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HEALTH & WELFARE PLAN LUNCH GROUP

June 12, 2025

One Atlantic Center
1201 W. Peachtree Street
Atlanta, GA 30309-3424
(404) 881-7885
E-mail: john.hickman@alston.com

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June 2025 Agenda

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One Big Beautiful Bill Act ICHRA/HSA Provisions

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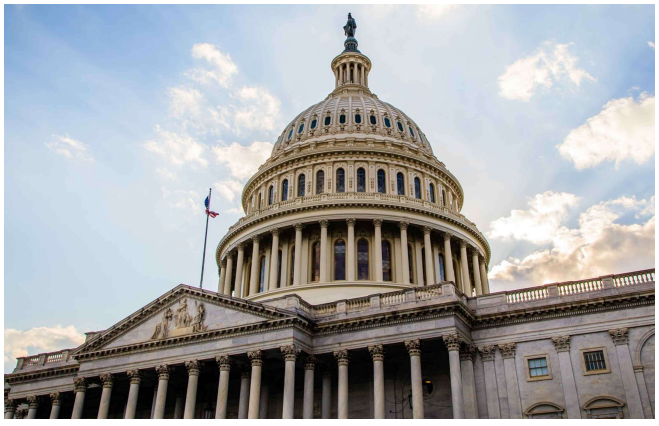
Title XI, Part 3, Investing in the Health of American Families and Workers

- On May 22, 2025, the U.S. House of Representatives passed **H.R.1 — One Big Beautiful Bill Act**. Title XI, Part 3 of the bill, titled "Investing in the Health of American Families and Workers,"
  - codifies and expands the regulatory framework for Individual Coverage Health Reimbursement Arrangements (ICHRAs), rebranded as CHOICE arrangements (Custom Health Option and Individual Care Expense), and
  - introduces sweeping reforms to Health Savings Accounts (HSAs).
- As of today, the bill [has not been approved by the Senate.]



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CHOICE Arrangements Highlights

The bill would codify existing ICHRA regulations and rebrand them as CHOICE arrangements, while expanding eligibility classes and apparently easing substantiation requirements.

Employers with fewer than 50 employees could qualify for a new tax credit for offering CHOICE arrangements.

The proposal would allow employees to use cafeteria plan salary reductions to purchase Exchange-based coverage through a CHOICE arrangement.

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CHOICE Arrangements: Eligible Employee Classes

Full-time employees	Part-time employees	Salaried employees	Non-salaried employees	Employees whose primary site of employment is in the same rating area
Employees covered by a collective bargaining agreement	Employees who have not satisfied a waiting period under the group health plan	Seasonal employees	Employees who are non-resident aliens with no U.S.-source earned income	Any other class of employees as designated by the Secretary of the Treasury

Employers may also combine two or more of these classes into a single specified class. Variations in benefit amounts are permitted based on age (up to 300% of the lowest maximum dollar amount) or number of dependents.

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CHOICE Arrangements Requirements

No Other GHP Requirement: Employers may not offer to those eligible for the CHOICE arrangement any other group health plan coverage other than a fully-insured small group market plan or coverage consisting solely of excepted benefits.

Substantiation Requirement: Employers must implement "reasonable procedures" to verify that covered individuals are enrolled in qualifying individual market coverage.

Notice Requirement: Employers must provide notice of CHOICE arrangement rights and obligations at least 60 days before the plan year begins. This shortens the timeframe from 90 days under the 2019 Final Rule for ICHRAs.

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CHOICE Arrangements

Summary of Benefits and Coverage: CHOICE arrangements that otherwise satisfy the bill requirements are treated as satisfying PHSA § 2715, which requires group health plans and health insurance issuers offering group or individual coverage to provide a standardized summary of benefits and coverage (SBC).

Tax Reporting: Employers must report total permitted CHOICE benefits for enrolled individuals on Form W-2.

Effective Date: Plan years beginning after December 31, 2025.

Cafeteria Plans: Employees enrolled in a CHOICE arrangement may use salary reduction contributions under a cafeteria plan to purchase Exchange-based individual health insurance coverage**.**

Effective Date: Taxable Years after December 31, 2025.

Employer Credit: 2-year tax credit for non-ALEs that offer a CHOICE arrangement for the first time: $100/month the employee is enrolled in year one, and one-half of that amount (currently $50/month) in year two (adjusted for inflation beginning in 2027). Must constitute affordable minimum essential coverage that provides minimum value to qualify for the tax credit. The proposed credit is allowed against the alternative minimum tax.

Effective Date: Taxable years after December 31, 2025.

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HSA Provisions Overview

Medicare Part A	Direct Primary Care	Bronze and Catastrophic Plans	On-Site Clinics	Fitness and Wellness Expenses
Catch-up Contributions	Qualified Rollovers from FSAs and HRAs	Pre-Established Medical Expenses	Spousal FSA Exception	Expanded Deductible Contribution Limit

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HSA Provisions

- *Medicare Part A Enrollees*: Individuals enrolled only in Medicare Part A may now contribute to HSAs, reversing prior restrictions that disqualified them from eligibility. **Effective Date: Months beginning after December 31, 2025.**

- *Direct Primary Care*: Direct primary care arrangements (excluding general anesthesia-required procedures, prescription drugs other than vaccines, and lab services not typically administered in an ambulatory primary care setting) will no longer disqualify individuals from HSA eligibility. Direct primary care expense could be an HSA eligible expense. **Effective Date: Months beginning after December 31, 2025.**

- *Bronze and Catastrophic Plans*: These plans are now treated as HDHPs irrespective of deductible level. **Effective Date: Months beginning after December 31, 2025.**

- *On-Site Clinics*: Certain limited on-site clinic services (e.g., immunizations, injury treatment, chronic care) will not disqualify individuals from HSA eligibility. **Effective Date: Months beginning in taxable years after December 31, 2025.**

- *Fitness and Wellness Expenses*: Up to $500 (individual) or $1,000 (joint or head of household) annually, limited to 1/12th of the total amount monthly, may be withdrawn tax-free from HSAs for qualified physical activity and fitness expenses. **Effective Date: Taxable years after December 31, 2025.**

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HSA Provisions

- *Catch-Up Contributions*: Married couples may now contribute both spouses' (both must be at least age 55) catch-up contributions to a single HSA. **Effective Date: Taxable years after December 31, 2025.**
- *Qualified Rollovers from FSAs and HRAs*: The bill reinstates and expands the ability to roll over unused FSA or HRA funds into an HSA when transitioning to HDHP coverage, provided the individual was not covered by an HDHP in the prior four years. **Effective Date: Distributions made after December 31, 2025.**
- *Pre-Establishment Medical Expenses*: Medical expenses incurred up to 60 days before HSA establishment are now eligible for tax-free reimbursement, provided the HSA is opened within that window. **Effective Date: Coverage beginning after December 31, 2025.**
- *Spousal FSA Exception*: Coverage under a spouse's general-purpose FSA will not disqualify an individual from HSA eligibility if reimbursements are limited to the spouse's own expenses. **Effective Date: Plan years beginning after December 31, 2025.**
- *Expanded Contribution Limits*: The bill increases HSA contribution limits by $4,300 (self-only) and $8,550 (family), subject to income-based phaseouts starting at $75,000 (single) and $150,000 (joint) and ending at $100,000 and $200,000, respectively. **Effective Date: Taxable years after December 31, 2025.**

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MHPAEA Enforcement Developments

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Agency Pullback on MHPAEA Regulations

- On May 15, 2025, the U.S. Departments of Labor, Health and Human Services, and the Treasury published a statement of temporary non-enforcement (the "Relief") for the 2024 Mental Health Parity and Addiction Equity Act (MHPAEA) Final Rule to
  - Reconsider the 2024 Final Rule
    - Notice of proposed rulemaking rescinding or modifying the 2024 Final Rule through notice and comment
  - Reexamine each Department's respective MHPAEA enforcement approach
  - Update MHPAEA subregulatory guidance
    - FAQs About Mental Health and Substance Use Disorder Parity Implementation and the CAA, 2021 Part 45
- Litigation contesting parts of the 2024 Final Rule triggered the Relief.
  - January 2025: The ERISA Industry Committee (ERIC), an association representing the employee benefits interests of large employers, alleged that the 2024 Final Rule is impermissibly vague and violates the Administrative Procedures Act (APA).
  - ERIC challenged the 2024 Final Rule on several grounds, including the comparative analysis requirements, meaningful benefits standard, the material differences in access provision, and the fiduciary certification requirement. [ERISA Industry Committee v. Department of Health and Human Services et al, D.D.C., No. 1:25-cv-00136.]

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2024 MHPAEA Final Rule Enforcement Relief

- The Relief provides that:
  - The Departments 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 Relief applies only with respect to those portions of the 2024 Final Rule that are ***new*** in relation to the 2013 MHPAEA Final Rule.
  - MHPAEA's statutory obligations, as amended by the Consolidated Appropriations Act, 2021 (CAA), continue to have effect. This means that the comparative analysis, which was first required to be complete as of February 10, 2021, is still in effect.
- **IMPORTANT:** This Relief applies to the Departments, *but plans would still be at risk for action from participants* (and perhaps even providers) until the 2024 Final Rule is rescinded or modified.

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Provisions Subject to Relief:

1/1/2025 Applicability Date under the 2024 Final Rule:	1/1/2026 Applicability Date under the 2024 Final Rule:
Fiduciary certification of the comparative analysis.	Prohibition on discriminatory information used in the design and application requirement.
New and revised definitions, including limited flexibility in relying on state laws, and the mandate to align with definitions in Diagnostic and Statistical Manual of Mental Disorders (DSM) or the International Classification of Diseases (ICD)	Relevant data evaluation requirements: A "material difference" in access is a "strong indicator" of noncompliance, and "reasonable action" must be taken.
ERISA §104(b) Disclosures: Codifying the comparative analysis as an instrument under which the plan is established or operated for purposes of document requests under ERISA §104(b) (though the Relief applies to federal regulators, not plan participants, and at least one court determined that the document is subject to 104(b) even before the 2024 Final Rule)	Meaningful benefits standard, which includes the new "core treatments" requirement.

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Do Plans still need to have a Comparative Analysis?

YES.

Not only do plans still have to have a comparative analysis, but the Relief applies only with regard to enforcement from a federal agency.

The 2013 Final Rule and CAA 2021 still apply and together require:

- A comparative analysis (as of February 2021) for all NQTLs.
- Still must provide the comparative analysis to regulators upon request.
- Timeframes for corrective action (45 days) and notifying plan participants and beneficiaries of non-compliance determinations (7 days) still apply (but presumably the 10-day turnaround time in the 2024 Final Rule for other requests from EBSA is on hold).
- Definition for MH/SUD benefits must still align with generally recognized standard of medical practice.
- The basic requirements that NQTLS comply with MHPAEA "as written and in operation".

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PBM Reporting and State Issues

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PBM Reporting and State Issue

- Flury of state legislation after SCOTUS decision *Rutledge v. PCMA* in 2020
- States interpret *Rutledge* to exempt state laws from ERISA preemption that regulate *only* the PBM
- 10th Circuit Court of Appeals rejected the state's approach in *Mulready v. PCMA* holding that four provisions of Oklahoma's Patient's Right to Pharmacy Choice Act were preempted by ERISA b/c the provisions governed central matters of ERISA plan administration even when the laws do so by regulating third parties.
- Oklahoma appealed to SCOTUS arguing that decision conflicts with *Rutledge* and 8th Circuit's decision in *PCMA v. Wehbi*.
- US Solicitor General filed an amicus brief in May 2025 arguing that 10th Circuit's decision did not conflict with *Rutledge* or *Wehbi* and the appeal was a "suboptimal vehicle for addressing ERISA preemption" because the lower courts did not address application of ERISA's savings or "deemer" clauses.

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PBM Reporting and State Issues

- Arkansas' Act 624, prohibiting PBMs from owning retail and mail order pharmacies in the state, has been challenged as unconstitutional in the E.D. of Arkansas.
- Various states are auditing PBMs and requesting identifiable claims from self-funded plans administered by the PBM.
  - Are these laws preempted by ERISA if the law only regulates the PBM? What about *Gobeille v. Liberty Mut. Ins. Co.*, 577 U.S. 312 (2016)?
  - Are these permitted disclosures to a state health oversight agency under 45 CFR § 164.512(d)(1) if the plan is self-funded?
  - If the claims contain reproductive health care, are disclosures permissible without an attestation?
  - Are the records subject to state FOIA requests?

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Health Benefits Litigation Update

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Grab Bag

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Litigation Update: No Surprises Act (NSA)

Split in Circuits over Arbitration

- Under the NSA, the IDR entity's determination is binding and the parties cannot adjudicate in court unless certain circumstances exist:
  - (1) the existence of fraud, corruption, or undue means,
  - (2) partiality or corruption of the arbitrator,
  - (3) arbitrator misconduct in refusing to postpone a hearing or refusing to hear material and pertinent evidence, or
  - (4) the arbitrator exceeded their powers or a mutual, final, and definitive determination was not made.
- But what if the losing party in arbitration does not pay, or pays too little or too late?

New Jersey:

- A federal district court in New Jersey (3rd Circuit) found in September 2023 that the FAA applies to enforce NSA awards.
- Provider rendered emergency services to a beneficiary covered by defendant insurer on an out-of-network basis; insurer only partially paid the claim provider billed.
- The parties entered the federal IDR process; the insurer's offer was determined to be the appropriate reimbursement rate.
- The provider sued in court to overturn the decision; the insurer moved to confirm the award under the FAA. The court sided with insurer.
- The court emphasized the strong presumption in favor of upholding arbitration awards and finding no evidence of procedural failures or improper presumptions.

Texas:

- A district court for the Northern District of Texas (5th Circuit) reached the opposite conclusion, ruling in May 2024 that the FAA does not provide a mechanism to enforce NSA awards.
- Air ambulance providers sued the payor, arguing that the payor had failed to timely pay NSA awards the providers obtained in the arbitration process.
- The providers argued that FAA was the proper mechanism to enforce NSA awards; the court disagreed.
- Because the NSA does not include an express provision allowing for the enforcement of arbitration awards under the FAA, Congress did not intend to create such a mechanism within the NSA.
- The court also dismissed the plaintiffs' ERISA benefits and unjust enrichment claims, because there was no concrete injury to the plan's beneficiaries and no direct benefit to the plan.

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Litigation Update: No Surprises Act (NSA) (continued)

- Air ambulance providers sued insurers in a Connecticut district court (2nd Circuit) to enforce payments awarded to the providers in the IDR process. [*Guardian Flight LLC et al. v. Aetna Life Insurance Co. Inc. et al]*
  - Plaintiffs alleged that these additional payments were made short, late, or not at all, and sued under the NSA and ERISA to recover.
  - Defendants filed motions to dismiss claims under NSA, ERISA, and state law.
  - On May 14, 2025, District court sided with plaintiffs, stating plaintiffs have a private right of action under the NSA to enforce IDR awards, and plaintiffs have Article III standing to pursue injunctive relief under ERISA, although the claim for injunctive relief itself was dismissed.
  - On June 5, 2025, Insurer filed a memo in support of a motion to file an interlocutory appeal, arguing that:
    - Plaintiff providers have no Article III standing or derivative standing because the plan participant would have no ERISA right to payment of benefits for disputed IDR awards;
    - No standing exists because the plan's beneficiaries suffered no concrete injury from the insurer failing to timely pay the provider.

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Litigation Update: No Surprises Act (NSA) (continued)

- Ongoing Texas Medical Association (TMA) litigation: On May 30, 2025, the 5th Circuit granted TMA's request to rehear its challenge to a 2022 final rule governing the arbitration process for surprise medical bill disputes. [*Texas Medical Association et al. v. HHS*]
- Background: There were four cases known as TMA I, TMA II, TMA III and TMA IV. These cases involved the weight given to QPA when a claim goes to IDR and also how to calculate QPA.
  - Biden Administration lost each of the TMA decisions in district court.
  - But, in somewhat of a surprise, on October 30th 2024, the 5th Circuit Court of Appeals reversed the district court and upheld the Biden Administration regulations on several aspects of calculating QPA, including one that excluded bonuses and incentive payments.
  - The Departments issued FAQs Part 69 on January 14, 2025 stating that "Unless the Fifth Circuit decides to rehear its panel's TMA III decision and alters its judgment, plans and issuers will have to calculate QPAs using a good faith, reasonable interpretation of the applicable statutes and regulations that remain in effect 15 following the decisions of both the Fifth Circuit and the district court in TMA III (the 2024 methodology) upon issuance of the Fifth Circuit's mandate."
- On May 30, 2025, the 5th Circuit agreed to rehear its panel's TMA III decision.
  - A majority of the judges voted in favor of rehearing TMA's case.
  - Will the 5th Circuit reverse course and fall in line with previous rulings against HHS?

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Litigation Update: No Surprises Act (NSA) (continued)

- 11th Circuit: Oral arguments before an 11th Circuit panel raised the issue of whether providers and insurers are generally allowed to sue following arbitration over surprise medical bills.
  - At issue is how the NSA treats fraud as compared to accidental misrepresentation in the QPA calculation.
  - Plaintiff providers accused an insurer of fraudulently lowered a key payment factor for the calculation.
  - Statutory language in the NSA provides that arbitration awards "shall be binding upon the parties involved, in the absence of a fraudulent claim or evidence of misrepresentation of facts."
  - The U.S. District Court for the Middle District of Florida ruled in December 2023 that plaintiffs lacked a right to sue under the NSA.

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No Surprises Act and IDR: Technical Assistance (TA)

- June 6, 2025: HHS, DOL, and Treasury published *Federal Independent Dispute Resolution (IDR) Technical Assistance for Certified IDR Entities and Disputing Parties*
- The Departments categorized and defines three types of errors that a certified IDR entity may make, but is not identified until after a dispute is closed:
  - Clerical
  - Jurisdictional
  - Procedural
- These types of errors should be corrected by reopening a closed dispute to ensure the results of the Federal IDR process are aligned with the NSA and that the IDR entity complies with the NSA and its implementing regulations.
- The TA, which includes definitions, examples, and process guidelines, is intended only to provide clarity and is not intended to have the force of law or to impose substantive requirements on parties to the Federal IDR process or on certified IDR entities.

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No Surprises Act and IDR: Technical Assistance (continued)

- **Applicability Dates**:
  - TA applies to requests to reopen closed disputes received by the Departments:
    - On or after June 6, 2025; and
    - Prior to June 6, 2025, but to which the Departments had not responded prior to June 6, 2025.
  - Requests to reopen disputes that were denied prior to June 6, 2025 should not be resubmitted—they will not be reopened and reviewed.
- **Payment Deadlines:** If a payment determination is rescinded and reissued, a new 30-calendar-day period begins on the date the certified IDR entity issues a new binding payment determination following correction of a clerical, jurisdictional, or procedural error.
- **IDR Fees**: If the correction of an error reverses a determination that a dispute was or was not eligible for the IDR process, the certified IDR entity must either refund or invoice the parties for the fee as appropriate.
- **Denials of Requests to Reopen**: Generally, requests will be denied if:
  - Reopening would require the certified IDR entity to reconsider the factors described in the final rule for determining which offer to select (26 CFR 54.9816–8(c)(4)(iii)); or
  - The error was made by a disputing party, rather than the certified IDR entity.

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Litigation Update: Title VII and EEOC Enforcement

- Texas v. HHS—Title VII
  - May 15, 2025: Judge Kacsmaryck in the Northern District of Texas held that the EEOC exceeded its statutory authority by interpreting Title VII to prohibit harassment based on gender identity and sexual orientation and vacated portions on the agency's harassment guidance.
    - The ruling contrasts with the 2020 *Bostock v. Clayton County* decision in which SCOTUS held that terminating employees due to sexual orientation or gender identity constitutes sex discrimination under Title VII.
    - EEOC withdrew portions of its workplace harassment guidance in response to the ruling.
  - What does this mean for employers?
    - *Bostock* is still law, but the Texas ruling limits how EEOC can define harassment with respect to gender identity.

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HIPAA Enforcement

- Litigation: Texas v. HHS—HIPAA/Reproductive Healthcare
  - Texas sued HHS under the Biden administration for declaratory and injunction relief to prevent HHS from enforcing portions of the 2024 HIPAA privacy rules related to reproductive rights.
  - Although proposed intervenors questioned whether the Trump administration would defend the rule, the administration appears to be defending the contested rule.
  - Reminder: HIPAA Notice of Privacy Practices needs to be updated for Reproductive Health Care and HIPAA Part 2 by February 2026.
- Office for Civil Right (OCR): Seems to be following prior administration in penalties for security rule violations given recent news announcements of penalties.
  - Still awaiting finalization of proposed HIPAA cybersecurity rules—nothing yet at OMB.

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DOL Opinion Letters

- DOL launched an Opinion Letter Program across five agencies to expand compliance assistance. The program spans five key enforcement agencies within the department:
  - The Wage and Hour Division will issue opinion letters.
  - The Occupational Safety and Health Administration will provide letters of interpretation.
  - The Employee Benefits Security Administration will release advisory opinions and information letters.
  - The Veterans' Employment and Training Service will issue opinion letters.
  - The Mine Safety and Health Administration will provide compliance assistance resources through its new MSHA Information Hub, a centralized platform offering guidance, regulatory updates, training materials and technical support.
- The general landing page is at Opinion Letters | U.S. Department of Labor.
- EBSA's enhanced page is at https://www.dol.gov/agencies/ebsa/about-ebsa/our-activities/resources/opinion-letters

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Employee Benefits & Executive Compensation Advisory | House Reconciliation Bill Expands and Improves Health Savings Accounts and Individual Coverage Health Reimbursement Arrangements

June 16, 2025

Advisories

By: Ashley Gillihan, John R. Hickman, Laurie Kirkwood, Bria Smith

On May 22, 2025, the U.S. House of Representatives passed the One Big Beautiful Bill Act (H.R. 1). Title XI, Part 3 of the bill, "Investing in the Health of American Families and Workers," codifies and expands the regulatory framework for individual coverage health reimbursement arrangements (ICHRAs), rebranded as custom health option and individual care expense (CHOICE) arrangements, and introduces sweeping reforms to health savings accounts (HSAs). As of June 16, 2025, the bill has not been approved by the Senate. This summary provides a high-level overview of the current proposals for changes to ICHRAs and HSAs.

CHOICE Arrangements

The bill codifies the June 20, 2019 Final Rule, allowing employers to offer ICHRAs, which are HRAs integrated with individual market coverage, without violating group health plan requirements under the Affordable Care Act (ACA). Under the bill, ICHRAs are now termed "CHOICE arrangements." The following proposed changes and new requirements are **effective for taxable years beginning after December 31, 2025**.

CHOICE Arrangement

A CHOICE arrangement has five core requirements:

1. It is an HRA in its most basic form: an employer-provided group health plan funded solely by employer contributions to provide payments or reimbursement of medical care subject to a fixed dollar maximum for a given period.

2. Payments or reimbursements may be made only for medical care during periods during which a covered individual is also covered under individual health insurance coverage offered in the individual market (other than coverage that consists solely of excepted benefits) or Medicare Parts A and B or C.

   It meets certain:

3. Nondiscrimination requirements.

4. Substantiation requirements.

5. Notice requirements.

Eligibility

CHOICE arrangements must be offered on the same terms to all employees within a specified class. Employers may designate any of the following as a specified class of employees for purposes of offering CHOICE arrangements:

- Full-time employees.
- Part-time employees.
- Salaried employees.
- Non-salaried employees.
- Employees whose primary site of employment is in the same rating area.
- Employees covered by a collective bargaining agreement (CBA).
- Employees who have not satisfied a waiting period under the group health plan.
- Seasonal employees.
- Employees who are nonresident aliens with no U.S.-source earned income.
- Any other class of employees as designated by the Secretary of the Treasury.

These are the same classes as in the 2019 Final Rule's allowable employee classes except that the 2019 Final Rule also allowed a class for staffing company employees. Similar to the 2019 Final Rule, CHOICE arrangements also permit employers to combine multiple classes. In addition, CHOICE arrangements allow flexibility for the Secretary of the Treasury to designate additional classes, potentially expanding the original nine applicable classes.

Variations in benefit amounts are permitted based on age (up to 300% of the lowest maximum dollar amount) or number of dependents. Employers may prospectively offer CHOICE arrangements to newly hired employees in a class while maintaining traditional coverage for existing employees.

Nondiscrimination requirements

The bill states that CHOICE arrangements comply with the nondiscrimination provisions in Section 9802 of the Internal Revenue Code and Section 2705 of the Public Health Service Act (PHSA). To meet the nondiscrimination requirements of the bill itself, employers may not offer to those eligible for the CHOICE arrangement any other group health plan coverage other than a fully insured small group market plan or coverage consisting solely of excepted benefits.

Substantiation requirements

Employers must implement "reasonable procedures" to verify that covered individuals are enrolled in qualifying individual market or Medicare coverage. The bill does not describe what reasonable procedures are, which may signal an intent to provide sponsors and administrators with greater flexibility.

Notice requirements

Employers must provide notice of CHOICE arrangement rights and obligations at least 60 days before the plan year begins. This shortens the timeframe from 90 days under the 2019 Final Rule for ICHRAs.

Summary of benefits and coverage

CHOICE arrangements that otherwise satisfy the bill's requirements are treated as satisfying PHSA Section 2715, which requires group health plans and health insurance issuers offering group or individual coverage to provide a standardized summary of benefits and coverage.

Tax reporting

Employers must report total permitted benefits for enrolled individuals under a CHOICE arrangement on Form W-2 for such employees.

Effective Date: Plan years beginning after December 31, 2025.

Cafeteria Plans

Generally, employees cannot use salary reduction contributions through a cafeteria plan to purchase individual health insurance coverage on an Exchange. Such coverage is specifically excluded from the definitions of a "qualified benefit" under IRS Code Section 125 cafeteria plan. The bill amends Section 125 to make an exception to this exclusion, allowing employees who are enrolled in a CHOICE arrangement offered by the employee's employer to use salary reduction contributions under a cafeteria plan to purchase Exchange-based individual health insurance coverage. (Note: Code Section 125 rules require cafeteria plans to have a written plan document that lists the benefits offered through the plan.)

Effective Date: Taxable years after December 31, 2025.

Employer Credit

A new business tax credit is proposed for small employers (non-ALEs, or employers with fewer than 50 full-time equivalent employees) offering CHOICE arrangements. The credit is available to eligible employers during the "credit period," which is the two-year period beginning with the month during which the employer first establishes a CHOICE arrangement. The proposed credit is currently $100 per month that the employee is enrolled in year one, and one-half of that amount (currently $50 per month) in year two. CHOICE arrangements must constitute affordable minimum essential coverage that provides minimum value to qualify for the tax credit. The proposed credit is allowed against the alternative minimum tax, and the $100 credit amount will be adjusted for inflation beginning in 2027.

Effective Date: Taxable years after December 31, 2025.

HSA Reforms

The following sections outline the proposed HSA reforms, highlighting their potential impact on HSA participants. Notably absent from the bill is an extension of the COVID-era telehealth exception that allows for HSA participants to receive telehealth (or other remote care) benefits before satisfying their annual deductible.

Individuals entitled to age-based Medicare Part A

Currently, a person enrolled in Medicare Part A is not an "eligible individual" for HSA purposes. A person generally becomes enrolled in Part A automatically upon applying for Social Security benefits.

Under the bill, individuals enrolled only in Medicare Part A based on age (assuming no enrollment in Part B or D) would not be disqualified from HSA eligibility solely because of the Medicare Part A enrollment. In other words, an individual who is otherwise an eligible individual but is enrolled in Medicare Part A can still establish and contribute to an HSA.

The bill departs from current rules and prohibits HSA-eligible individuals who are age 65 and over from using HSA funds to purchase health insurance and imposes the 20% additional tax on HSA distributions not used for qualified medical expenses.

Also note that late enrollment penalties under Medicare are not addressed in the bill and would therefore generally still apply unless eligibility for the high-deductible health plan (HDHP) coverage is a result of active employment (either the eligible individual's or their spouse's).

Effective Date: Months beginning after December 31, 2025.

Direct primary care

Direct primary care arrangements, as defined by the bill, would no longer disqualify individuals from HSA eligibility. Generally, a direct primary care arrangement for HSA purposes means an arrangement consisting solely of "primary care" services that are qualified medical care provided by a primary care provider *in which a fixed periodic fee, irrespective of actual services provided, is the sole compensation.* The bill excludes from this definition any arrangement if the aggregate fee for all direct primary care service arrangements exceed $150 per month (or 2x such amounts if coverage is for more than one person), adjusted annually. Primary care services do not include the following for purposes of this definition: general anesthesia-required procedures, prescription drugs other than vaccines, and lab services not typically administered in an ambulatory primary care setting.

Effective Date: Months beginning after December 31, 2025.

Bronze and catastrophic plans

The bill would treat bronze-level and catastrophic-level plans available as individual coverage through an Exchange as HDHPs, irrespective of the deductibles under such plans.

Effective Date: Months beginning after December 31, 2025.

On-site clinics

Certain "qualified items and services" provided at employer on-site clinics or clinics operated primarily for the benefit of the employer's employees do not disqualify individuals from being able to contribute to an HSA. Qualified items and services include physical exams, immunizations (including antigen injections), drugs or biologicals (other than prescribed drugs), treatment for on-the-job injuries, preventive care for chronic conditions, drug testing, hearing/vision screening, and related services. While this is generally good news, employers that offer primary care coverage through an on-site clinic will presumably need to curtail benefits that go beyond the permitted HSA-compatible benefits described above. Note that telehealth services are not addressed by the bill.

Effective Date: Months beginning in taxable years after December 31, 2025.

Fitness and wellness expenses

The bill would allow up to $500 (individual) or $1,000 (joint or head of household) annually, limited to one-twelfth of the total amount monthly, to be withdrawn tax-free from HSAs for qualified sports and fitness expenses. Qualified sports and fitness expenses are amounts paid "exclusively" for the "sole purpose" of participating in a physical activity, including memberships at a "fitness facility" and instruction in a physical exercise or activity. Private clubs owned and operated by its members that offer golf, sailing, hunting, or riding facilities would not qualify as a "fitness facility" if the health or fitness component were incidental to the overall function or purpose of the facility or the facility was not fully compliant with any state or federal antidiscrimination laws. Expenses for personal trainers are excluded, as are expenses for videos, books, and remote or virtual instruction (unless live). One-off expenses are not allowed – membership, participation, or instruction must continue for

more than one day or one session.

Important: These proposed changes for qualified HSA expenses are in IRS Code Section 223, which specifically governs HSAs. The general provision for expenses that qualify as “medical care” for HSAs and other tax-advantaged arrangements (like health flexible spending accounts (FSAs) and HRAs) is Section 213(d). Importantly, the proposed change to include “fitness facility” expenses applies only to HSAs under Section 223 and does not extend to other tax-advantaged accounts governed by Section 213(d), such as health FSAs or HRAs. Unlike current rules under Section 213(d), the bill does not require the expense to be related to a diagnosed medical condition, marking a significant expansion in eligible uses.

Effective Date: Taxable years after December 31, 2025.

Catch-up contributions

The bill would allow married couples over 55 to each make catch-up contributions to a single HSA.

Effective Date: Taxable years after December 31, 2025.

Qualified rollovers from FSAs and HRAs

The bill generally reinstates (from 2012) and expands the ability to roll over unused FSA or HRA funds into an HSA (“qualified HSA distribution”) when transitioning to HDHP coverage, provided the individual was not covered by an HDHP in the prior four years. For a qualified HSA distribution made before the end of the plan year, the FSA or HRA must be converted to an HSA-compatible arrangement if the individual remains enrolled in the FSA or HRA for the remainder of the year.

For a given year, the total amount of qualified HSA distributions cannot exceed the annual limit for FSA contributions unless the eligible individual has family coverage under an HDHP, in which case the annual maximum is 2x this amount. Although the bill does not limit the number of qualified HSA distributions a person can make, the amount of the qualified HSA distribution reduces the limitation on deductible HSA contributions the eligible individual can make for the year.

The bill requires qualified HSA distributions to be reported on Form W-2 (presumably in Box 12).

Effective Date: Distributions made after December 31, 2025.

Pre-establishment medical expenses

The bill would allow medical expenses incurred up to 60 days before HSA establishment to be eligible for tax-free reimbursement. The HSA would be treated as having been established on the date coverage under the HDHP begins, but only for purposes of determining whether a medical expense is qualified.

Effective Date: Coverage beginning after December 31, 2025.

Spousal FSA exception

Coverage under a spouse’s FSA will not disqualify an individual from HSA eligibility if the aggregate amount of the reimbursements from the spouse’s FSA for the plan year do not exceed the aggregate amount of the eligible expenses for the plan year that do not include expenses incurred by the otherwise HSA-eligible individual. Presumably this could include expenses for covered children, so long as it does not include expenses for the spouse that is not enrolled in the FSA.

Effective Date: Plan years beginning after December 31, 2025.

Expanded deductible contribution limits

The bill increases the deductible limit for HSA contributions by $4,300 (self-only) and $8,550 (family), subject to income-based phaseouts starting at $75,000 (single) and $150,000 (joint) and ending at $100,000 and $200,000, respectively. This change would not apply to increases in employee contributions under IRS Code Section 125 plans or employer contributions, just to the deductible limit for employee contributions.

Effective Date: Taxable years after December 31, 2025.

A Look Ahead

We will continue to monitor the bill's legislative trajectory closely since its enactment could result in substantial modifications to the current framework governing HRAs and HSAs.

The bill has not yet been approved by the Senate, so plan sponsors should be aware that amendments or delays could materially affect the scope, timing, or implementation of the proposed ICHRA and HSA provisions.

If you have any questions, or would like additional information, please contact one of the attorneys on our Employee Benefits & Executive Compensation team.

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Meet the Authors

Ashley Gillihan
Partner

Phone: +1 404 881 7390
Email: ashley.gillihan@alston.com

John R. Hickman
Partner

Phone: +1 404 881 7885
Email: john.hickman@alston.com

Laurie Kirkwood
Senior Attorney

Phone: +1 404 881 7814
Email: laurie.kirkwood@alston.com

Bria Smith
Associate

Phone: +1 404 881 7559
Email: bria.smith@alston.com