instructed to allocate or apply the plan's portion of a rebate for the benefit of participants and beneficiaries who are covered by the policy to which the rebate relates provided doing so would be prudent and solely in the interests of the plan according to the above analysis. But, according to the DOL, "the use of a rebate generated by one plan to benefit the participants of another plan would be a breach of the duty of loyalty to a plan's participants."

Plans that are neither covered by ERISA nor are governmental plans (e.g., church plans)

With respect to policyholders that have a group health plan but not a governmental plan or a plan subject to ERISA, carriers must obtain written assurance from the policyholder that rebates will be used for the benefit of current subscribers or otherwise must pay the rebates directly to subscribers.

The final rule issued on February 27, 2015, provides that subscribers of non-federal governmental or other group health plans not subject to ERISA must receive the benefit of MLR rebates within three (3) months of receipt of the rebate by their group policyholder, just as subscribers of group health plans subject to ERISA do.

When do rebates need to be made to participants?

As soon as possible following receipt and, in all cases, within 3 months of receipt.

What is the form of rebate to participants?

There is no one way to determine this, but guidance has been provided to aid employers.

Reductions in future premiums for current participants is probably the best method.

If proceeds are to be paid to participants in cash, the DOL is likely to require that payments go to those who participated in the plan at the time the proceeds were "generated," which may include former employees. An option that may be easier to administer is to keep the proceeds in the plan and provide a "premium holiday" (suspension of required premiums) or a reduction in the amount of employee-paid premiums.

The interim final regulations for non-ERISA governmental plans require that rebates be used to reduce premiums for all health plan options for subscribers covered when the rebate is received, to reduce premiums for current subscribers to the option receiving the rebate, or as a cash refund to current subscribers in the option receiving the rebate. In each case, the regulations allow the rebate to be allocated evenly or in proportion to actual contributions to premiums. Note that the rebate

is to be used to reduce premiums for (or pay refunds to) employees enrolled during the year in which the rebate is actually paid (rather than the MLR reporting year on which the rebate was calculated).

To recap, here are some options to consider:

- Reduce future premiums for current plan participants. This is administratively easy with limited tax issues with respect to participants.
- Cash payments to current participants. This is administratively burdensome and results in tax consequences to participants.
- Cash payments to former participants. This is administratively burdensome and results in tax consequences to former participants.

The employer could also consider, with counsel, whether providing benefit enhancements or payment of reasonable plan expenses would be considered permissible.

What are the federal tax implications to employees?

Pre-Tax Premium Payments

When employees pay their portion of the premiums for employer-sponsored health coverage on a pre-tax basis under a cafeteria plan, MLR rebates will be subject to federal income tax and wages. Briefly:

- For rebates that are distributed as a reduction in premium (thus reducing an individual's pre-tax premium payment during the year), there is a corresponding increase to the employee's taxable salary that is also wages taxable for employment tax purposes.
- Rebates that are distributed as cash will result in an increase in taxable income that is also wages subject to employment taxes.

The result is the same regardless of whether the MLR rebates are provided only to employees participating in the plan both in the year employees paid the premiums being rebated and the year in which the MLR rebates are paid, or to all employees participating in the plan during the year the MLR rebates are paid (even if some employees did not participate in the plan during the year to which the rebate applies.)

After-Tax Premium Payments

When employees pay their portion of the premiums on an after-tax basis, MLR rebates generally are not subject to federal income tax or employment taxes. This applies when the rebate is provided as a reduction in premiums or as a cash. The result is the same regardless of whether the MLR rebates are provided only to employees participating in the plan both in the year employees paid the premiums being rebated and the year in which the MLR rebates are paid, or to all employees participating in the plan during the year the MLR rebates are paid (even if some employees did not participate in the plan during the year to which the rebate applies).

What are the tax implications to employers?

Employers should review the tax implications of a rebate with tax advisors. Generally, amounts used for benefits (e.g., to pay premiums with respect to insured plans) should not be taxable.

When employees pay premiums on a pre-tax basis, does reducing a participant's premiums mid-year allow them to make election changes?

Probably not.

If employee contributions are paid on a pre-tax basis and there is a mid-year rate change, the cafeteria plan must determine whether such a change is permitted under the Section 125 rules.

If the plan incorporates the permitted election change rules, the relevant issue is whether this change in cost is permitted under the regulations.

- If there is an insignificant decrease[1], there can be an automatic adjustment.
- If there is a significant decrease, employees may make a corresponding change including commencing participation in the cafeteria plan for the first time for the option with a decrease in cost.

Generally, MLR rebates are expected to be fairly low dollar amounts and may not rise to the level of a significant change. Employers should consider either taking the position that the cost change is insignificant or that the cost change is significant and the "corresponding change" is to simply allow the reduction or increase. The cafeteria plan document should be consistent with the employer's position.

[1]There is little guidance in the regulations on what constitutes a "significant change." An example relating to dependent care assistance program benefits indicates that, under the particular facts, a 12.5% change in the cost of care (from $4,000 to $4,500) may be significant. However, this 12.5% threshold should not be viewed as a safe harbor. Consequently, employers will need to make the "significant vs. insignificant" determination based upon all the facts and circumstances.

Connecticut Expands Leave to Certain School Employees

Issued date: 09/16/25

Connecticut Governor Ned Lamont recently signed HB 7288 which, among other things, expands job-protected unpaid leave under the Connecticut Family Leave Act ("CTFMLA") and the Connecticut Paid Leave Act ("CTPLA") to certain non-certified school employees. Beginning October 1, 2025, the bill amends CTFMLA and CTPLA to cover employees that are employed by "public school operators" in a position that does not require a professional certification under Chapter 166 of the Connecticut General Statutes. These public school operators are now required to register with the Connecticut Paid Leave Authority (the "Authority"), deduct the 0.5% contributions from eligible employees' wages, and remit those contributions quarterly to the Authority.

Employer Action

Public school operators should work with employment and labor counsel to review their leave policies and procedures to ensure they are compliant with the new requirement effective October 1, 2025. In addition, employers should monitor the Connecticut Department of Labor ("CTDOL") and CTPLA websites for additional guidance and regulations. We will continue to monitor this issue as well and will keep employers updated as applicable.

Delaware Amends Paid Family and Medical Leave Law

Issued date: 09/17/25

On July 30, 2025, Governor Matt Meyer signed HB 128 ("the Act") into law, amending Delaware's paid family and medical leave law ("PFML"). The Act was effective immediately once it was signed into law.

Background

Delaware's PFML law, the Healthy Delaware Families Act, requires certain employers to provide their covered employees with up to $900 per week in paid leave for parental, family caregiving, medical, and qualified military exigency leave. Contributions to the state plan began on January 1, 2025, and benefits will begin on January 1, 2026.

The Act amends several provisions of the PFML law, specifically the following:

- The coordination of an employer's other paid leave with PFML leave;
- An employer's ability to require a covered employee to use other paid time off ("PTO") prior to using PFML leave;
- The annual deadline for applying for a private plan; and
- Private plan claims documentation requirements.

Paid Leave Coordination with PFML

The Act clarifies that PFML is the primary payor of benefits and that an employer may offset other employer paid leave policies (e.g., short-term disability policies) based on an employee's receipt of PFML benefits. This offset must be conveyed in the terms of the policy.

Required Use of PTO No Longer Allowed

The law previously allowed employers to require an employee to use any accrued but unused PTO prior to receiving PFML benefits and that the use of such PTO could be counted toward the length of benefits received under PFML. This is no longer the case as the Act has amended the law so that an employer may NOT require that an employee use accrued but unused PTO prior to accessing PFML benefits. In addition, the employer and a covered employee must now agree for an employee to use accrued but unused PTO to supplement PFML benefits.

Private Plan Application Deadlines

If an employer wishes to comply with the PFML law by using a private plan, the law previously required the employer to annually apply to the Delaware Department of Labor ("DOL") between September 1 and December 1 of each year. The Act amends the law so that the DOL must now accept private plan applications on a rolling basis with effective dates for approved private plans now being January 1, April 1, July 1, and October 1.

Private Plan Claims Documentation

Employers utilizing a private plan are no longer required to provide claim documentation to the DOL unless the claim is subject to an appeal, complaint, audit, or specific inquiry from the Department.

Employer Action

- Employers providing other forms of income replacement to employees covered under Delaware's PFML law should ensure that their policies permit them to offset these benefits by any PFML benefits received.
- Employers should review, and amend as necessary, all PTO policies to ensure that they do not require covered employees to use accrued but unused PTO prior to the receipt of PFML benefits.
- Employers should adjust as necessary any timelines for application for a private plan with the DOL.

San Francisco HCSO Expenditures and Reporting Update for 2026

Issued date: 09/18/25

The San Francisco Health Care Security Ordinance ("HCSO") minimum expenditure rates for 2026 have been released, and the HCSO Annual Reporting Form for calendar year 2025 is due on April 30, 2026.

2026 Minimum Expenditure Rates

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

Employer Size	Number of Employees	2025 Health Care Expenditure Rate	2026 Health Care Expenditure Rate
Large	All employers with 100 or more employees	$3.85 per hour payable	**$4.11** per hour payable
Medium	Businesses with 20-99 employees Nonprofits with 50-99 employees	$2.56 per hour payable	**$2.74** per hour payable
Small	Businesses with 19 or fewer employees Nonprofits with 49 or fewer employees	Exempt	Exempt

The hours payable under the HCSO for each employee are capped at 172 hours per month. Therefore, for 2026 the maximum required health care expenditure for a covered employee of a large employer is $709.92 per month ($4.11/hour x 172 hours). For a medium-sized employer, the maximum required expenditure for a covered employee is $471.28 per month ($2.74/hour x 172 hours).

Managerial, supervisory, or confidential employees who earn more than a specified amount are exempt from the minimum health care expenditures requirement under the HCSO. For 2025, the earnings threshold for these employees to be exempt from the HCSO is $125,405 per year (or $60.29 per hour). As of January 1, 2026, the new threshold will be $128,861 per year (or $61.95 per hour).

Annual Reporting Form

Covered employers must submit an online report each year that summarizes how they complied with the HCSO. The web-based HCSO Annual Reporting Form for the prior calendar year is typically available on the San Francisco Office of Labor Standards Enforcement ("OLSE") HCSO website by April 1 and must be submitted by April 30. For example, the HCSO Annual Reporting Form for calendar year 2025 is expected to become available on the HCSO website by April 1, 2026, and is due by April 30, 2026.

Employer Action

Covered employers should ensure that they will be making the required minimum health care expenditures in 2026 at the new rates for employees in San Francisco and maintain records showing compliance with the HCSO requirements.

The 2026 version of the HCSO poster, which must be posted in all workplaces with covered employees, is expected to become available by December 2025. Covered employers should monitor the San Francisco HCSO website (linked below) to obtain and post the 2026 version of the poster by January 1, 2026.

www.sf.gov/information--health-care-security-ordinance

Covered employers should also be prepared to submit the HCSO Annual Reporting Form for calendar year 2025 no later than April 30, 2026.

Washington Expands PFML Protections

Issued date: 09/19/25

Washington's Paid Family and Medical Leave ("WA PFML") program, administered by the Employee Security Department ("ESD"), provides partial wage replacement benefits to employees on leave for certain family and medical reasons. With the passage of HB 1213, various WA PFML employee protections will be expanded effective January 1, 2026.

Background

Effective January 1, 2020, all employers with at least one (1) employee performing services in Washington must provide paid family and medical leave benefits through the state insurance fund or an approved voluntary plan. WA PFML benefits are funded by premiums paid by employer and employee contributions. Employees may receive wage replacement benefits of up to 90% of weekly wages up to the maximum. Employers are also required to report employee wages and hours when premiums are remitted to ESD.

Employees are eligible for leave benefits if they worked at least 820 hours for any WA employer during a qualifying year. Employees may be eligible for up to 12 weeks of medical or family leave. WA PFML leave can run concurrently with the federal Family and Medical Leave Act ("FMLA"). Based on employer size and depending on their eligibility, employees may be entitled to job protection and benefits continuation during their period of leave.

HB 1213

On May 17, 2025, HB 1213 was signed into law. HB 1213 expands several employee benefits and protections under WA PFML. The changes become effective January 1, 2026.

Notable changes follow.

Minimum leave increments

The minimum leave increment is reduced from eight (8) to four (4) hours.

Significant changes to job protection provisions

- Smaller employers will be required to provide job protection to employees taking WA PFML as follows:
    - 25 or more employees from January 1, 2026 to December 31, 2026
    - 15 or more employees from January 1, 2027 to December 31, 2027
    - Eight (8) or more employees on or after January 1, 2028
- The minimum hours worked for employees to qualify for job protection is removed
- Benefits continuation is now required during any leave when an employee is eligible for job protection

Leave stacking

Currently, employees can "stack" FMLA and WA PFML leave by claiming leave under FMLA first without applying for leave under WA PFML. Stacking makes it possible for an employee to take 12 weeks of leave under FMLA and then the full amount of available WA PFML, potentially providing an employee with up to 30 weeks of protected leave.

HB 1213 now provides a maximum period of job protection of 16 weeks in a 52-week period when an employee takes FMLA that is also eligible for WA PFML. The maximum job protection period requires the employer to provide notice to the employee containing the following information:

- That the FMLA leave is counting against any period of job protection under WA PFML
- That the use of unpaid FMLA leave does not affect the employee's eligibility for benefits under WA PFML

The maximum period of job protection that is available to an employee requires the employee to exercise their right to restoration of employment by the earlier of:

- First scheduled workday following the period of leave; or
- First scheduled workday following a continuous or intermittent period of 16 weeks.

This means an employee's job protection expires after the 16-week period even if the employee is still off work on approved WA PFML, making it possible for the employer to avoid job restoration and discontinue benefits continuation. Employers should be sure to confirm whether an employee in this situation should be offered COBRA.

Small employer grants

HB 1213 also changes the grants available to assist small employers with costs related to WA PFML

- Only employers with 50 to 150 employees will be eligible for existing grants
- A new $3,000 grant is available to employers with fewer than 50 employees that can be used for:
    - Costs related to hiring a temporary worker for more than seven (7) days; or
    - Significant additional wage related costs due to an employee's leave
- Any employer receiving a grant will be assessed for all premiums for three (3) years

Employer Action

Employers will need to become familiar with the additional rights and responsibilities imposed by HB 1213. While the changes related to employee leave stacking are welcomed, employers should update existing leave policies to account for the changes related to job protection and benefit continuation. Additionally, employers should consider updating leave and benefit continuation policies to account for possible required COBRA continuation coverage offered during WA PFML leave. Employers will likely need to confirm processes with COBRA administrators to ensure compliance.

ESD may provide sample notices that can be used to satisfy the notice obligation that allows an employer to limit the maximum period of job protection and benefit continuation.

2025 Compliance Bulletins: Quarter Four

October

November

December

Washington State Expands EHBs Starting January 1, 2026

Issued date: 10/10/25

Under the Affordable Care Act ("ACA") individual and small group health plans are required to provide coverage for 10 categories of essential health benefits ("EHB"). For plan years after January 1, 2020, states are permitted to set the specific coverage requirements for the EHBs in the state's benchmark plan. For plan years beginning on or after January 1, 2026, Washington has added new coverage requirements to their EHB benchmark plan.

Background

The ACA established the EHB requirement for individual and small group plans to ensure plans provided comprehensive items and services in ten categories of benefits. States are permitted to update the specific coverage requirements in their benchmark plan with approval by CMS.

Importantly, self-funded and large group plans are not required to provide coverage for any particular EHBs. However, to the extent the plan (including self-funded and large group fully insured plans) covers an EHB then:

1. Lifetime and annual dollar limits may not be imposed (in-network and out-of-network); and

2. In-network cost sharing accumulates to deductible and maximum out-of-pocket ("MOOP").

As states are permitted to determine which items and services are included as EHBs in the state's benchmark plan, self-funded group plans are permitted to select their benchmark plan. For this purpose, self-funded group health plans may select any state's benchmark plan.

New Essential Health Benefits

In late 2024, Washington state expanded the list of EHBs that would be included in the state benchmark plan as of January 1, 2026. The specific items and services included will be considered EHBs for any self-funded plan that selects Washington state's benchmark plan. This means lifetime and annual limits and cost sharing aggregation rules apply to any items and services included in the state benchmark plan for any self-funded plan that selects the Washington benchmark plan.

The new EHBs include the following:

- **Hearing aids**
    - New hearing aid benefit that includes an annual hearing exam and one hearing aid per ear with hearing loss every three years.
    - No lifetime or annual dollar limit.
    - Generally, not subject to the deductible except in qualified high-deductible health plans ("HDHPs") to preserve eligibility to contribution to a health savings account ("HSA").
- **Donor human milk**
    - Coverage for human milk for inpatient use, when an infant is unable to receive maternal milk or when the parent is unable to produce maternal milk in sufficient quantities or caloric density.
- **Artificial insemination**
    - Coverage for artificial insemination in vivo, a fertilization treatment in which fertilization occurs internally as opposed to externally and in a lab.

Impact on Employer Sponsored Health Plans

Small group insurance

- Employers purchasing a small group insured health plan in Washington will have these new EHBs included as part of that coverage for plan years beginning on or after January 1, 2026.

Large group insurance

- A large insured group health plan is not required to cover any EHBs. To the extent it does and includes these new EHBs, the plan will be required to comply with the annual/lifetime limit prohibition and cost-sharing aggregation. The changes take effect for plan years beginning on or after January 1, 2026.

Self-funded group health plans

- If a self-funded group health plan includes the above benefits and the plan is benchmarked to WA, then the plan will be required to comply with the annual/lifetime limit prohibition and cost sharing aggregation for any EHBs, including these new benefits. The changes take effect for plan years beginning on or after January 1, 2026.
    - Self-funded plan sponsors may need to confirm with their TPA which state benchmark plan is applicable.
- Self-funded plan sponsors may select any of the 50 benchmark plans from any state. A plan sponsor that does not want to treat the expanded list of items and services as EHBs will need to work with their TPA to select the appropriate benchmark plan. Additionally, the benchmark plan should be identified in the SPD so amendment or updates to the SPD may be required.

- Self-funded plan sponsors that selected the Washington benchmark plan and provide fertility services through a third party may need to comply with these requirements as it relates to artificial insemination (i.e., no annual/lifetime dollar limit, cost-sharing aggregation). Employers should discuss this discuss this with the vendor.

- There is likely no issue for a plan that excludes coverage for the EHB.

2026 Cost of Living Adjustments

Issued date: 10/14/25

The IRS has released cost of living adjustments for 2026 under various provisions of the Internal Revenue Code ("Code"). Some of these adjustments may affect your employee benefit plans.

Cafeteria Plans – Health Flexible Spending Arrangements

Annual contribution limitation

For plan years beginning in 2026, the dollar limitation under Code Section 125(i) for voluntary employee salary reductions for contributions to health flexible spending arrangements ("health FSAs") increased from $3,300 to $3,400.

Annual maximum carryover

For cafeteria plans that permit the carryover option, the maximum unused amount from a health FSA that can be carried over to the following plan year is $680 for plan years beginning in 2026 (up from $660 in 2025).

Qualified Transportation Fringe Benefits

For calendar year 2026, the monthly exclusion limitation for transportation in a commuter highway vehicle ("vanpool") and any transit pass (under Code Section 132(f)(2)(A)) and the monthly exclusion limitation for qualified parking expenses (under Code Section 132(f)(2)(B)) increased from $325 to $340.

The Consolidated Appropriations Act of 2016 permanently changed the pre-tax transit and vanpool benefits to be at parity with parking benefits.

Highly Compensated

The compensation threshold for a highly compensated employee or participant (as defined by Code Section 414(q)(1)(B) for purposes of Code Section 125 nondiscrimination testing) for testing in calendar year 2026 is $160,000 in the prior year, 2025.

Under the cafeteria plan rules, the term *highly compensated* means any individual or participant who for the preceding plan year (or the current plan year in the case of the first year of employment) had compensation in excess of the compensation amount as specified in Code Section 414(q)(1)(B). *Prop. Treas. Reg. 1.125-7(a)(9).*

Key Employee

The dollar limitation under Code Section 416(i)(1)(A)(i) concerning the definition of a key employee for testing in calendar year 2026 is $230,000 in the prior year, 2025.

For purposes of cafeteria plan nondiscrimination testing, a *key employee* is a participant who is a key employee within the meaning of Code Section 416(i)(1) at any time during the preceding plan year. *Prop. Treas. Reg. 1.125-7(a)(10).*

Non-Grandfathered Plan Out-of-Pocket Cost-Sharing Limits

As previously reported, the 2026 maximum annual out-of-pocket limits for all non-grandfathered group health plans are $10,600 for self-only coverage and $21,200 for family coverage.

These limits generally apply with respect to any essential health benefits ("EHBs") offered under the group health plan. For coverage other than self-only (e.g., family coverage), the self-only annual out-of-pocket limit applies to each covered individual.

Health Reimbursement Arrangements

Qualified Small Employer Health Reimbursement Arrangements

For tax years beginning in 2026, to qualify as a qualified small employer health reimbursement arrangement ("QSEHRA") under Code Section 9831(d), the arrangement must provide that the total amount of payments and reimbursements for any year cannot exceed $6,450 ($13,100 for family coverage), which increased from $6,350/$12,800 in 2025.

Excepted Benefit Health Reimbursement Arrangements

For plan years beginning in 2026, to qualify as an excepted benefit health reimbursement arrangement ("EB HRA") under Treas. Reg. Section 54.9831-1(c)(3)(viii), the maximum amount that may be made newly available for the plan year for an excepted benefit HRA is $2,200 (increased from $2,150 in 2025).

Health Savings Accounts

As previously reported, the inflation adjustments for health savings accounts ("HSAs") for 2026 were provided by the IRS in *Rev. Proc. 2025-19.*

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)

Note 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)

      Note that 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. See IRS Notice 2004-50, Q/A-86 (Aug. 9, 2004), https://www.irs.gov/pub/irs-drop/n-04-50.pdf.

Employer Action

Employers with plan years beginning on or after January 1, 2026, should ensure the correct limits are applied to respective benefit plan options.

Immunization Schedule Updated by the CDC

Issued date: 10/16/25

On October 7, 2025, the Centers for Disease Control and Prevention ("CDC") updated its immunization schedule regarding COVID-19 and chickenpox vaccinations. Based on the new recommendations from the Advisory Committee on Immunization Practices ("ACIP"), the CDC is now recommending application of individual-based decision making to COVID-19 vaccination and that toddlers receive protection from varicella (chickenpox) as a standalone immunization.

Background

The CDC's ACIP is a federal advisory committee that makes formal recommendations as to adult and child vaccinations. The ACIP recommendations become official CDC policy once they are adopted by the CDC's Director.

The Patient Protection and Affordable Care Act ("ACA") requires group health plans and carriers to provide coverage for certain preventive services without imposing out of pocket costs, including immunizations recommended by the ACIP and adopted by the CDC.

A high-deductible health plan ("HDHP") used in connection with a health savings account ("HSA") generally must provide ACA mandated preventive care without cost-sharing. In addition, other types of preventive care (including adult and child immunizations), may be treated as preventive care and provided first dollar without affecting an individual's HSA contribution eligibility.

Updated Recommendations for Vaccines

The ACIP voted on the below actions, which were adopted by the CDC's Acting Director:

- to recommend that the COVID-19 vaccination for individuals over the age of six (6) months be based on individual-based decision making (between a health care provider and patient);
- against requiring a prescription to receive the COVID-19 vaccination; and

- to recommend that children ages 12-23 months receive the chickenpox vaccine separately, rather than in combination with measles, mumps and rubella vaccination.

The CDC's immunization schedule was formally updated on October 7, 2025.

Under the CDC's new recommendation for individual based decision-making, plans and carriers should allow coverage for COVID-19 vaccinations without imposing cost sharing requirements when provided in-network. This means that any COVID-19 vaccination received by an individual based on individual decision making would be considered an ACA preventive service, including for those with HDHP coverage.

According to a press release, the Department of Health and Human Services ("HHS") will examine all insurance coverage implications following this new recommendation. At the time of publication, no additional guidance has been issued.

Employer Action

For current plan years, prior ACIP recommendations continue to apply.

For plan years beginning after the ACIP recommendation changes (e.g., a plan year beginning January 1, 2026), non-grandfathered group health plans must provide the COVID-19 vaccine in-network and without cost sharing based on individual decision making.

- *Fully insured health plans.* Carriers are generally responsible for complying with preventive service coverage requirements and making updates as to these recommendations. Plan sponsors should not need to take any action at this time.

    - Note that some states may choose to require or recommend coverage for the COVID-19 vaccine under the prior ACIP recommendation. For example, California passed AB 144 in response to the changes to the ACIP recommendation, codifying the prior federal recommendations that were in effect as of January 1, 2025, and allowing the California Department of Public Health to supplement those recommendations. Insured health plans and HMOs in California are required to cover preventive care items and services, including immunizations, under the recommendations. State insurance mandates generally do not apply to ERISA governed self-funded health plans.

- *Self-funded health plans.* TPAs are generally responsible for complying with preventive service coverage requirements and making updates as to these recommendations. Plan sponsors should discuss any questions as to coverage changes with TPAs.

Gag Clause Attestation Due December 31, 2025

Issued date: 10/27/25

As previously reported, insurance carriers and plan sponsors of group health plans must submit information annually to the Centers for Medicare and Medicaid Services ("CMS") attesting that their plans do not include prohibited gag clauses by December 31st each year. The next attestation is due by **December 31, 2025**.

A gag clause is a contractual term that directly or indirectly restricts specific data and information that a plan or issuer can make available to another party. These clauses may be found in agreements between a plan or carrier and any of the following parties:

- A health care provider;
- A network or association of providers;
- A third-party administrator ("TPA"); or
- Another service provider offering access to a network of providers.

A gag clause may also be found in the downstream agreements of the service provider.

Carriers and TPAs are notifying clients how they intend to comply with the Gag Clause Prohibition Compliance Attestation ("GCPCA"). Similar to last year, it seems there is no uniformity as to how the various carriers/TPAs will address the attestation requirements.

Fully Insured Plans

If the group health plan is fully insured, the plan and the carrier both have the obligation to file an attestation; however, if the carrier submits the attestation on behalf of the fully insured arrangement, no further action should be required by the plan. Plan sponsors should not assume the carrier will submit the attestation on their behalf. The carrier may request information from the employer to enable submission on the employer's behalf or may decline to submit and place the obligation on the employer to file the attestation.

While we anticipate many carriers will file the attestation on behalf of fully insured group health plans, it is important to confirm your particular carrier's approach.

Self-Funded Plans

A self-funded plan (including level-funded) is responsible for the attestation; however, the plan sponsor may enter into a written agreement with the provider (TPA, PBM) to submit the attestation on behalf of the plan. TPAs may request information from the employer to enable submission on the plan's behalf. That said, some TPAs have indicated they will not submit the attestation for the plan. If that is the case, plan sponsors will need to submit the attestation for their plans and should obtain written confirmation from the TPA and other service providers that the contractual arrangements (including any downstream agreements) do in fact satisfy the gag clause prohibition requirements.

Plan sponsors who will need to file an attestation will submit their attestation via the webform by selecting the link for "Gag Clause Prohibition Compliance Attestation" at hios.cms.gov/HIOS-GCPCA-UI.

Plan sponsors should carefully review any communication provided by the carrier or TPA to ascertain what approach they will undertake for the December 31, 2025 submission.

Illinois PBM Law Takes Effect January 1, 2026

Issued date: 10/28/25

New legislation, the Prescription Drug Affordability Act (the "Act"), expands requirements on pharmacy benefits in Illinois. The law joins a trend across the country in regulating pharmacy benefit managers ("PBMs") to prevent certain common industry practices, including spread pricing, steering to PBM owned or affiliated pharmacies, as well as retention of prescription drug rebates. In addition, the law imposes a new fee on PBMs that is likely to be passed on to carriers and employer-sponsored group health plans.

The provisions of the Act are summarized below. Unless stated otherwise, all the reforms take effect for all plans that are amended, delivered, issued, or renewed on or after January 1, 2026.

Prohibition on Spread Pricing

Spread pricing is a practice where a pharmacy benefit manager supplies prescription drugs to a retail pharmacy for one price and then charges the health plan a greater price. The difference between the two prices, or the "spread" is retained by the PBM as a revenue stream. The Act prohibits PBMs from engaging in spread pricing. A violation of this provision is considered an unfair and deceptive practice and may be subject to civil penalties and/or license revocation.

Steering Prohibited

At times, PBMs and health insurers will offer more advantageous pricing to plans and members to fill prescriptions at pharmacies that are owned or affiliated with the PBM. This can negatively impact independent and rural pharmacies by reducing their volume. Under the Act, insurers and PBMs are prohibited from requiring participants to fill prescriptions exclusively through a mail-order or specialty pharmacy that is affiliated with the PBM, designating drugs as specialty medications solely for the purpose of limiting access, and requiring individuals to use a PBM-affiliated retail pharmacy if it would result in an increased cost to participants.

Prescription Rebates

Many prescription drug manufacturers issue rebates to PBMs when their brand name drug is filled, making the brand drug relatively more attractive and competitive when compared to a generic therapeutic equivalent. Depending on market segment and contract, the PBM may not pass through all of the rebates to the health insurer or the plan sponsor, retaining those rebates as an additional revenue stream. The Act requires the PBM to remit 100% of all prescription drug manufacturer rebates to the health benefit plan sponsor, covered individual, or employer. Records demonstrating compliance must be remitted to the Illinois Department of Insurance annually.

Transparency Rights and Reporting

All contracts between a PBM and a plan sponsor or an insurer must now contain a term that permits the sponsor or insurer the right to audit compliance with the terms of the contract at least once per year. The PBM must pay for the cost of the audit. The audit may be performed by an auditor selected by the plan sponsor, the insurer, or a designee. The plan must then give a copy of the audit to the PBM, which will remit a copy to the IL Department of Insurance within 60 days.

In addition, PBMs must annually submit reports to the IL Department of Insurance, health benefit plan sponsors, and each insurer no later than September 1st. The report must include the following information, amongst other data:

- List of drugs including therapeutic class, brand name, generic name, or specialty drug name;
- Number of covered individuals;
- Number of drug-related claims;
- Average wholesale acquisition cost per drug;
- Amount received by the plan in rebates, fees, or discounts related to drug utilization or spending;
- Total gross and net spending by health benefit plan;
- Any information collected by drug manufacturers pertaining to copayment assistance;
- And any compensation paid to brokers, consultants, advisors or any other individual or firm for referrals, consideration, or retention by the health benefit plan.

If the PBM fails to provide all required elements to the Department of Insurance, a fine up to $10,000 per day, per offense may apply.

Tax

On or before September 1st, 2025, and annually thereafter, all PBMs licensed to do business in Illinois must remit the IL Department of Insurance $15 (or an alternate amount determined by the Director of the Department of Insurance) per covered individual enrolled by the pharmacy benefit manager in Illinois. These amounts will be placed in a Prescription Drug Affordability Fund in the State Treasury. The first $25m collected annually shall be placed into a Department of Commerce and Economic Opportunity Projects Fund for grants to pharmacies. While the fee per covered individual must be paid by the PBM, it is likely that those amounts will be passed on to plans or insurers for reimbursement.

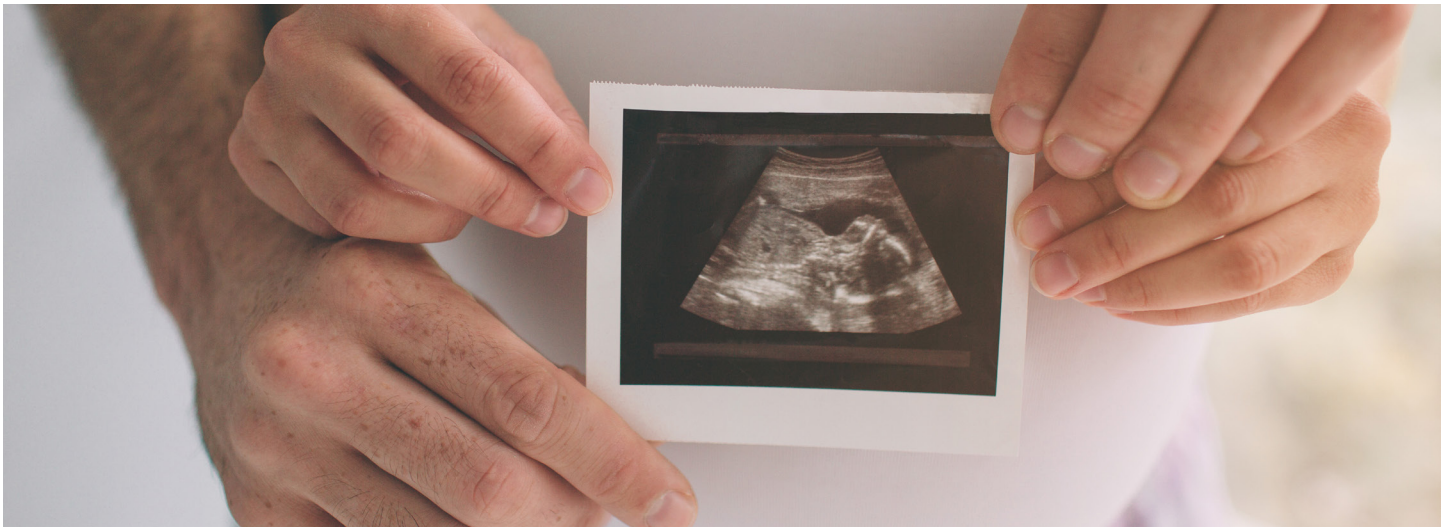
Who Does the Act Apply To?

These new requirements apply to PBMs that administer both fully insured and self-funded programs in Illinois.

Certain aspects of this PBM law could be preempted as to self-funded plans under ERISA (for example the prohibition on steering). ERISA preempts state laws that have a substantial impact on employer-sponsored health plans. At this time, there do not seem to be any legal challenges to this law, but we will continue to monitor developments.

ERISA does not apply to plans administered by state or local governments or church plans.

Employers should discuss the implication of these new requirements with carriers, third-party administrators, and PBMs.



Illinois Mandates Fertility Benefits & Dependent Coverage for Parents

Issued date: 10/29/25

The Illinois legislature enacted two new laws impacting certain health benefits plans. These provisions take effect for policies issued, amended, delivered or renewed in Illinois on or after January 1, 2026.

Briefly, these Illinois benefit mandates:

- Broaden benefits related to infertility treatment, and
- Expand dependent coverage to include the tax dependent parent (or stepparent) of the insured.

These provisions apply to fully insured group health plans issued in Illinois. ERISA covered self-funded health plans are not required to comply.

Mandatory Fertility Benefits

The new law broadens mandatory coverage of infertility and provides that no group policy of accident and health insurance that provides pregnancy-related benefits may be issued, amended, delivered, or renewed in Illinois on or after January 1, 2026, unless the policy contains coverage for the diagnosis and treatment of infertility, including specified procedures. Covered plans must also include coverage for the procedures necessary to screen or diagnose a fertilized egg before implantation.

State insurance mandates are generally pre-empted by ERISA and apply to fully insured group health plans with Illinois as their situs state. However, since the law also amended the County, Municipal, and School Codes, the mandates also apply to non-ERISA self-funded group health plans sponsored by Illinois state or local governmental entities as well as public schools.

Additionally, any group policy that covers more than 25 employees that is amended, delivered, issued, or renewed on or after January 1, 2026, shall provide, for individuals 45 years of age and older, coverage for an annual menopause health visit without any cost-sharing applied to the insured member.

Dependent Parent and Stepparent Coverage

The Illinois Insurance Code was amended so that a group or individual policy of accident and health insurance issued, amended, delivered, or renewed after January 1, 2026, which provides dependent coverage, shall make that dependent coverage available to the parent or stepparent of the insured if the parent or stepparent:

- Meets the definition of a qualifying relative under 26 U.S.C. 152(d); and
- Lives or resides within the accident and health insurance policy's service area.

The expanded definition does not apply to specialized health care service plans, Medicare supplement insurance, hospital-only policies, accident-only policies, or specified disease insurance policies that reimburse for hospital, medical, or surgical expenses.

Generally, to satisfy the definition of a "qualifying relative" the parent or stepparent must have:

1. Gross income for the calendar year in which such taxable year begins that is less than $5,200 for 2025 (*as indexed for inflation*); and
2. The taxpayer (the primary insured) provide over one-half of the individual's support for the calendar year in which such taxable year begins.

This Illinois state insurance mandate is generally preempted by ERISA and would only apply to fully insured group health plans with Illinois as their situs state.

Employer Action

Carriers issuing and renewing group health plan policies in Illinois should be making the necessary changes to the plan designs to comply with the law.

Self-funded non-ERISA plans employers should work with their TPAs and stop loss carriers to comply with new fertility requirements.

If applicable, employers should amend plan documents to make sure to include dependent parent/stepparent eligibility language.

New York Paid Family Leave 2026 Contributions and Benefits

Issued date: 10/31/25

The New York State Department of Financial Services has announced the contribution rate under the New York Paid Family Leave ("PFL") law effective January 1, 2026, will be set at **0.432%** of weekly wages, an 11.31% increase from last year.

Employee contributions for PFL are calculated as a percentage of an employee's gross wages per pay period up to the maximum contribution based on the *annualized* New York State Average Weekly Wage ("NYAWW"). For 2026:

- NYAWW in effect will be $1,833.63, an increase of 4.3% from the 2025 NYAWW of $1,757.19. The *annualized* NYAWW is $95,348.76.
- The maximum annual employee contribution will be $411.91 ($354.53 in 2025).

The PFL benefit is 67% of an employee's Average Weekly Wage (up to the NYAWW) payable for 12 weeks. For 2026:

- The maximum weekly PFL benefit will be $1,228.53 ($1,177.32 in 2025).
- The maximum annual PFL benefit payable for 12 weeks will be $14,742.36 ($14,127.84 in 2025).

The following should be noted:

- The maximum amount of PFL and disability leave under the New York Disability Law ("DBL") that may be taken in a *52-consecutive week period* is limited to 26 weeks.
- If an employee begins continuous leave in 2025 and the leave extends into 2026, the benefit is based on the rate in effect on the first day of leave (i.e., in 2025) and is not recalculated at the 2026 rate.
- If an employee begins intermittent leave in 2025 and the leave extends into the following year and there is at least a three-month lapse in days taken under New York PFL, the leave is considered a new claim under the law in 2026, and the benefit is calculated at the 2026 rate.

Employer Action

Employers should prepare for the 2026 New York PFL contribution and benefit changes that begin in January. PFL coverage will typically be added as a rider on an employer's existing disability insurance policy, although benefits can be provided through a self-funded plan approved by the New York Workers' Compensation Board.

Fertility Services as Excepted Benefits

Issued date: 10/31/25

The expansion of access to infertility treatment and specifically IVF has been a priority of the Trump Administration. On October 16, 2025, the Departments of Labor, Health and Human Services, and the Treasury (collectively, "the Departments") issued FAQs about Affordable Care Act Implementation Part 72 ("FAQ 72") to provide new guidance that allows employers to offer coverage to employees for fertility treatments as excepted benefits.

Background

Under the Affordable Care Act ("ACA"), group health plans ("GHPs") offered to employees must satisfy various market reform provisions or risk significant penalties. There are four categories of benefits that are not subject to the ACA market reforms if they meet stringent requirements to qualify as excepted benefits. They are:

1. Benefits that are generally not health coverage – e.g., automobile insurance, liability insurance, and workers' compensation insurance.

2. Limited excepted benefits – e.g., limited scope dental and vision insurance, long term care, and nursing home care.

    - Pursuant to subsequent rule making, the following benefits may qualify as limited excepted benefits: certain employee assistance programs ("EAPs"), and excepted benefit health reimbursement arrangements ("EBHRAs").

3. Independent, non-coordinated excepted benefits – e.g., coverage for a specified disease or illness, hospital indemnity, and other fixed indemnity insurance.

4. Supplemental excepted benefits – e.g., Medigap, CHAMPVA, or similar coverage that is supplemental to GHP coverage.

FAQ 72 provides a mechanism for certain fertility benefits to be provided as independent, non-coordinated excepted benefits (3) or limited excepted benefits (2) above.

Independent Non-Coordinated Excepted Benefits

Coverage for specified diseases or illnesses, such as cancer-only policies, or hospital indemnity or other fixed indemnity coverage, can be excepted benefits when they satisfy the following conditions:

- The benefits are provided under a separate policy, certificate, or contract of insurance,
- There is no coordination between the provisions of such benefits and any exclusion of benefits under any GHP maintained by the same employer, and
- The benefits are paid with respect to an event regardless of whether there is other coverage under any GHP offered by the same employer, or individual coverage offered by the same carrier.

Based on FAQ 72, employers may now offer fertility benefits that satisfy the above conditions as excepted benefits. This includes employers that do not offer a traditional GHP with major medical coverage, as well as coverage for employees that are not enrolled in major medical coverage offered by their employer.

Importantly, to qualify as an excepted benefit under this definition the benefit must be provided under an insurance policy. A self-funded fertility benefit will not meet this definition. Additionally, there can be no coordination between the benefits provided by the excepted fertility benefits and any exclusion of benefits under any GHP offered by the same plan sponsor.

It should be noted that, currently, there may not be options in the insurance market to purchase fertility coverage that meets the requirements to qualify as an excepted benefit. It will be interesting to see whether the market develops specific disease/illness insurance policies that provide fertility benefits.

HSA Contribution Compatibility

Employees covered on a high-deductible health plan ("HDHP") may not have other impermissible coverage in order to maintain eligibility to make or receive HSA contributions. However, additional coverage for a specific disease or illness is permitted. FAQ 72 makes clear that fertility treatment coverage offered as a non-coordinated excepted benefit can be provided to employees with HDHP coverage with no impact on their eligibility to make or receive HSA contributions.

Limited Excepted Benefits

Under the limited excepted benefits rules, employers may offer an EBHRA that satisfies the following conditions:

- Other GHP coverage that is not limited to excepted benefits is made available by the plan sponsor
- Benefits are limited in amount – $2,200 for plan years beginning in 2026 and indexed annually
- The HRA may not reimburse premiums for other individual coverage, group coverage, or Medicare coverage that are not excepted benefits
- The HRA must be offered on the same terms to all similarly situated individuals

EBHRAs must comply with ERISA notice requirements and provide notice including the following:

- A description of eligibility conditions to receive benefits,
- Annual or lifetime dollar limits,
- Other limits on benefits under the plan, and

- A description or summary of the benefits

If the above conditions are satisfied, an employer may provide coverage for fertility services via an EBHRA that reimburses out of pocket costs related to fertility services.

It is important to note that, while this relief is helpful, the annual EBHRA benefit limit ($2,200 for 2026) may not be enough to cover the out-of-pocket costs associated with fertility expenses.

Employee Assistance Programs

The guidance further allows employers to include coaching and navigator services to help employees understand their fertility options under an EAP that qualifies as a limited excepted benefit. The FAQ makes clear that the addition of fertility-related coaching or navigator services to an EAP will not risk the EAP's status as an excepted benefit.

Importantly, the FAQ notes that an EAP cannot qualify as an excepted benefit if it:

- Offers any fertility benefits that are significant benefits for medical care,
- Coordinates benefits with any GHP,
- Requires employees to pay premiums for coverage, or
- Imposes any cost sharing

Penalties

If fertility benefits are not integrated with major medical coverage or do not meet the definition of an excepted benefit (as described above), these benefits may not satisfy the ACA's market reforms and risk a penalty equal to $100 per person per day ($36,500 annually).

Many employers integrate the fertility benefits/program into a major medical group health plan that otherwise satisfies the ACA market reforms.

Employer Action

Many vendors provide fertility services through programs that are not structured to qualify as excepted benefits. Usually, the fertility benefits are integrated into the major medical plan coverage (which otherwise meets the ACA's market reforms).

Importantly, the guidance does not limit employers to providing fertility benefits through these excepted benefits options. Rather, the FAQ is providing clarity on additional avenues through which an employer may provide fertility services as excepted benefits to avoid risking ACA market reform violations.

Employers currently offering fertility benefits should discuss FAQ 72 with their vendor to determine if the program currently qualifies as an excepted benefit or whether any changes are needed. Again, a self-funded fertility benefit will not be able to qualify as an independent non-coordinated excepted benefit.

Employers considering adding fertility benefits should carefully review the guidance to determine whether providing fertility services as an excepted benefit meets their needs.

Employers sponsoring EAPs that would like to add fertility coaching or navigator services should reach out to the EAP provider to ensure these services are provided within the boundaries of the guidance.

Reminder: Massachusetts HIRD Reporting Due December 15, 2025

Issued date: 11/03/25

As a reminder, Massachusetts employers must file the annual Health Insurance Responsibility Disclosure ("HIRD") form through the MassTaxConnect ("MTC") web portal. The HIRD reporting will be available to be filed starting November 15th and must be completed by December 15th.

The HIRD form collects employer-level information about employer-sponsored health insurance ("ESI") offerings. The HIRD form assists MassHealth in identifying members with access to qualifying ESI who may be eligible for the MassHealth Premium Assistance Program.

State law requires every employer with six or more employees in Massachusetts to annually submit a HIRD form. If you are an employer who currently has (or had) six or more employees in any month during the past 12 months preceding the due date of this form (December 15 of the reporting year), you are required to complete the HIRD form.

- An individual is your employee if you, as the employer, included such individual in your quarterly wage report to the Department of Unemployment Assistance ("DUA") during the past 12 months. You are required to complete the HIRD form if you reported six or more employees (includes all employment categories) in any DUA wage report during the past 12 months.

- If you are an out-of-state employer that is not required to file a quarterly wage report to the DUA, an individual is your employee if they are hired for a wage or salary in Massachusetts to perform work, regardless of full-time or part-time status.

For HIRD FAQs, visit: www.mass.gov/info-details/health-insurance-responsibility-disclosure-hird-faqs.

For more information about the Premium Assistance Program and additional employer resources, visit the MassHealth Premium Assistance web page: www.mass.gov/info-details/masshealth-premium-assistance-pa.

Massachusetts Paid Family Leave 2026 Contributions and Benefits

Issued date: 11/04/25

The Massachusetts Department of Family and Medical Leave ("DFML") has recently announced the contribution rate, the State Average Weekly Wage, and the maximum weekly benefit amount for the Massachusetts Paid Family and Medical Leave ("PFML") program effective January 1, 2026. The DFML has also published the FY2025 Annual Report for the PFML program.

Contributions

The 2026 contribution rate on eligible wages will be 0.88% (the contribution rate remains unchanged since 2024). Individual contributions are capped by the Social Security income limit. The 2026 Social Security income limit is expected to be released later in October and will likely be significantly higher than the 2025 limit which is currently set at $176,100.

If an employer has at least 25 covered individuals (i.e., employees and 1099 contractors in MA), both the employer and the employee share in the cost of medical leave benefits. The employee is responsible for the entire cost of family leave benefits. The following illustrates the PFML contribution breakdown for 2026:

- Medical Leave Contribution: **0.70%** of eligible wages allocated as follows:
    - Employer: At least 60% of the medical leave cost is paid by the employer (0.42%)
    - Employee: No more than 40% of medical leave can be deducted from the employee's wages (0.28%).
- Family Leave Contribution: 0.18% of eligible payroll deduction
    - May be paid entirely from employee wages (no employer contribution required).

If the employer has fewer than 25 covered individuals in Massachusetts, the employer is not required to contribute toward the medical or family leave portions of the benefit. The employee's 2026 contribution for medical and family leave benefits is 0.46% of eligible wages.

Amount of Benefit

The weekly benefit amount for employees and self-employed individuals on family or medical leave is determined as follows:

- the portion of an employee's or self-employed individual's average weekly wage ("AWW") that is equal to or less than 50 percent of the state average weekly wage ("MAAWW") is replaced at a rate of 80 percent; and
- the portion of an employee's or self-employed individual's AWW that is more than 50 percent of the MAAWW is replaced at a rate of 50 percent, up to the maximum allowed benefit amount.

For 2026:

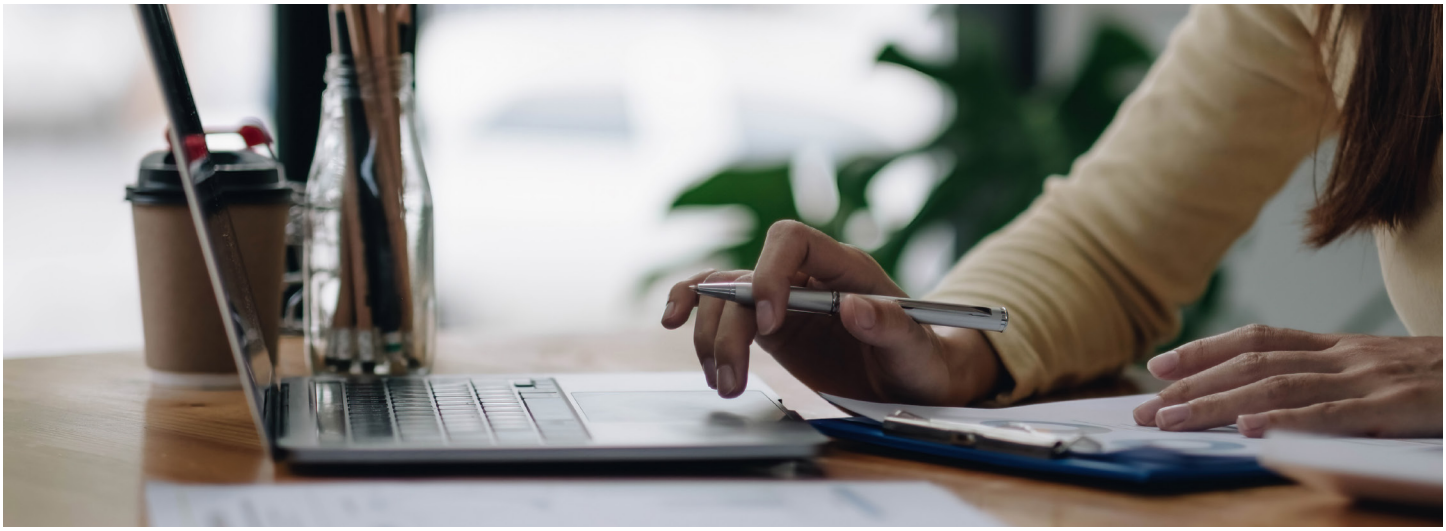
- The MAAWW will be $1,922.48, an increase of 5.1% from the 2025 MAAWW of $1,829.13.
- The maximum weekly PFML benefit will be $1,230.39, an increase of 5.1% from the maximum weekly benefit of $1,170.64 in 2025

FY2025 Annual Report

As required by the Family and Medical Leave Law, the DFML has issued its annual report containing information on benefits, applications, and certain characteristics of applicants during Fiscal Year 2025.

Employer Action

Employers should prepare for the 2026 PFML contribution and benefit requirements by working with payroll processors, approved private plan vendors and employment counsel to ensure their leave policies and procedures are compliant by January 2026. Updated workplace posters and notifications for the 2026 contribution rates and benefit amounts will be available to employers on the PFML website soon.



New PCOR Fee Announced

Issued date: 11/07/25

On November 3, 2025, the IRS released Notice 2025-61, announcing that the adjusted applicable dollar amount used to determine the PCOR fee for plan years ending on or after October 1, 2025, and before October 1, 2026, is $3.84.

The PCOR filing deadline is **July 31, 2026**, for all self-funded medical plans (including level-funded) and some HRAs (including ICHRAs) for plan years (including short plan years) ending in 2025. Carriers are responsible for paying the fee for insured policies.

PCOR fee due July 31, 2026:

Plan Years Ending on	Amount of PCOR Fee
January 31, 2025	$3.47/covered life/year
February 28, 2025	$3.47/covered life/year
March 31, 2025	$3.47/covered life/year
April 30, 2025	$3.47/covered life/year
May 31, 2025	$3.47/covered life/year
June 30, 2025	$3.47/covered life/year
July 31, 2025	$3.47/covered life/year
August 31, 2025	$3.47/covered life/year
September 30, 2025	$3.47/covered life/year
October 31, 2025	**$3.84/covered life/year**
November 30, 2025	**$3.84/covered life/year**
December 31, 2025	**$3.84/covered life/year**

Employer Action

For now, no action by employers with self-funded health plans (or an HRA) is required. It is important to note that we have seen increased enforcement activity from the IRS around missing PCOR fees. Specifically, the IRS is issuing notices to employers who appear to have missed a prior year PCOR fee filing, requesting payment (including interest and penalties).

For the Form 720 and Instructions, visit www.irs.gov/forms-pubs/about-form-720. The Q2 Form 720 for 2025 which is used to file and pay this fee is typically not available until April of the filing year.

California Enacts PBM Reform Law

Issued date: 11/07/25

A recently enacted California law establishes extensive new requirements for pharmacy benefit managers ("PBMs") doing business in the state. The law is intended to increase regulatory oversight, enhance transparency, and address the revenue-generating abilities of PBMs. Effective dates vary by provision, with many going into effect on January 1, 2026.

Senate Bill 41

On October 11, 2025, California Governor Gavin Newsom signed Senate Bill 41 ("SB 41") into law. SB 41 covers a wide range of topics relating to PBMs. This update summarizes key provisions that could affect employer-sponsored health plans, and is not intended to cover all details of the law.

Price and Compensation

- No spread pricing. PBMs are prohibited from including spread pricing in contracts starting January 1, 2026. Spread pricing is a model of prescription drug pricing in which the contracted price charged for a drug by a PBM differs from the amount paid to the pharmacy. Spread pricing terms in existing contracts will be void on or after January 1, 2029.

- Passthrough pricing required. PBMs must use a passthrough model of pricing for prescription drugs. Under this model, payments made by a health care service plan or health insurer to a PBM for a prescription drug must equal the payments the PBM makes to a pharmacy for the drugs, including dispensing fees.

- 100% rebate passthrough. The law requires PBMs to direct 100% of manufacturer rebates received to be passed through to the payer or program for the sole purpose of offsetting cost sharing and reducing premiums for plan participants.

- Cost sharing cannot exceed the "actual rate" paid or "net price" paid. Health care service plan contracts or health insurance policies issued, amended, or renewed on or after January 1, 2026, are generally prohibited from calculating an insured's cost sharing for a prescription drug (including deductibles and copayments) at an amount that is greater than the "actual rate" paid by the plan for the drug or, if the contract includes disclosure of the "net price," the "net price" paid by the PBM for the drug.

- Note that these cost-sharing requirements appear to only apply to fully insured plans issued in California. They are not applicable to ERISA self-funded plans.

- Limitations on PBM compensation. PBMs cannot derive income from PBM services provided to a payer other than a defined service fee for those services. The amount must be defined in the agreement between the PBM and payer and cannot be tied to drug prices or patient cost sharing. The law permits performance bonuses to PBMs based on savings, depending on what the bonus is based.

- Other pharmacy pricing protections.

  - PBMs cannot reduce payments for pharmacist services under a reconciliation process to achieve certain reimbursement rates.

  - PBMs cannot retroactively deny or reduce pharmacy claims after adjudication except in limited circumstances (e.g., the claim was submitted fraudulently).

  - PBMs can reverse and resubmit claims from a contract pharmacy only: (1) with prior written notification; (2) with just cause or after attempting to first reconcile the claim; and (3) within 90 days of the claim being adjudicated.

  - PBMs cannot charge a pharmacy a fee to process claims electronically.

Limitations on Manufacturer Exclusivity and Treatment of Nonaffiliated Pharmacies

- Limitations on exclusivity with manufacturers. PBMs cannot enter exclusive arrangements with manufacturers on or after January 1, 2026, unless it can be demonstrated that the arrangements result in the lowest cost to the payer and the lowest cost sharing for the plan participant.

- Limitations on favorable treatment of affiliated pharmacies over nonaffiliated pharmacies. PBMs are prohibited from denying a nonaffiliated pharmacy the opportunity to participate in their network if the pharmacy is willing to accept the same terms and conditions established for affiliated pharmacies. The law also limits certain "steering" actions by PBMs that favor affiliated pharmacies over nonaffiliated pharmacies (e.g., requiring a plan participant to use only an affiliated pharmacy if there are nonaffiliated pharmacies in the network). PBMs are prohibited from discriminating against a nonaffiliated pharmacy in connection with dispensing drugs. PBMs also cannot enter into contracts that restrict or impose exclusivity on nonaffiliated pharmacies' ability to contract with employers and payers, beginning January 1, 2026.

Regulatory Oversight, Transparency, and Ethical Obligations

- Licensure requirement. For PBM contracts issued, amended, or renewed on or after January 1, 2027, the PBM must be licensed and in good standing with the California Department of Managed Health Care ("DMHC").

- Ethical and fiduciary obligations. PBMs must exercise good faith and fair dealing and must inform a purchaser in writing of any activity, policy, or practice presenting a conflict of interest. PBMs owe a fiduciary duty to a self-insured employer plan, as well as a payer client, which includes a duty to be fair and truthful toward the client, to act in the client's best interests, to avoid conflicts of interest, and to perform its duties with care, skill, prudence, and diligence.

- Disclosure and reporting requirements. PBMs must provide detailed disclosures to a purchaser, including drug pricing, rebate, administrative fee, drug utilization, and pharmacy financial arrangement information, quarterly upon request. PBMs must also submit financial statements to the DMHC. The DMHC may conduct periodic routine and nonroutine surveys of a PBM.

Scope and Applicability

SB 41 aims to regulate PBMs conducting business in California, which will affect fully insured group health plans that contract with PBMs in the state.

While SB 41 specifically excludes a "self-insured employee welfare benefit plan" subject to ERISA from the definition of a PBM, it is unclear how much of the law intends to apply to PBMs working with self-insured plans. Certain provisions regulating PBM practices are drafted in a way that may affect PBM contracts more broadly, including those with self-funded ERISA plans. The law also specifically addresses a PBM's fiduciary obligation to self-insured employer plans, as well as to payer clients.

State PBM laws that are merely regulating PBM reimbursement practices to pharmacies are not preempted by ERISA. Indeed, SB 41 appears to have been drafted with an intent to avoid ERISA preemption. However, given the evolving ERISA preemption landscape with respect to state PBM laws, it is not yet clear which provisions of SB 41 will be preempted by ERISA and therefore not apply to self-funded ERISA plans.

Additional guidance from the California Department of Insurance (DOI) and DMHC is expected and we will continue to monitor this issue as more information and regulations become available.

The law specifically does not apply to a collectively bargained Taft-Hartley self-insured plan under ERISA or to a PBM's provision of PBM services pursuant to that Taft-Hartley plan.

Employer Action

Employers that sponsor fully insured plans contracting with PBMs in California can expect their insurance carrier to work with the PBMs to comply with the new requirements and do not need to take any action at this time.

Employers that sponsor self-funded plans contracting with PBMs in California should reach out to their TPA and/or PBM to determine if the new law requires any benefit design changes.

Final 2025 ACA Reporting Instructions and Forms Issued

Issued date: 11/10/25

The IRS released final instructions and forms for calendar year 2025 ACA reporting, including Forms 1094-C, 1095-C, 1094-B, and 1095-B. As a reminder, it is important to ensure the forms are accurate, timely furnished to participants and filed with the IRS as good faith relief from penalties is no longer available.

There are no significant changes to the 2025 forms.

Forms 1094-C/1095-C

Applicable large employers ("ALEs") must furnish Form 1095-C to full-time employees and file Form 1094-C and all 1095-Cs with the IRS. ALEs offering a self-insured group health plan must also furnish Forms 1095-C to covered employees or other primary insured individuals in the self-funded health plan (e.g., covered part-time employees, COBRA qualified beneficiaries).

It is important to note that self-funded health plans include level-funded arrangements and individual coverage health reimbursement arrangements ("ICHRAs").

The calendar year 2025 Form 1095-C must be furnished to full-time employees and other individuals by March 2, 2026. The Form 1094-C and all Forms 1095-C must be filed with the IRS electronically by March 31, 2026.

ALEs, in coordination with their payroll or other reporting vendors, should have records to determine each employee's status as an ACA FTE or not an ACA FTE for each month during 2025 in preparation to complete, furnish and file these forms for 2025.

Forms 1094-B/1095-B

Employers that are not ALEs and offer self-funded group health plan coverage, including level-funded plans and ICHRAs, must furnish and file forms regarding minimum essential coverage. Specifically, as the provider of the self-funded plan, the employer reports to the IRS and all covered individuals (e.g., employees, COBRA qualified beneficiaries, spouses,

dependents) the coverage they had during the calendar year. To meet this requirement, employers use Forms 1094-B and 1095-B.

The calendar year 2025 Form 1095-B must be furnished to covered individuals by March 2, 2026. Form 1094-B and all Forms 1095-B must be filed with the IRS electronically by March 31, 2026.

Employers should coordinate with payroll or other reporting vendors to assist in this process.

What's New?

There are no significant changes to the 2025 forms, however, the instructions include further explanation of the relief available for furnishing these Forms to full-time employees and covered individuals in a self-funded health plan.

Employers are permitted to only furnish these Forms upon request when certain requirements are met, including providing advance notice. An employer that wants to take advantage of this relief, and only furnish the Form upon request, must:

- Provide a clear, conspicuous and accessible notice on its website so that an individual may request a copy of their statement.
- Post the notice by March 2, 2026, and have it remain accessible through October 15, 2026.
- Upon request, timely furnish a copy of the statement. A statement is timely furnished if provided no later than the later of January 31, 2026, or 30 days after the date of the request.

Notice requirement

The notice should:

- Be written in clear language with font size large enough (or provide other visual cues) to call to the reader's attention that the notice contains important tax information.
- Contain a statement that individuals have a right to receive a copy of the Forms upon request as well as contact information (e-mail, mailing address, and phone number) and instructions on how to request a copy of the Form(s).
- Be posted in a location on the employer's website that is reasonably accessible to all individuals. For example, a reporting entity's website provides a clear and conspicuous notice if it includes a statement on the main page – or a link on the main page, reading "Tax Information," to a secondary page that includes a statement in capital letters "IMPORTANT HEALTH COVERAGE TAX DOCUMENTS."

While the IRS did not furnish a sample notice in its guidance, it referred to a notice found in previously issued regulations. Note that employers that are required to furnish Forms 1095-C (or 1095-B) pursuant to a state individual coverage mandate may still need to furnish these Forms as they have in prior years to covered employees who reside in states with an individual mandate (e.g., California, Washington D.C., New Jersey, and Rhode Island).

Electronic Filing Required (10+ Forms)

Employers required to file 10 or more information returns (e.g., Forms W-2, 1094-C, 1095-C, 1094-B, 1095-B) during the year must file these forms electronically with the IRS on or after January 1, 2024. Previously, the IRS allowed employers filing fewer than 250 returns to file hard-copy (paper) forms.

The IRS also encourages employers filing fewer than 10 returns to consider electronic filing.

Penalties for Non-Compliance

The instructions reiterate that all ALEs and other employers that sponsor self-funded group health plans that fail to comply with the information reporting requirements may be subject to the general reporting penalty provisions for failure to file correct information returns and failure to furnish correct payee statements. *Good faith relief is no longer available.* However, penalties may be waived if the failure is due to reasonable cause and not willful neglect.

For 2025, the following penalties may apply:

- Failure to file a correct return is $340/statement (total calendar year penalty not to exceed $4,098,500).
- Failure to furnish a correct statement is $340/statement (total calendar year penalty not to exceed $4,098,500).

It should be noted that an employer that fails to both file and furnish a correct statement is subject to a combined penalty of $680/statement with a maximum penalty of $4,098,500.

Employer Action

It is important to identify vendors, like payroll or other reporting administrators, to assist in this process, especially as most employers will be required to file forms electronically with the IRS. A health plan carrier typically does not prepare this reporting.

ALEs should begin preparing and ensure that Form 1095-C is furnished to full-time employees and other individuals by March 2, 2026. Form 1094-C and all Forms 1095-C should be electronically filed with the IRS by March 31, 2026.

Employers that are not ALEs but offer self-funded group health plan coverage should ensure a process is in place for furnishing and filings Forms 1094-B and 1095-B. Form 1095-B must be furnished to covered individuals by March 2, 2026, and all forms 1095-B along with Form 1094-B must be electronically filed with the IRS by March 31, 2026.

Employers choosing to take advantage of the available relief, and only furnish the applicable Forms upon request, must review and implement the specific notice requirement and timely furnish Forms upon request. Don't forget that all Forms 1095-C along with Form 1094-C (or all Form 1095-B along with Form 1094-B) must still be filed with the IRS.

Employers should be certain the statements are complete and accurate since good faith relief is no longer available.

Employers may have additional reporting obligations for employees residing in states with an individual mandate (California, Massachusetts, New Jersey, Rhode Island, Vermont, Washington D.C.). Ensure vendors will assist with state reporting obligations. We will issue a compliance update when information on state reporting for 2025 becomes available.

Texas' Woman and Child Protection Act

Issued date: 11/17/25

Effective December 4, 2025, the Woman and Child Protection Act (the "Act," also known as House Bill 7) allows individuals to sue individuals who import abortion drugs into Texas, with potential damages of at least $100,000 per violation.

Background

Following the Supreme Court's decision in *Dobbs v. Jackson Women's Health Organization* (2022), which overturned *Roe v. Wade*, and Texas' subsequent criminal ban on all elective abortion under the Human Life Protection Act, abortion-inducing drugs are increasingly being purchased online from out-of-state entities. Texas is seeking to curtail this practice by creating civil remedies similar to those in the Texas Heartbeat Act which allows individuals to bring civil lawsuits against those who perform or are involved in the facilitation of a medical abortion.

The Act

The Act authorizes a private citizen to initiate a civil action against anyone who manufactures, distributes, mails, transports, delivers, prescribes, or provides abortion-inducing drugs in Texas. Remedies include injunctive relief, damages of at least $100,000 per violation, and attorneys' fees and costs. A private citizen unrelated to a pregnant woman seeking abortion pills would receive $10,000, with $90,000 going to the charity of their choice, if they prevail.

In defining who could be a defendant in a civil action under the Act, the list is extensive and includes out-of-state actors.

The bill includes several exemptions, including:

- Suits against pregnant women seeking or obtaining abortion-inducing drugs for their own abortions;
- Suits against hospitals, health care facilities, and physician groups;
- Abortion-inducing drugs used for medical emergencies, ectopic pregnancies, or removing a deceased unborn child;

- Conditional exemptions for internet service providers, search engines and cloud providers, transportation companies, delivery networks, and pharmaceutical manufacturers; and

- "Speech or conduct protected by the First Amendment."

Potential Effects on Health Plans

Importantly, in the context of employee benefits, there is no exemption for plan sponsors. Therefore, an employer whose drug program covers abortion-inducing drugs in violation of this law might be held liable.

The Act does not expressly define what "distribute" or "provide" means, or at what point First Amendment protected conduct crosses into "providing" abortion-inducing drugs.

Because lawsuits can be brought by private citizens, plan sponsors face the risk of litigation from ideologically or financially motivated individuals, even if the legal grounds are tenuous. Defending against these lawsuits could be costly, regardless of the outcome.

Under ERISA, state law is preempted to the extent that it relates to benefits. Although unclear, employers other than governmental and church employers may be protected under this doctrine.

Abortion shield laws (state-level protections designed to shield individuals seeking and providing reproductive care from legal action, particularly from out-of-state investigations and prosecutions) enacted in the provider's home state have made it challenging for these types of lawsuits to advance.

Employer Action

Employers with self-funded plans covering abortion-inducing drugs in Texas should decide whether they want to continue to do so.

Employers should watch for further developments, as this law is expected to face legal challenges.

California Redefines Approach to Preventive Care Standards

Issued date: 11/18/25

California has enacted legislation allowing the state to set its own standards for preventive care required to be provided at no cost by fully insured health plans. The new law adopts the federal recommendations for preventive care and immunization coverage as they existed on January 1, 2025, as a baseline, and authorizes the state to modify or supplement these guidelines in the future. The new state law does not apply to self-funded plans governed by ERISA.

Background

Under the Patient Protection and Affordable Care Act ("ACA"), non-grandfathered group health plans must provide coverage for in-network preventive items and services and may not impose any cost-sharing requirements (such as a copayment, coinsurance, or deductible) with respect to those items or services. Specifically, the following must be covered as preventive:

- Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force ("USPSTF");
- Immunizations for routine use in children, adolescents, and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices ("ACIP") of the Centers for Disease Control and Prevention ("CDC");
- With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration ("HRSA"); and
- With respect to women, preventive care and screening provided for in comprehensive guidelines supported by HRSA, to the extent not already included in certain recommendations of the USPSTF.

Previously, California's health insurance preventive care mandates were tied to these federal preventive care guidelines.

New State Legal Framework

California Governor Gavin Newsom signed Assembly Bill 144 ("AB 144") into law on September 17, 2025, effective immediately. The law was intended to preserve health care coverage of preventive services and vaccines for California residents, regardless of any rollback in federal policy.

To accomplish this, AB 144 codifies the federal recommendations for preventive care and immunization coverage in effect on January 1, 2025 (before the current administration took office), and allows the California Department of Public Health ("CDPH") to supplement those recommendations.

Specifically, AB 144:

- Establishes the list of preventive services, items, and immunizations recommended as of January 1, 2025, by USPSTF, ACIP, and HRSA as the baseline recommendations for California.
- Authorizes the CDPH to modify or supplement the baseline recommendations, taking into consideration guidance and recommendations from additional medical and scientific organizations, including, but not limited to, the American Academy of Pediatrics, the American College of Obstetricians and Gynecologists, and the American Academy of Family Physicians.
- Authorizes CDPH to incorporate subsequent evidence-based recommendations from USPSTF, ACIP, or HRSA, to the extent the department determines them to promote public health.
- Requires CDPH to publish the baseline recommendations, including any modification or supplement, and that any updates, modifications, or supplements are deemed effective on the date of publication.
- Replaces references to USPSTF, ACIP, or HRSA for coverage of preventive services and items, and for the administration of vaccines by various health professionals and other personnel and entities, with references to these federal recommendations as they existed on January 1, 2025, as modified or supplemented by CDPH pursuant to its authority under the baseline recommendations.

On September 18, 2025, the California Department of Managed Health Care ("DMHC") issued All Plan Letter 25-015 providing information and guidance to health care plans on the protections enacted under AB 144.

Application of California Insurance Law to Group Health Plans

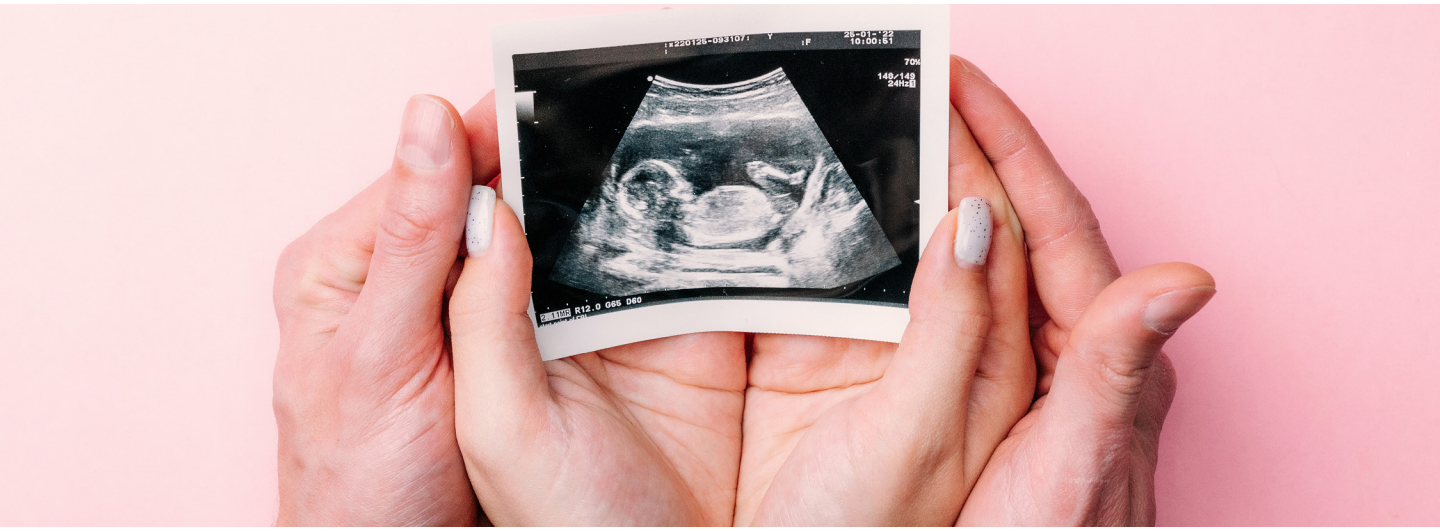
The California insurance law requirements set forth above generally apply to:

- Group health insurance policies issued or delivered (i.e., sitused) in California.
- HMOs in California.
- Group health insurance policies issued or delivered (i.e., sitused) outside of California, to the extent that the policy covers California residents; but not if (a) the employer's principal place of business is located outside of California, and (b) a majority of employees are located outside of California.

In addition, the California law does not apply to self-funded group health plans governed by ERISA.

Employer Action

Carriers are generally responsible for complying with preventive service coverage requirements and making updates as needed. Plan sponsors should not need to take any action at this time. However, sponsors of plans with employees in multiple states should be aware that the preventive coverage requirements under a fully insured plan in California may differ from federal guidelines or the coverage requirements in other states.



Reminder: Illinois Fertility Benefits & Dependent Coverage for Parents Go Into Effect Jan 1, 2026

Issued date: 12/19/25

The Illinois legislature enacted two new laws impacting certain health benefits plans. These provisions take effect for policies issued, amended, delivered or renewed in Illinois on or after January 1, 2026.

Briefly, these Illinois benefit mandates:

- Broaden benefits related to infertility treatment, and
- Expand dependent coverage to include the tax dependent parent (or stepparent) of the insured.

These provisions apply to fully insured group health plans issued in Illinois. ERISA covered self-funded health plans are not required to comply.

Mandatory Fertility Benefits

The new law broadens mandatory coverage of infertility and provides that no group policy of accident and health insurance that provides pregnancy-related benefits may be issued, amended, delivered, or renewed in Illinois on or after January 1, 2026, unless the policy contains coverage for the diagnosis and treatment of infertility, including specified procedures. Covered plans must also include coverage for the procedures necessary to screen or diagnose a fertilized egg before implantation.

State insurance mandates are generally pre-empted by ERISA and apply to fully insured group health plans with Illinois as their situs state. However, since the law also amended the County, Municipal, and School Codes, the mandates also apply to non-ERISA self-funded group health plans sponsored by Illinois state or local governmental entities as well as public schools.

Additionally, any group policy that covers more than 25 employees that is amended, delivered, issued, or renewed on or after January 1, 2026, shall provide, for individuals 45 years of age and older, coverage for an annual menopause health visit without any cost-sharing applied to the insured member.

Dependent Parent and Stepparent Coverage

The Illinois Insurance Code was amended so that a group or individual policy of accident and health insurance issued, amended, delivered, or renewed after January 1, 2026, which provides dependent coverage, shall make that dependent coverage available to the parent or stepparent of the insured if the parent or stepparent:

- Meets the definition of a qualifying relative under 26 U.S.C. 152(d); and
- Lives or resides within the accident and health insurance policy's service area.

The expanded definition does not apply to specialized health care service plans, Medicare supplement insurance, hospital-only policies, accident-only policies, or specified disease insurance policies that reimburse for hospital, medical, or surgical expenses.

Generally, to satisfy the definition of a "qualifying relative" the parent or stepparent must have:

1. Gross income for the calendar year in which such taxable year begins that is less than $5,300 for 2026 (as indexed for inflation); and
2. The taxpayer (the primary insured) provide over one-half of the individual's support for the calendar year in which such taxable year begins.

This Illinois state insurance mandate is generally preempted by ERISA and would only apply to fully insured group health plans with Illinois as their situs state.

Employer Action

Carriers issuing and renewing group health plan policies in Illinois should be making the necessary changes to the plan designs to comply with the law.

Self-funded non-ERISA plans employers should work with their TPAs and stop loss carriers to comply with new fertility requirements.

If applicable, employers should amend plan documents to include dependent parent/stepparent eligibility language and communicate these changes with participants.

IRS Notice 2026-5: Key HSA Eligibility Updates Under OBBA

Issued date: 12/19/25

On December 9, 2025, the IRS issued Notice 2026-5 (Notice), providing guidance on Health Savings Account (HSA) changes introduced by the One Big Beautiful Bill Act (OBBA). The IRS is seeking comments on all aspects of this Notice with comments due by March 6, 2026.

HSA Eligibility Generally

Section 223 of the Internal Revenue Code allows eligible individuals to establish HSAs. To qualify, an individual must:

- Be covered under a high-deductible health plan (HDHP).
- Have no disqualifying coverage (coverage that provides cost-sharing before meeting HDHP minimums).

HDHPs must meet minimum deductible and maximum out-of-pocket limits set by the IRS, though preventive care and certain other coverage can be disregarded without affecting HSA eligibility. OBBA expanded these rules to increase access to HSAs, and the Notice addresses these changes, specifically on telehealth services, bronze and catastrophic plans, and direct primary care service arrangements (DPCSA).

Telehealth and Remote Services

Telehealth, or other remote care services, provided for free, or at a reduced cost, before satisfying the minimum deductible in an HDHP are generally disqualifying coverage. OBBA made a permanent safe harbor that permits first dollar coverage for telehealth and other remote care services. The guidance addresses telehealth services that can be reimbursed by an HDHP without affecting HSA eligibility. Services that are reimbursed by the plan are qualified if the services appear in the Health and Human Services annual Medicare telehealth payable list. The list is updated annually. It should be noted that this relief is optional for employers and are not required to offer free or reduced telehealth services.

The Notice also confirms that in-person services, medical equipment, and drugs furnished in connection with a telehealth or other remote care service may not be offered before the minimum deductible is met unless they would otherwise be treated as telehealth services in accordance with the Medicare payable list.

Individual Bronze and Catastrophic Plans

Effective January 1, 2026, bronze and catastrophic plans will be treated as HDHPs if available as individual coverage through an ACA Marketplace, whether they meet standard HDHP deductible minimums or out-of-pocket limits or not. This also applies to off-Marketplace plans that are identical to Marketplace versions. However, if an individual has no reason to believe that a plan is not offered on the Marketplace and is enrolling in off-Marketplace coverage, they can still enroll in the plan and be eligible for an HSA.

For employers:

- ICHRAs can be used to purchase coverage without affecting HDHP status. However, it is important to note that reimbursements should be limited to either premiums or post-deductible expenses in order for the individual to retain HSA eligibility.

- Bronze plans offered through SHOP do not qualify under this provision. Thus, employer sponsored plans must continue to comply with HDHP requirements.

Direct Primary Care Service Arrangements

DPCSAs charge a fixed fee and provide an array of primary care services and items, such as physical examinations, vaccinations, urgent care, laboratory testing and the diagnosis and treatment of some sicknesses and injuries. Before OBBA, this type of arrangement would be disqualifying coverage for purposes of contributing to an HSA because it provides coverage for non-preventive care services before the minimum HDHP deductible is satisfied.

The Notice confirms much of what was already in OBBA but provides some additional insights. It reiterates that DPCSAs will not be treated as health plans if they meet strict criteria: primary care services only provided by primary care practitioners, a fixed periodic fee not exceeding the statutory annual limit ($1,800 self-only / $3,600 family for 2026) and there is no separate billing for any items and services provided to the participant.

It also clarifies that for billing purposes, the arrangement can be made for periods more than a month, but the fee must be a fixed amount that does not exceed the annual limit. The following examples were provided for a single individual:

- Option 1: One $1,800 payment for the year

- Option 2: $900 for six months (two payments during the year)

- Option 3: $450 for three months (quarterly payments).

With respect to paying for the fee, the Notice permits reimbursement on the first day of each month of coverage on a pro rata basis, the first day of the period of coverage, or the date the fees are paid. The HDHP may not pay for the fee without a deductible or before the deductible has been satisfied and the fees paid by the individual for the DPCSA do not count toward the annual HDHP deductible or out-of-pocket maximum.

Finally, fees paid through a Section 125 plan or employer-paid fees cannot be reimbursed by the HSA. And, if fees are higher than the annual limit, the individual will be ineligible to contribute to the HSA, but the fee remains reimbursable.

Employer Action

Employers interested in implementing telehealth or DPCSA solutions with HDHP/HSA plans, or those that already have these in place, should review the guidance and discuss with applicable carriers, TPAs, and vendors to ensure compliance.

Consider the following action items in response to this Notice:

- Review telehealth services that may go beyond what is permitted, to not cause a loss of eligibility.
- Assess DPCAs offered to employees to ensure fees and services meet IRS criteria, including the periodic fee limits.
- Be aware that offering services more than primary care will create problems for HSA eligibility, even if the individual can waive the non-primary care services.
- Update plan communications to explain to employees how these arrangements might affect HSA eligibility.
- SHOP Employers: be prepared to answer questions from employees on whether their bronze plan can be paired with an HSA, if offering SHOP coverage.
- Stay tuned for additional guidance!

New Jersey Releases 2026 Disability and Family Leave Amounts

Issued date: 12/22/25

New Jersey has announced the 2026 contribution rates and benefit level parameters for the Temporary Disability Insurance ("TDI") and Family Leave Insurance ("FLI") programs. The 2026 rates and benefit parameters are as follows:

	2025	2026
Maximum TDI and FLI Weekly Benefit	**$1,081**	**$1,119**
Alternative Earnings Test Amount for TDI and FLI	**$15,200**	**$15,500**
Base Week Amount for TDI and FLI	**$303**	**$310**
Taxable Wage Base (employers) for TDI	**$43,300**	**$44,800**
Taxable Wage Base (employees) for TDI and FLI	**$165,400**	**$171,100**
Employee Contribution Rate for TDI	**0.23%**	**0.19%**
Employee Contribution Rate for FLI	**0.33%**	**0.23%**

Temporary Disability Insurance 2026

Temporary Disability Insurance provides benefits to eligible New Jersey workers for non-job-related illness, injury, or other disability that prevents them from working or due to certain public health emergency reasons.

To be eligible for TDI employees must have –

- Worked 20 weeks earning at least $310 per week ("Base Week Amount"), or
- Have earned a combined total of $15,500 ("Alternative Earnings Test") in the four quarters ("base year") prior to taking leave.

Following a 7-day waiting period (except for certain public health emergencies), the weekly TDI benefit is 85% of an employee's average weekly wage but no greater than $1,119. TDI may be payable for up to 26 weeks in a 52-week period.

The maximum contribution for 2026 is 0.19% up to the Taxable Wage Base (Employee) of $171,100 equal to $325.09.

Family Leave Insurance 2026

Family Leave Insurance provides benefits to eligible New Jersey workers for (i) the first 12 months following the birth, adoption or foster care placement of a child, or (ii) to care for a seriously ill family member.

To be eligible for FLI employees must have –

- Worked 20 weeks earning at least $310 per week ("Base Week Amount"), or
- Have earned a combined total of $15,500 ("Alternative Earnings Test") in the four quarters ("base year") prior to taking leave.

The weekly FLI benefit is 85% of an employee's average weekly wage but no greater than $1,119. FLI may be payable for 12 consecutive weeks in a 12-month period, or up to 8 weeks (56 individual days) in a 12-month period, if taking leave intermittently.

Employees contribute 0.23% of wages up to the 2026 Taxable Wage Base (Employee) of $171,100 equal to $393.53.

Employer Action

- Adjust payroll systems to reflect the new employee contribution rates.
- Notify employees about updated contribution rates, maximum weekly benefits and eligibility requirements for 2026.
- Ensure internal leave policies align with updated benefit parameters and eligibility rules.
- Confirm employer taxable wage base for TDI and adjust employer contributions.

Another Round of Changes to Delaware's Paid Family and Medical Leave Law

Issued date: 12/23/25

On December 1, 2025, Delaware published new regulations amending Delaware's paid family and medical leave ("PFML") law. These new regulations will impact the implementation of the PFML program which is set to begin paying benefits on January 1, 2026.

Background

Delaware's PFML law, the Healthy Delaware Families Act, requires certain employers to provide their covered employees with up to $900 per week (for 2026 and 2027, and will be adjusted for inflation thereafter) in paid leave for parental, family caregiving, medical, and qualified military exigency leave. Contributions to the state plan began on January 1, 2025, and benefits will begin on January 1, 2026.

Employers must provide written notice to each employee of their rights at the time of the employee's hire, whenever an employee requests covered leave, or the employer has reason to believe an employee's leave is due to a qualifying event

The regulations address several provisions of the PFML law, specifically the following:

- The definition of "application year";
- The definition of "employee";
- Clarification of when employers can deduct employee contributions to the program from their pay; and
- Providing guidance for employers utilizing a self-funded private plan to meet the law's requirements regarding their claim reserve accounts

New Definition of "Application Year"

Previously, the Act defined "application year" consistent with the federal Family and Medical Leave Act ("FMLA"). The FMLA allows employers to choose amongst four different methods for determining the 12-month period during which covered employees are entitled to leave.

The regulations now specifically define the "application year" as the 12-month period beginning on the first day that an employee takes family and medical leave continuing forward for the next 12-months.

Modified Definition of "Employee"

The regulations modify the definition of "employee" so that instead of basing eligibility on where the individual physically works, it is now based on where the individual earns their wages. Under this new definition, an individual is considered an employee if they are earning at least 60% of their wages physically in Delaware each calendar quarter. Individuals primarily reporting for work, earning wages at a worksite, or telecommuting outside of Delaware are not considered "employees" under PFML unless the employer and employee agree in writing to reclassify them as such.

In addition, the regulations clarify that owners or officers of an employer that receive a Form W-2 are considered "employees" under PFML. They are eligible for benefits and subject to contribution withholding requirements.

Clarification on Deducting Employee Contributions from Wages

Employers with 10-24 employees are only required to provide paid parental leave. While not required to provide paid leave for medical, family caregiver, or military exigency leave, an employer can voluntarily opt into providing these lines of coverage. The regulations clarify that an employer that voluntarily opts into any additional line of coverage under PFML, the employer is responsible for the additional cost and cannot require employee contributions for these voluntary benefits.

Guidance Regarding the Claims Reserve Account for Self-funded Plans

Employers utilizing a self-funded private plan must prefund a claims reserve account with at least half of the required maximum benefits that a self-funded plan must be able to pay. The regulations state that this reserve account is a separate fiduciary non-interest-bearing account established for the sole purpose of paying benefits under the law. In addition, all employee and employer contributions to the private plan must be deposited into the reserves account.

Finally, the reserve account must be maintained according to sound actuarial principles and must not be over or underfunded. If employee contributions are held by the account, employers must file annual actuarial study reviews with the Division of Paid Leave. The manner of these studies will be provided by the Division of Paid Leave at a later date. Based on the results of these studies, employers may be required to make increased employer contributions or refund employee over-contributions.

Employer Next Steps

Many employers have already adopted their leave policies, so the timing of these regulations is less than ideal. Employers should promptly review their leave policies and determine whether they should adjust them according to these new regulations.

- Employers utilizing an "application year" other than measuring forward from the date PFML benefits are first received should amend their policy to ensure that they are utilizing the updated definition of "application year."

- Employee eligibility should be modified to reflect where wages are earned.
- Employers voluntarily opting into lines of coverage should ensure that employee contributions are required only for the parental leave line of coverage.
- If a self-funded private plan is being utilized, employers should make sure they are not commingling PFML contributions, that all PFML contributions are deposited into their reserve account, and that contributions are calculation using sound actuarial principles.
- Stayed tuned for additional updates as they are released.

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