ALSTON & BIRD

HEALTH & WELFARE PLAN LUNCH GROUP

September 4, 2025

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INDEX

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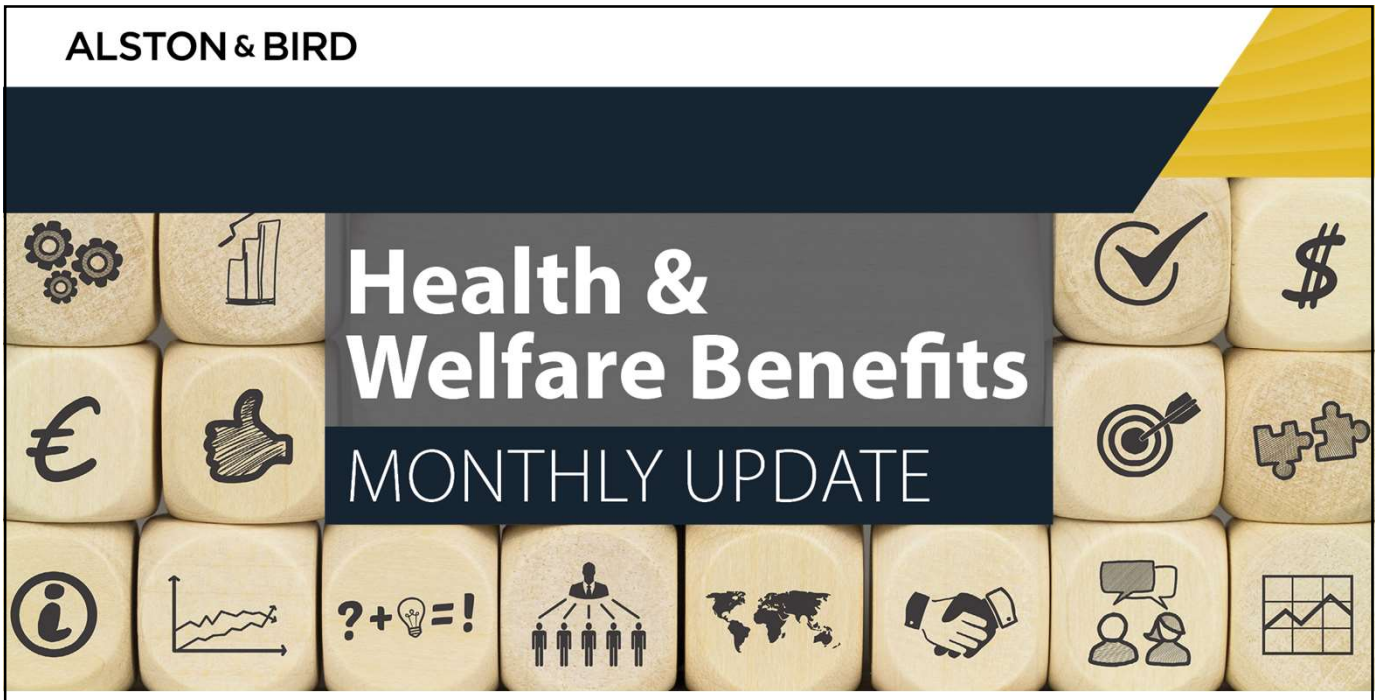

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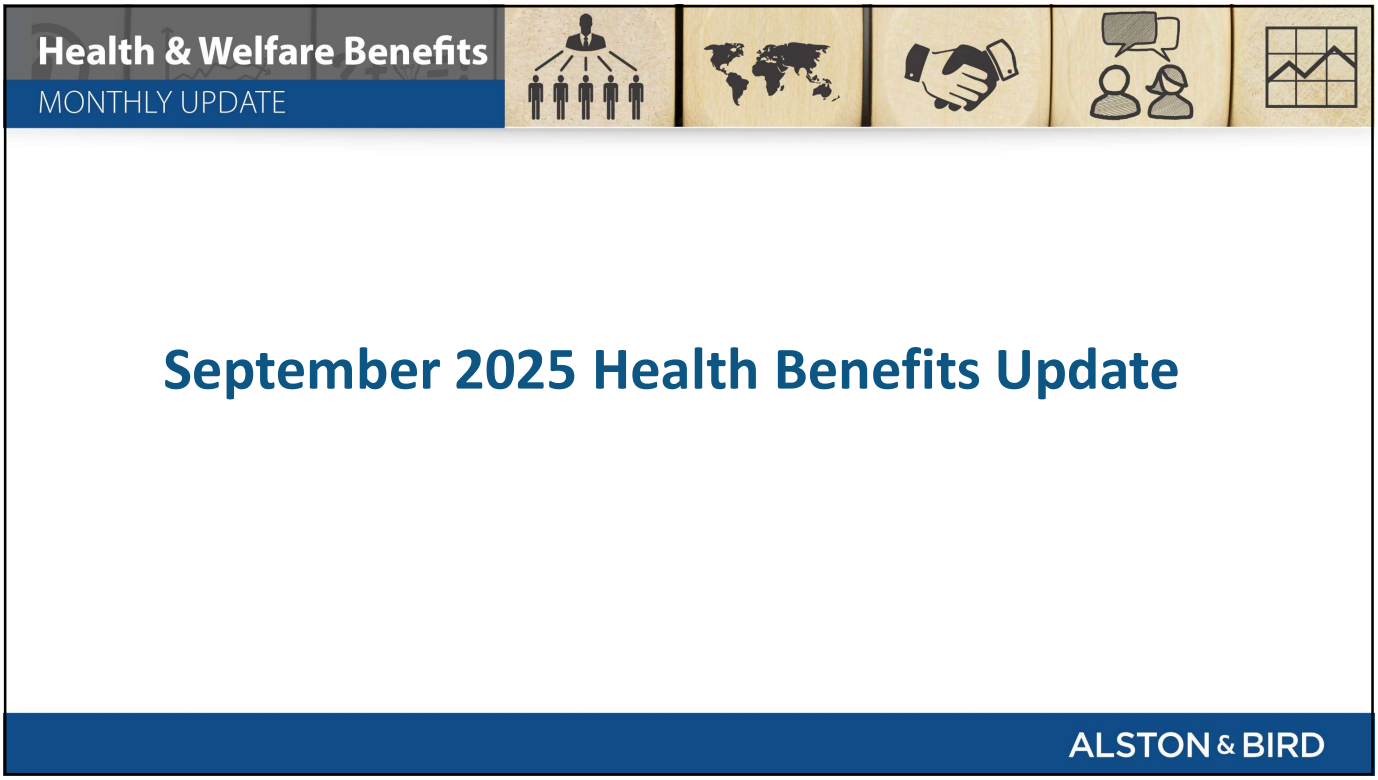

September 2025 Health Benefits Update

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1

Health & Welfare Benefits
MONTHLY UPDATE

September 2025 Agenda

- One Big Beautiful Bill HSA and Health Plan Provisions
- Other Health Benefit Developments
- New Agency Guidance
- Health Benefits Litigation
- Open Enrollment Update for 2026

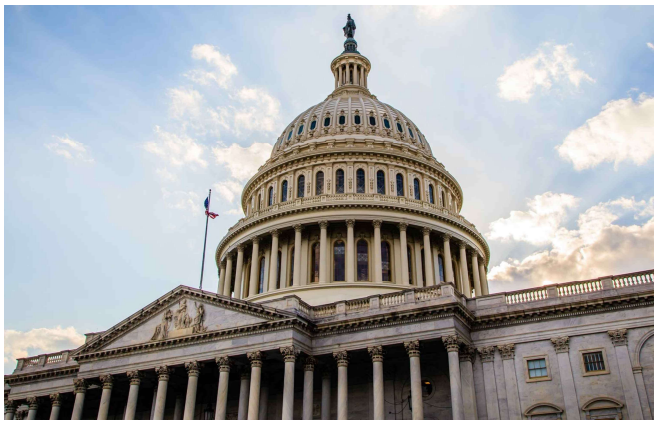
Health & Welfare Benefits
MONTHLY UPDATE

One Big Beautiful Bill -- HSA and Health Plan Provisions

Health & Welfare Benefits
MONTHLY UPDATE

House Bill, 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,"
  - codified the regulatory framework for Individual Coverage Health Reimbursement Arrangements (ICHRAs), rebranded as CHOICE arrangements (Custom Health Option and Individual Care Expense), and
  - proposed sweeping reforms to Health Savings Accounts (HSAs).
- The Senate approved a modified version of the House Bill, removing the CHOICE Act provisions and limiting the HSA improvements
- The Senate version became law on July 4th



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4

Health & Welfare Benefits
MONTHLY UPDATE

Comparison of Senate and House Versions

Senate version (enacted into law)

-Telehealth exception for HSAs made permanent (retro to 1/1/25). Section 71306 (Not in House Bill)

- Bronze and Catastrophic Exchange Plans Qualify as HDHP. Section 71307 (from House Bill)

- Certain Direct Primary Care (up to $150 individual/$300 plus one or more) compatible with HSAs. Section 71308 (from House Bill)

- Dependent Care Assistance (e.g., DCAP FSA) benefits increased to $3750/$7500 (up from $2500/$5000). Section 70404

- Permanent extension of CARES Act tax-free student loan repayment assistance (annual limits still $5,250, but cost of living adjustment applies for taxable years after 2026). Section 70412 (from House Bill)

- Note: Bicycle (commuter) benefit is eliminated effective for tax years on/after 12/31/25. Section 70112

House version provisions left on cutting room floor (NOT enacted)

- ICHRA codification

- Medicare Part A eligibility
- Onsite clinic compatibility
- Fitness/Wellness expenses
- Catchup contribution for spouse
- FSA/HRA rollovers
- Spousal FSA eligibility
- Increased HSA contribution
- Establishment Date Issue fix

5

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5

Health & Welfare Benefits
MONTHLY UPDATE

Provisions enacted into Law

- *Telehealth Exception for HSAs made permanent:* Telehealth (or other remote care) will not disqualify an individual from HSA eligibility. **Effective Date: Plan years beginning after December 31, 2024 (effectively bridges existing arrangements)**
  - Huge interest by employers with HDHPs
  - When is care telehealth or remote care ?? Is it applicable to DME or Rx?
- *Direct Primary Care (DPC)*: Direct primary care arrangements (up to $150 individual/$300 for two or more per month) compatible with HSA eligibility and an HSA-eligible expense. **Effective Date: Months beginning after December 31, 2025**
  - DPC is defined to include care by a primary care provider or PA within a list of specified codes. But excludes general anesthesia-required procedures, prescription drugs other than vaccines, and lab services not typically administered in an ambulatory primary care setting.
  - Many questions: Can annual payment be prorated; can payments be made by employer or pre-tax by employee?
- *Bronze and Catastrophic Exchange Plans*: These plans are now treated as HSA compatible irrespective of deductible level. **Effective Date: Months beginning after December 31, 2025.**
  - Exchange plans cannot be pre-tax under a cafeteria plan; applicable to HRAs?

6

Health & Welfare Benefits
MONTHLY UPDATE

Provisions enacted into Law

- DCAP benefits increased to $3750/$7500 (up from $2500/$5000) - no indexing. **Effective Date: Years beginning after December 31, 2025**
  - But changes also made to tax credit significantly complicating DCAP discrimination testing
- *Permanent extension for student loan repayment assistance*: CARES Act tax-free student loan repayment assistance under Code Section 127 of up to $5,250 annually. Adjusted for cost of living (for taxable years after 2026) . **Effective Date: Payments made after December 31, 2025**
- *Bicycle Commuter Benefit:* Provision for bicycle commuter benefit NOT extended beyond 12/31/2025. Inflation adjustments for other commuter benefits modified.

7

Health & Welfare Benefits
MONTHLY UPDATE

House Bill Provisions (NOT Enacted)

- The following House Bill provisions for HSAs and ICHRAs/CHOICE arrangements were not enacted, but may make their way into future legislation
  - **ICHRA codification (CHOICE Arrangements) – Not enacted as part of OBBB**
  - HSA changes (not enacted as part of OBBB)
    - Medicare Part A eligibility
    - Onsite clinic compatibility
    - Fitness/Wellness expenses
    - Catchup contribution for spouse
    - FSA/HRA rollovers
    - Spousal FSA eligibility
    - Increased HSA contribution
    - Establishment Date Issue fix

8

Health & Welfare Benefits
MONTHLY UPDATE

House Bill CHOICE Arrangements Highlights (Not Enacted)

The House bill would have codified existing ICHRA regulations and rebranded them as CHOICE arrangements.

NEW: Employers with fewer than 50 employees would have qualified for a new tax credit for offering CHOICE arrangements.

NEW: The House proposal would have allowed employees to use cafeteria plan salary reductions to purchase Exchange-based coverage through a CHOICE arrangement.

9

Health & Welfare Benefits
MONTHLY UPDATE

House Bill CHOICE Arrangement Requirements (NOT enacted)

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 would have shortened the timeframe from 90 days under the 2019 Final Rule for ICHRAs.

Health & Welfare Benefits
MONTHLY UPDATE

House Bill CHOICE Arrangements (NOT Enacted)

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).

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 (if enacted): Taxable Years after December 31, 2025.

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

Effective Date (if enacted): Plan years beginning 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 (if enacted): Taxable years after December 31, 2025.

Health & Welfare Benefits
MONTHLY UPDATE

House Bill HSA Provisions Overview (NOT enacted)

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

Health & Welfare Benefits
MONTHLY UPDATE

House Bill HSA Provisions Overview (NOT enacted)

Medicare Part A Enrollees:	• Individuals enrolled only in Medicare Part A would have been eligible to contribute to HSAs, reversing prior restrictions that disqualified them from eligibility. • **Effective Date (if enacted): Months beginning after December 31, 2025.** • Did not include VA or IHS plans
On-Site Clinics:	• Certain limited on-site clinic services (e.g., immunizations, injury treatment, chronic care) would not disqualify individuals from HSA eligibility. • **Effective Date (if enacted): Months beginning in taxable years after December 31, 2025.** • Can DPC fill this void?
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, could be withdrawn tax-free from HSAs for qualified physical activity and fitness expenses. • **Effective Date (if enacted): Taxable years after December 31, 2025.**
Catch-Up Contributions:	• Married couples could have contributed both spouses' (both must be at least age 55) catch-up contributions to a single HSA. • **Effective Date (if enacted): Taxable years after December 31, 2025.**

Health & Welfare Benefits
MONTHLY UPDATE

House Bill HSA Provisions Overview (NOT enacted)

Qualified Rollovers from FSAs and HRAs:

- The bill would have reinstated and expanded 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 (if enacted): Distributions made after December 31, 2025.**

Pre-Establishment Medical Expenses:

- Medical expenses incurred up to 60 days before HSA establishment would have been eligible for tax-free reimbursement, provided the HSA is opened within that window.
- **Effective Date (if enacted): Coverage beginning after December 31, 2025.**

Spousal FSA Exception:

- Coverage under a spouse's general-purpose FSA would not have disqualified an individual from HSA eligibility if reimbursements are limited to the spouse's own expenses.
- **Effective Date (if enacted): Plan years beginning after December 31, 2025.**

Expanded Contribution Limits:

- The bill would have increased 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 (if enacted): Taxable years after December 31, 2025.**

Health & Welfare Benefits
MONTHLY UPDATE

Preparing for 2026: Next Steps

Telehealth Extension for HSAs:	Bronze and Catastrophic Exchange Plans qualify as HDHP.	Certain Direct Primary Care compatible with HSAs.	Dependent Care Assistance (benefits increased to $3750/$7500 (up from $2500/$5000).	Tax-free student loan repayment assistance extension.	Bicycle (commuter) benefit is eliminated effective for tax years on/after 12/31/25.
• **Optional—Plan sponsors do not have to adopt.** • If removed in 2025, plan sponsors may add it back (using proper process/procedure). • If never removed, the extension is retroactive.	• **Required**, if pre-tax HSA contributions are permitted under the 125 plan for participants who are not enrolled in employer's HDHP. • Ensure that HSA eligibility language describing compatible HDHP coverage does not inadvertently exclude Bronze and Catastrophic Exchange Plans. • [NOTE: Contributions for individual exchange policies *cannot* be made pretax under a cafeteria plan.]	• **Required.** Review any definition of eligible medical expenses for HSAs and ensure it aligns with Code section 223(d).	• **Optional—Plan sponsors do not have to adopt the increase.** If adopting, consider nondiscrimination testing issues. • Consider whether to exclude HCEs entirely. • Use proper plan process/procedure for any amendments. • Include changes in open enrollment materials. • **Required:** If the DCAP SPD includes a discussion on the child and dependent care tax credit, review and update, if needed, to align with OBBBA amendment.	• **Optional—Plan sponsors do not have to adopt.**	• **Required:** Permanently remove bicycle commuter benefits from qualified Code Section 132 plans.

Proposed Legislation

16

Health & Welfare Benefits
MONTHLY UPDATE

Proposed Legislation—Patients Deserve Price Tags

"Patients Deserve Price Tags Act" (S. 2355) Introduced 7/17/25 by Sen. Marshall [R-KS]

New prohibited transaction exemption (PTE):

- Amends ERISA Section 408(b) to add a PTE for agreements with certain covered service providers.
- Key provisions tie in with gag clause requirements.
- Imposes a **civil monetary penalty of $10,000 per day** for each day the violation continues on service providers that violate these requirements.
- Would apply to excepted benefits.

New statutory sections:

- Amends the PHSA and ERISA (in parallel provisions) to provide ongoing oversight of administrative services providers with respect to the gag clause requirements.
- Imposes a **civil penalty of $100,000 per day** for violations by service providers.
- Would not apply to excepted benefits.

17

Proposed Legislation—Patients Deserve Price Tags (cont.)

- New PTE: An agreement is not reasonable (and therefore is a prohibited transaction) unless it meets certain requirements:
  - **Mandatory Data Access (ties in to Gag Clause rules):** Agreement must allow the plan fiduciary access to all claims and encounter information or data, and any documentation supporting claim payments, including medical records and policy documents or data/information described in ERISA 724 (a)(1)(B) (i.e., the Gag Clause requirements), to enable compliance with plan terms and applicable law, and to determine payment accuracy or reasonableness.
  - **No Unreasonable Restrictions:** Agreement must not unreasonably limit or delay access to such information (no longer than 15 days), limit the volume of data, restrict disclosure of pricing terms for value-based or capitated arrangements, overpayments, audit rights, or public disclosure of de-identified/aggregate information.
  - **HIPAA Compliance:** Data must be provided in a manner consistent with HIPAA privacy and security rules.
  - **Void Provisions:** Any contract provision that unduly delays or limits access to required information, or otherwise violates the new requirements, is void as against public policy.
  - **Civil Penalties:** Service providers that violate these requirements are subject to a civil penalty of $10,000 per day for each day the violation continues.

18

Health & Welfare Benefits
MONTHLY UPDATE

Proposed Legislation—Patients Deserve Price Tags (cont.)

- Amends the PHSA and ERISA (in parallel provisions) to provide ongoing oversight of administrative services providers with respect to the gag clause requirements:
  - Prohibits agreements that limit or delay (beyond the required reporting period) the disclosure of information needed by the plan to comply with federal requirements.
  - Requires health plan service providers to provide, at least quarterly and at no cost, detailed disclosures to the plan, including claims and encounter data, which tie in with gag clause requirements, as well as:
    - Payment methodologies, pricing schedules, and formulas
    - Rebates, fees, alternative discounts, and all other remuneration
    - Payment data and reconciliation information for alternative compensation arrangements (e.g., value-based programs, shared savings, capitation)
  - Mandates that all data be provided in standard electronic formats.
  - Any contract provision that restricts or delays access to required information, or restricts the format/timing of such information, is prohibited and void as against public policy.
  - Imposes a **civil penalty of $100,000 per day** for violations.
  - Requires the Secretary to implement these requirements through rulemaking.

19

Proposed Legislation—Workers' Disability Benefits Parity Act

"**Workers' Disability Benefits Parity Act**" (H.R. 3758) Introduced 6/05/2025 by Rep. DeSaulnier [D-CA-10] and referred to House Committee on Education and Workforce.

Amends ERISA Title I to add a new Part 9 to establish parity in the treatment of behavioral health and physical health conditions under disability benefit plans, covering both private and governmental plans.

Would impose significant new burdens (and potential liability) on disability coverage:

- Disability benefit plans could not impose more restrictive limitations, exclusions, or restrictions on benefits for disabilities arising from mental health or substance use disorders than for physical health conditions.
- Provides definitions for "disability benefit," "disability benefit plan," "mental health condition," and "substance use disorder," referencing the WHO ICD and DSM for diagnostic criteria.
- Authorizes DOL to assess civil penalties for violations, with penalties accruing daily for each affected participant or beneficiary during the period of noncompliance.
- Provides for both state and federal enforcement, including a private right of action for aggrieved individuals to seek equitable relief in state or federal court.
- Does not preempt state laws that provide greater protections, except where such laws prevent application of the federal parity requirements.

Health & Welfare Benefits
MONTHLY UPDATE

Health Benefits Litigation Update

Litigation Update: Skrmetti

Background: Tennessee law SB1 restricted medical treatments for transgender minors. The law included classifications such as age and medical use. Plaintiffs alleged that the law violates the Equal Protection Clause of the Fourteenth Amendment.

June 18, 2025: SCOTUS affirmed the judgment of the Sixth Circuit and upheld Tennessee's SB1.

- SB1 did not trigger heightened scrutiny and satisfied rational basis review.
- SB1 does not classify based on sex or transgender status but rather on age and medical use.
- The court emphasized the state's discretion in areas of medical and scientific uncertainty.
- The Court declined to extend the reasoning of *Bostock v. Clayton County* (which interpreted Title VII's prohibition on sex discrimination in employment to include discrimination based on transgender status) to the Equal Protection context, noting that the application of SB1 does not change if a minor's sex or transgender status is changed.

Practical consequences of Skrmetti for plans: Similar to the *Dobbs* opinion, the outcome of *Skrmetti* affects the ability of states to regulate certain medical procedures. Plans may have to contend with a patchwork of state laws with respect to certain types of care for minors.

Litigation under 1557 of the ACA in the 9th and under Title VII in the 11th Circuits is still pending.

Short-Term Limited Duration Insurance (STLDI)

April 2024:

- Cut back the current 36-month max renewal limit on STLDI to three months with one month extension Imposed new notice requirements on both STLDI and certain types of fixed indemnity excepted benefits.

December 2024:

- A Texas court vacated the notice requirement for fixed indemnity (see *ManhattanLife Insurance and Annuity Company et al v. HHS et al* E.D.Tex. 6:24-cv-00178-JCB).

February 2025:

- A separate challenge on STLDI restrictions is stayed to allow new agency leadership to evaluate the government's position and consider rulemaking. (see *American Association of Ancillary Benefits et al. v. Becerra et al.*, 4:24-cv-00783, August 29, 2024).

June 2025:

- June 2: A Texas federal judge paused the lawsuit that challenges the Final Rule as related to STLDI (*American Association of Ancillary Benefits*). The Trump administration stated that it intends to revisit the rule in new rulemaking "as soon as practicable", and the court instructed the Departments to provide a timeline for new rulemaking by Aug. 28, 2025.
- June 10: The 5th Circuit dismissed HHS's appeal in *ManhattanLife Insurance and Annuity Company* that vacated only the notice requirements for excepted benefits.

August 2025:

- August 7: Departments of Labor, Health & Human Services, and Treasury issued a statement of intent ***not*** "to prioritize enforcement actions" for violations related to failing to meet the definition of STDLI in the 2024 final rules, including the notice provision. HHS encouraged States to adopt a similar approach to enforcement.
- August 28: HHS files a motion to extend the stay in *American Association of Ancillary Benefits*, informing the court HHS expects to publish a notice of proposed rulemaking no later than Summer 2026, with a final rule later that year.

Health & Welfare Benefits
MONTHLY UPDATE

Kennedy v. Braidwood Management, Inc.

2020: Plaintiffs (Braidwood and others) filed suit challenging the appointment of the U.S. Preventive Services Task Force (USPSTF) under the Appointments Clause.

March 30, 2023: District Court granted summary judgment for plaintiffs, holding Task Force members were principal officers and unconstitutionally appointed. Injunction issued against enforcement of Task Force recommendations post-2010 ACA.

June 2023: While appeal was pending, Secretary of HHS ratified and re-appointed existing Task Force members and began personally appointing new members.

October 2023: 5th Circuit affirmed District Court in relevant part, holding Task Force members are principal officers not subject to Secretary's supervision, and thus unconstitutionally appointed.

January 2025: Supreme Court granted certiorari to review whether appointment of Task Force members by the Secretary of HHS violates the Appointments Clause.

April 2025: Oral Arguments held at SCOTUS.

June 27, 2025: Supreme Court issued opinion, reversing the Fifth Circuit and holding Task Force members are inferior officers whose appointment by the Secretary of HHS is constitutional.

The dissent argued that Congress had not clearly vested appointment authority in the Secretary and that the statutory language was insufficient to overcome the Appointments Clause's default rule. The dissent also maintained that the Task Force was designed to be independent of the Secretary.

Health & Welfare Benefits
MONTHLY UPDATE

Tobacco Surcharge: Litigation Update

- Over 40 cases pending.
- Recent lawsuits focus on "no full reward" and explanation of "reasonable alternative."
- Plaintiff's goal is to survive motion to dismiss and settle.
  - To date, in every case that has denied a motion to dismiss, in whole or in part, the plan at issue failed to offer retroactive reimbursement at all and/or failed to include a statement that a physician's recommendation would be accommodated.
- In one case from the W.D. of North Carolina, the court dismissed the breach of fiduciary duty claims finding that the plaintiffs failed to plausibly allege that the surcharge amounts collected were plan assets. The court also found that the plaintiffs failed to allege that the plan suffered any harm, which is similar to the decision in a Minnesota district court.
- In a case before the District Court of Minnesota:
  - Participants had until March 31 to enroll in a tobacco cessation program. If they enrolled by March 31, and completed the program by December 15, they received retroactive reimbursement and prospective removal. If they enrolled after March 31, participants only received prospective removal. *The court held that this program did not violate ERISA § 702 and dismissed plaintiff's breach of fiduciary duty claim and prohibited transaction claim*.
  - Plaintiff's allegation that the plan materials failed to allege that a physician's recommendation would be accommodated survived the motion to dismiss.

Tobacco Surcharge: Sodexo and Arbitration

- *Platt v. Sodexo, S.A.*: Plaintiff sued Sodexo defendant, claiming that a monthly tobacco surcharge on his employee health insurance premiums violated ERISA. The court addressed whether Sodexo could unilaterally amend an ERISA-governed plan to include an arbitration provision without the consent of the relevant parties.
- On August 4 2025 the Court filed its opinion, holding that:
  - **Consent Is Required for Arbitration Provisions in ERISA Plans:** Employer cannot unilaterally amend an ERISA-governed plan to add an arbitration provision without obtaining consent from the relevant party.
  - **Who Must Consent Depends on the Nature of the ERISA Claim**
    - For claims under ERISA § 502(a)(1)(B) and § 502(a)(3) (claims for benefits and equitable relief by plan participants), the relevant consenting party is the plan participant. The court found that Platt did not consent to arbitration because he did not receive sufficient notice of the new arbitration provision or that continued participation in the plan would constitute consent.
    - For claims under ERISA § 502(a)(2) (breach of fiduciary duty claims brought on behalf of the plan), the relevant consenting party is the plan itself. The court found that the plan, through its terms granting broad amendment authority to Sodexo, had consented to the arbitration provision.
  - **Limits on Arbitration: Effective Vindication Doctrine:** Prevents enforcement of arbitration agreements that would prospectively waive a party's right to pursue statutory remedies, such as plan-wide relief under ERISA
    - A provision in the arbitration agreement prohibiting representative actions (i.e., actions brought on behalf of the plan) was held to be invalid under the effective vindication doctrine.
  - **Unconscionability Defenses:** ERISA does not preempt unconscionability defenses to arbitration provisions—these defenses are available under common law. The issue was remanded to the district court.

HIPAA Reproductive Healthcare Final Rule

April 2024: The HIPAA Privacy Rule to Support Reproductive Health Care Privacy was published (89 Fed. Reg. 32976)

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June 2025: The U.S. District Court for the N.D. of Texas issued a universal vacatur of all but a few provisions of the HIPAA Privacy Rule in *Purl v. HHS*. The court severed unchallenged provisions related to substance use disorder records (HIPAA Part 2).

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July 2025: The court granted the parties' motion to stay proceedings in *Texas v. HHS*, in light of the *Purl* decision.

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August 2025:

- August 18: The deadline to appeal the district court's judgment in *Purl v. HHS*. The government did not appeal, but proposed intervenors filed a protective notice of appeal regarding the denial of their motion to intervene.
- August 25: The parties in *Texas v. HHS* filed a joint status report requesting the court to continue the stay pending resolution of appellate proceedings in *Purl v. HHS*.

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November 24, 2025: If the court continues the stay, the parties have agreed to meet, confer, and file a joint status report by this date to address whether the stay should continue and to propose any appropriate next steps.

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Every 90 days After: The parties will continue to file joint status reports every 90 days after November 24, 2025, to update the court on the status of the stay and propose next steps, until the appellate proceedings in *Purl* are resolved or the court orders otherwise.

Health & Welfare Benefits
MONTHLY UPDATE

HIPAA Reproductive Healthcare and HIPAA Part 2

February 2026: HIPAA Notice of Privacy Practices (NPP) must be updated for the HIPAA Reproductive Healthcare Final Rule and HIPAA Part 2

- What updates need to be made to the HIPAA NPP for HIPAA Part 2?
  - HHS promised model language, which has not yet been issued.
  - On August 27, 2025, HHS's delegation of authority to the HHS Office for Civil Rights (OCR) to enforce the confidentiality of substance use disorder (SUD) patient records under 42 CFR Part 2 was published in Federal Register.

HIPAA Reproductive Healthcare Final Rule has been vacated by a Texas district court, but proceedings are still pending.

- What should plans do to comply with the HIPAA Reproductive Healthcare Final Rule while litigation is ongoing?
- Do attestations still need to be collected?
- Do NPPs need to be updated?

Health & Welfare Benefits
MONTHLY UPDATE

Grab Bag

State PBM Laws

States continue to pass laws that may affect ERISA self-funded plans, directly or indirectly

Common provisions in some state laws--Preempted or not preempted?

- *PBM Reimbursement Rate Regulation*. Minimum reimbursement for independent pharmacies.
- *Spread Pricing Prohibition*. Ban on PBM spread pricing unless required by plan; reporting requirements
- *Rebate Pass-Through Requirements*. PBMs must pass 100% of rebates to plan or as directed by plan sponsor.
- *Transparency/Disclosure Requirements*. Reporting reimbursement, pricing, or audit data to state regulators.
- *Prohibition on Gag Clauses*. PBMs cannot prohibit pharmacists from sharing price/cost info with covered persons
- *Any-Willing-Provider / Network Access Mandates*. PBMs must allow any pharmacy meeting terms to join network; cannot restrict network composition
- *Prohibitions on Mail-Order/Specialty Pharmacy Restrictions*. PBMs cannot require use of mail-order or affiliate pharmacies
- *Credentialing Standards Beyond State License*. PBMs cannot impose credentialing beyond state pharmacy board
- *Prohibition on Steering*. PBMs cannot steer covered persons to certain pharmacies
- *Audit and Enforcement by State Insurance Commissioner*

Laws are complex and effects on plans should be evaluated by legal counsel.

Health & Welfare Benefits
MONTHLY UPDATE

Mental Health Parity: Compliance Still Required during Nonenforcement

Not currently being enforced:

- Fiduciary certification
- New definitions for "mental health" and "substance use disorder" tied to the Diagnostic and Statistical Manual (DSM) and the International Classification of Diseases (ICD)
- Outcomes data review standards/ material differences
- Meaningful benefit/core treatment standard
- Prohibition on discriminatory factors
- Comparative analysis codified as an instrument under which the plan is established or operated for purposes of document requests under ERISA §104(b).

Still in effect:

- 2013 Final Rule
- Consolidated Appropriations Act of 2021 and the required comparative analysis
- FAQ Part 45
- Parity for quantitative and nonquantitative treatment limitations for MH/SUD as compared to Med/Surg

How long is the non-enforcement?

- 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.
- Case: ERISA Industry Committee v. Department of Health and Human Services et al, D.D.C., No. 1:25-cv-00136
- May 15, 2025 Nonenforcement Policy

Health & Welfare Benefits
MONTHLY UPDATE

Open Enrollment Update 2026

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32

Health & Welfare Benefits
MONTHLY UPDATE

What's New?

- HSA Limits
  - Minimum Deductible: $1,700 self/$3,400 other than self-only
  - Out-of-Pocket Maximum: $8,500 self/$17,000 other than self-only
  - Contribution Limit: $4,400 self/$8,750 other than self-only
- DCAP Limits
  - $3,750/$7,500 (up from $2,500/$5,000)
- ACA OOP Maximum: $10,600 for self/$21,200 for other than self-only

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33

Annual Notices

- Medicare Part D Creditable Coverage Notices
  - Best practice is to give to all participants and beneficiaries
  - Required before October 15 annually
  - Reminder: Inflation Reduction Act changes to standard Part D prescription drug coverage are in effect for 2026
    - *Changes increased the actuarial value of the Part D standard prescription drug coverage.*
    - Annual out-of-pocket (OOP) threshold is $2,100 for 2026
    - For 2026 only, non-RDS group health plans are permitted to use either the existing simplified determination methodology or the revised simplified determination methodology to determine whether their prescription drug coverage is creditable.

Health & Welfare Benefits
MONTHLY UPDATE

Annual Notices

- Medicare Part D Creditable Coverage
  - Online disclosure to CMS is due no later than 60 days after the beginning date of the plan year (contract year, renewal year, etc.).
  - Also, within 30 days of change of the plan's creditable coverage status or termination of a prescription drug plan.

Health & Welfare Benefits
MONTHLY UPDATE

Annual Notices

- Women's Health and Cancer Rights Act (WHCRA)
  - Provide annually to all participants and beneficiaries
- HIPAA Notice of Privacy Practices
  - Plans must provide notice or notice of its availability every three years
    - Notice of availability is short, so suggest providing every year with annual enrollment materials
    - Electronic delivery not permitted unless specific consent requirements are met
  - New notice required if material changes
    - Part 2 requirements by February 16, 2026, still awaiting regulations from OCR
    - Include Reproductive Rights?
    - Reminder – if there is a benefits website, then the HIPAA privacy notice must be posted there

Health & Welfare Benefits
MONTHLY UPDATE

Annual Notices

- HIPAA Notice of Special Enrollment Rights
  - Provide to all eligible employees who are offered the opportunity to enroll in group health coverage
- CHIPRA Notice
  - Must provide to ALL employees regardless of benefits eligibility
  - No specific deadline
  - Model available at https://www.dol.gov/sites/default/files/ebsa/laws-and-regulations/laws/chipra/model-notice.doc

Annual Notices

- REMINDER
  - COBRA qualified beneficiaries generally get annual notices and open enrollment materials!
  - Employees on paid or unpaid FMLA generally have open enrollment rights, as well
  - "Alternate Recipients" covered pursuant to QMCSO have rights to receive notices as well (but not separate enrollment rights)

Wellness Notices

- Required if the plan offers a wellness program that requires individuals to meet a standard related to a health factor (*e.g.*, be a non-smoker) in order to obtain a reward (*e.g.*, premium discount).
- Availability of reasonable alternative method to earn the reward must be disclosed in all plan materials that describe the terms of the wellness program
  - Does not include SBC

Wellness Notices

- EEOC also has notice requirement to comply with Americans with Disabilities Act (ADA)
  - Overlaps with DOL notice, but not the same
  - Must provide before providing any health information and with enough time to decide whether to participate
    - In other words, before completing health risk assessment or medical exam
  - https://www.eeoc.gov/laws/regulations/ada-wellness-notice.cfm
  - Note: AARP v. EEOC does not impact current compliance requirements

40

Health & Welfare Benefits
MONTHLY UPDATE

GINA Wellness Consent

- Consent must be obtained before spouse provides health information for a wellness program
  - For example, consent must be obtained before spouse completes a health risk assessment
  - Impact of GINA on incentives to provide such information (even with consent) is unclear in light of vacated regulations

41

Summary of Benefits and Coverage (SBC)

- Distribution requirements are different than many other forms
- Posting on enrollment website will satisfy disclosure requirements in many cases
  - However, website must note that paper versions are available free of charge upon request

Summary Plan Description (SPD)

- Generally required every five years (if changes in the plan)
- Some annual notices can be included in the SPD if it will be provided at open enrollment, but others must/should be provided as separate document

Summary of Material Modifications

- If new SPD will not be provided, then consider providing SMM with open enrollment materials
  - Can annual enrollment materials serve as SMM?
- Notice of material changes to plan generally required within 60 days of change

Electronic Distribution

- Poses many challenges
- Rules vary by notice
  - for example, different standards for SPD vs. HIPAA notice of privacy practices
- In some cases, electronic distribution is not practical (*e.g.*, COBRA).
- Recommend consulting with counsel
- However, nothing in ERISA prohibits online enrollment! Rules in the IRC generally apply to 125 elections but no real hurdles

Who are your enrollees?

- Newly eligible
- Employees on leave (FMLA, military)
- COBRA qualified beneficiaries
- Alternate Recipients of QMCSOs
- If retiree coverage, then spouse/dependents of deceased retirees
- Guardians/representatives of incapacitated persons still covered by the plan

46

Different Materials for Different Groups?

- Do you have different employee groups that receive different materials? For example, different locations.
- Materials should be accurate, complete, and not misleading
- Materials should be consistent with SPD, plan document, and name the document that governs if there is a conflict

47

Health & Welfare Benefits
MONTHLY UPDATE

Elections

- Will elections carry over from 2025 into 2026?
  - Should specify in SPD
- Distinguish between automatic "basic" benefits and those that must be elected.
  - Consider state law requirements to obtain written consent before withholding salary deductions
- Generally, FSA and HSA elections do not carry over
  - Have you adequately communicated that FSA and HSA will not carry over?
- Include clear statement of consequences of failing to enroll. State that elections can only be changed mid year when permitted by law.

Health & Welfare Benefits
MONTHLY UPDATE

Additional Content

- Deadlines
- Changes to benefit from last year
- Employee contribution amount
- Special eligibility rules (*e.g,*, rehired employees, union employees)
- Actively at work requirements
- Evidence of insurance requirements
- Contact information

Additional Content

- Statement that employer can amend or terminate benefits at any time
- Warnings about enrolling ineligible individuals
  - Plan's right to audit and request proof of eligibility
- If applicable, statement regarding medical plan's grandfathered status under the ACA
- Special tax considerations (*e.g.*, domestic partners, pre-tax vs. post-tax payment of disability coverage, etc.)

50

Health & Welfare Benefits
MONTHLY UPDATE

During Enrollment

- Have documents ready to send if asked (e.g., SPD, SMM)
- Have a procedure for responding to questions
  - Select and train employees responsible for answering questions
    - Employees should refer to written enrollment materials or SPD when responding to questions
  - Prepare list of FAQs
- Keep records of which enrollment materials were furnished – how, who, and when

51

After Enrollment

- Develop procedure for dealing with spouses and dependents dropped at open enrollment
  - Determine if spouse was dropped in anticipation of divorce, spouse might have COBRA rights
  - COBRA rights for child dependent who lost dependent status
  - Ensure child is not covered by court order (QMCSO/NMSN)
- Ensure employees who enroll in non-HDHP did not make HSA election
- Send confirmation letters

Health & Welfare Benefits
MONTHLY UPDATE

Questions