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HEALTH & WELFARE PLAN LUNCH GROUP

December 4, 2025

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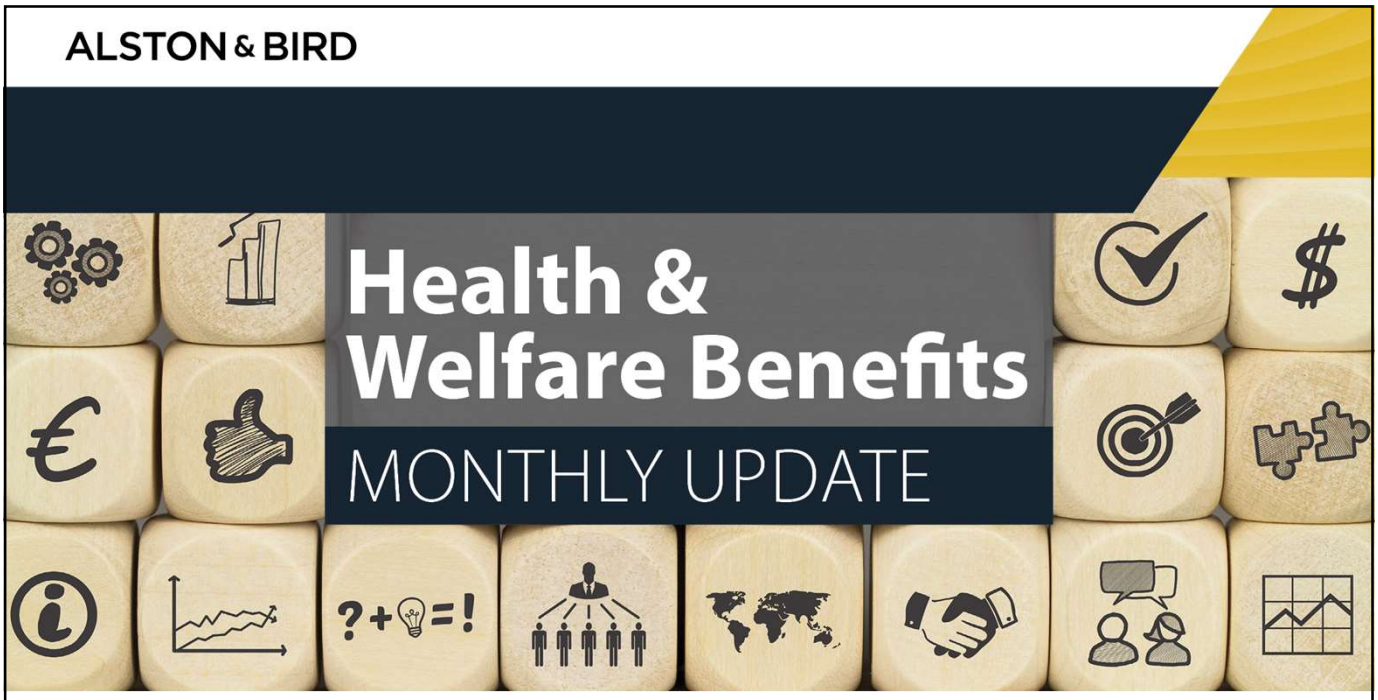

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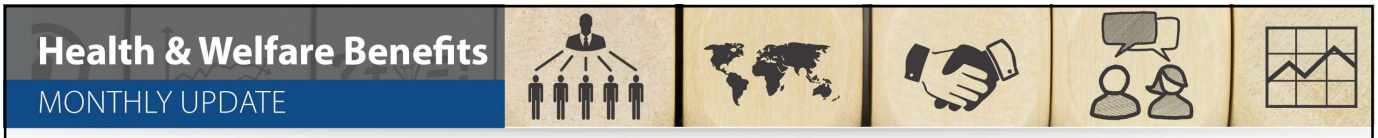

December 2025 Health Benefits Update
Year In Review

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Health & Welfare Benefits
MONTHLY UPDATE

December 2025 Agenda

- Washington Update: One Big Beautiful Bill
- Federal Legislation and Regulations
- Health Benefits Litigation Update
- Prescription Drugs
- Preventive Services and Fertility Benefits
- Year-End Reminders

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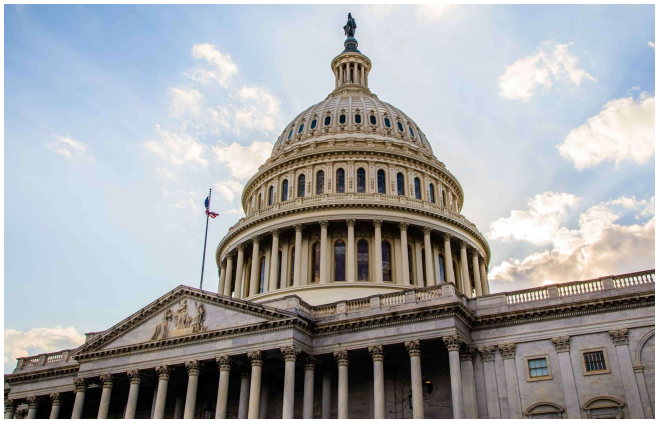
Health & Welfare Benefits
MONTHLY UPDATE

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,"
  - Would codify 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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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 (per month 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)

- - CHOICE Act ICHRA codification
- - HSA Improvements (more below)

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
  - But could be HRA eligible

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.

Health & Welfare Benefits
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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

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.

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. •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. •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.
Catch-Up Contributions:	•Married couples could have contributed both spouses' (both must be at least age 55) catch-up contributions to a single HSA.

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.

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.

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.

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.

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.	• If pre-tax HSA contributions are permitted under the 125 are they permitted 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.

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Legislative and Regulatory Update

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At the Office of Management and Budget (OMB)

These proposed rules are under review at OMB and are not yet publicly available:

- Proposed Rule: **HHS Notice of Benefit and Payment Parameters for 2027**, rec'd 11/14/2025 (HHS-CMS)
- Proposed Rule: **Requirement to Provide Paper Statements in Certain Cases-Amendments to Electronic Disclosure Safe Harbors**, rec'd 9/30/2025 (DOL-EBSA)
- Proposed Rule: **Improving Transparency into Pharmacy Benefit Manager Fee Disclosure**, rec'd 9/10/2025 (DOL-EBSA)
- Proposed Rule: **Transparency in Coverage**, rec'd 8/20/2025 (HHS-CMS)
- Proposed Rule: **Global Benchmark for Efficient Drug Pricing (GLOBE) Model**, rec'd 09/25/2025 (HHS-CMS)

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New Proposed Legislation

- **"More Affordable Care Act" (**S.3264**)** Introduced 11/20/2025 by Scott, Rick [Sen.-R-FL]: Would give states broad authority to waive federal health insurance mandates, create new health account structures, change small employer incentives, restrict certain types of coverage, and impose new transparency requirements.
- **"Reform of Health Savings Accounts" (**H.R.6183**)** Introduced 11/20/2025 by Doggett, Lloyd [Rep.-D-TX-37]: Would amend the Internal Revenue Code to impose new rules on health savings accounts (HSAs), including income-based limits on deductible contributions, new substantiation requirements for distributions, a two-year limit for reimbursement of medical expenses, and excise taxes on excessive HSA fees.
- **Supplemental Benefits for Individuals Act of 2025 (**H.R.5839**)** Introduced 10/28/2025 by Balderson, Troy [Rep.-R-OH-12]: Would amend the PHSA to clarify that certain supplemental coverage provided to individual health insurance coverage is an excepted benefit.
- **"Choice Arrangement Act of 2025"** (H.R.5463) Introduced 09/18/2025 by Hern, Kevin [Rep.-R-OK-1]: Would amend the Internal Revenue Code to provide for the treatment of employer-provided HRAs that are integrated with individual market coverage. It sets requirements for nondiscrimination, substantiation, and notice, and allows employees participating in such arrangements to purchase exchange insurance under a cafeteria plan. The bill also creates a new employer tax credit for offering these arrangements.

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New Proposed Legislation

- **Safe Step Act** (H.R.5509) -- Introduced 09/19/2025 by Allen, Rick W. [Rep.-R-GA-12] and referred to the House Committee on Education and Workforce. Would require ERISA group health plans and health insurance issuers to implement a clear, prompt, and transparent exceptions process for any medication step therapy protocol.
- **Small Business Health Options Awareness Act of 2025** (H.R.5498) Introduced 9/18/25 by Rep. Van Duyne, Beth [R-TX-24]: Would require the Small Business Administration ("SBA") to provide more outreach and information about the availability of ICHRAs as a means for small businesses to deliver health care coverage for their employees. The press release for the bill states that "low awareness of this option has prevented more widespread utilization."
- **"Patients Deserve Price Tags Act" (**S. 2355) Introduced 7/17/25 by Sen. Marshall [R-KS]: Would amend ERISA and the PHSA to align with the gag clause rules.
- "**Workers' Disability Benefits Parity Act**" (H.R. 3758) Introduced 6/05/2025 by Rep. DeSaulnier [D-CA-10]: Would amend ERISA to establish parity in the treatment of behavioral health and physical health conditions under disability benefit plans.

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Vacated Regulations

- **Portions of ACA 1557 Regs:** *Tennessee v. Kennedy*
  - Key portions of the 2024 Rule relating to gender identity and gender-affirming care are vacated.
  - The district court ruled HHS exceeded its authority by interpreting "sex" to include "gender identity."
  - Will other circuits follow? See *C.P. v. BCBSIL* and *L.B. v. Premera Blue Cross*.
- **ACA Preventive Services Exemptions**: *Pennsylvania v. Trump*
  - District Court found both the Religious and Moral Exemption Rules to be arbitrary and capricious under the APA and vacated them in full. The pre-2017 framework applies.
  - Notice of Appeal Filed in late August
- **Most of HIPAA Reproductive Health Care Regs:**
  - **Appeal Dismissed**: In **June 2025**, a Texas district court vacated most provisions of the Final Rule in *Purl v. HHS*, finding HHS exceeded its statutory authority. On **September 10, 2025**, the Fifth Circuit dismissed an appeal by proposed intervenors, confirming the vacatur and ending the litigation. No recent docket activity on *Texas v. HHS*.
  - **Surviving Portions of the Rule**: HIPAA Part 2 updates to the **Notice of Privacy Practices**. Compliance deadline: **February 16, 2026.**
- **EBSA Withdraws Defense of DOL Fiduciary Rule in 5th Circuit:**
  - On Nov. 28th the U.S. 5th Circuit Court of Appeals granted the Department of Labor's motion to withdraw its defense of the Biden administration's fiduciary rule. September Semi-annual agenda noted replacement rule in the works.

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Regulations Under Limited Agency Enforcement

- **2024 Short-Term Limited Duration Insurance (STLDI) Regs**:
  - Departments 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.
- **Mental Health Parity and Addiction Equity Act:**
  - **Nonenforcement policy:** Departments issued a Nonenforcement Policy and 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 ERISA Industry Committee v. Department of Health and Human Services et al, plus an additional 18 months.

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Health Benefits Litigation Update

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Health Plan Litigation Update

- Gender-Affirming Care Post-*Skrmetti*
- *Tobacco cessation programs*
- *Fiduciary Breach*
- *Telephone Consumer Protection Act*
- *No Surprises Act*
- *4980H penalties*
- *For further information on these cases see our Advisory*

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Prescription Drugs

States Target PBMs – Patchwork Rules

- **Arkansas**
  - **PBM Ownership Law (Act 624)**: Bars PBMs from owning pharmacies (effective Jan 1, 2026); preliminary injunction issued—Commerce & Supremacy Clause challenges likely.
  - **Rule 128 Reporting**: ERISA preemption challenge dismissed (*Cent. States v. McClain*); appeal filed Sept 30, 2025; next reporting deadline March 1, 2026.
- **California SB 41 (Effective Jan 1, 2026)**
  - PBM licensing & DMHC oversight.
  - Spread pricing banned; 100% rebate passthrough.
  - Fiduciary duties imposed on PBMs serving self-insured plans.
  - Transparency: Quarterly reporting; 30-day notice for contract changes.

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States Target PBMs – Patchwork Rules

- **Iowa SF 383**
  - Preliminary injunction (July 2025) on provisions: any-willing-provider, cost-sharing, mail-order rules (*Iowa Ass'n of Bus. & Indus. v. Ommen*).
  - Appeal filed Oct 1, 2025; similar relief extended to Wellmark (Oct 29, 2025).
  - Some provisions remain: rebate passthrough, NADAC rates, reporting.
- **Illinois HB 1697 (Effective Jan 1, 2026)**
  - PBM restrictions: no spread pricing, no steering, 100% rebate passthrough.
  - Annual audit/reporting; $15 per-enrollee fee.
  - Applicability to self-funded ERISA plans unclear; statutory language excludes plan sponsors but includes certain welfare plans.

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States Target PBMs – Patchwork Rules

- **North Carolina SCRIPT Act (Effective Oct 1, 2025)**
  - PBM rules: reimburse ≥ acquisition cost for independents; anti-affiliate parity; 90% rebate passthrough at point of sale.
  - Annual transparency reporting; no express ERISA exemption.
- **Tennessee**
  - Federal court struck down PBM restrictions for ERISA plans (*McKee Foods v. BFP*); permanent injunction issued.
  - Appeal to 6th Circuit; oral arguments scheduled for December.
  - Court agreed with 10th Circuit (*Mulready*) that network design is core plan function.

Health & Welfare Benefits
MONTHLY UPDATE

States Target PBMs – Patchwork Rules

- ***What Plan Sponsors Need to Know:***
  - *ERISA Preemption is Complicated and Legal Uncertainty Persists:* Courts continue to interpret ERISA preemption differently, especially when state laws regulate PBMs but affect plan design. Several appeals have been filed.
  - *State-by-State Compliance:* Laws targeting PBMs may still impact self-funded ERISA plans. Sponsors should monitor state legislative and judicial developments and consult legal counsel to assess exposure and compliance strategies.

Health & Welfare Benefits
MONTHLY UPDATE

GLP-1 Coverage – Cost & Compliance

- **Rising Costs:** GLP-1 drugs for diabetes and weight loss are driving up plan expenses; employers are using exclusions, medical management, and condition-based limits.
- **Compliance Concerns:**
  - *ADA:* Condition-based exclusions may implicate ADA protections.
  - *HIPAA & ACA:* Avoid discriminatory eligibility criteria; consider essential health benefit rules for dollar limits.
  - *ERISA Fiduciary Duties:* Document rationale for coverage decisions.
- **Timing & Communication:** SBC and SMM rules govern when changes take effect and notice requirements.

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Preventive Services and Fertility Benefits

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MONTHLY UPDATE

Supreme Court Upholds ACA Preventive Services Mandate

- ***Kennedy v. Braidwood Management*** (June 2025)
  - Court affirmed constitutionality of USPSTF appointment process.
  - ACA mandate stands: employer health plans must cover USPSTF A/B-rated preventive services without cost-sharing.
  - Examples: cancer screenings (breast, cervical, colorectal), STD screenings, HIV PrEP.
- **What's Next**
  - Case returns to lower courts to review challenges to:
  - HRSA (women's & children's preventive services, contraceptives).
  - ACIP (childhood & adult vaccine recommendations).

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MONTHLY UPDATE

HRSA Expands Women's Preventive Services

- **Finalized Updates**
  - Additional imaging (MRI, ultrasound, mammography) and pathology after initial screening added to HRSA Women's Preventive Services Guidelines.
  - Plans must cover these for plan years beginning on or after 1/1/2026.
- **Notice of Proposed New Guideline:**
  - Notice of Request for Comments on Draft Recommendations to Update the HRSA-Supported Women's Preventive Services Guidelines Relating to Screening for Cervical Cancer. (published in FR 10/01/2025)
  - Women aged 30 to 65 years:
    - Primary hrHPV testing every 5 years (preferred) or cytology and hrHPV testing (co-testing) every 5 years. If hrHPV testing is not available, continue screening with cytology alone every 3 years.
    - Patient-collected hrHPV testing should be offered as an option for cervical cancer screening in women at average ris
  - Women of all screening ages: If additional testing (e.g., cytology, biopsy colposcopy, extended genotyping, dual stain) and pathologic evaluation are indicated, these services also are recommended.

Health & Welfare Benefits
MONTHLY UPDATE

ACA Implementation FAQs – Part 72 (Oct. 2025)

- ACA FAQs Part 72: Clarify how stand-alone fertility benefits can be structured as "excepted benefits" under existing law if certain conditions are met.
  - **Does *NOT* change existing law.**
- **Excepted benefits** are types of coverage not subject to ACA group health plan requirements:
  - **Non-health coverage** (e.g., auto, liability, workers' comp, accident/disability income) – always excepted.
  - **Limited excepted benefits** (e.g., vision, dental, long-term care, certain HRAs/EAPs).
  - **Independent, noncoordinated excepted benefits** (e.g., specified disease/illness policies, hospital indemnity).
  - **Supplemental excepted benefits** (e.g., Medigap, CHAMPVA/Tricare supplements).
- ***Self-Funded Arrangements:*** Currently, self-funded arrangements cannot qualify as independent, noncoordinated excepted benefits. The Departments intend to address this in future rulemaking.
- ***Supplemental Coverage Standards:*** The Departments are considering changes to the limitation-on-value safe harbor for supplemental coverage, which could impact how supplemental fertility benefits are structured.
- ***Note:*** Clarification and expansion of the types of fertility services and treatment that qualify as a Code Section 213(d) medical expense would also be welcome.

Stand-alone Fertility Benefits: Current Pathways

- **Independent, Noncoordinated Excepted Benefits**
  - Must be provided under a separate insurance policy, certificate, or contract.
  - No coordination with any group health plan exclusions.
  - Benefits paid regardless of group health plan enrollment.
  - Cannot be self-funded by the employer—must be insured.
  - Compatible with Health Savings Accounts (HSAs).
- **Limited Excepted Benefits (EBHRAs)**
  - Must not be an integral part of the main health plan (other group health coverage must be available).
  - Annual benefit cap applies ($2,150 for 2025).
  - Cannot reimburse major medical premiums (except for excepted benefits).
  - Must be uniformly available to all similarly situated employees.
  - Reimbursements limited to IRS Code Section 213(d) medical expenses.
- **Employee Assistance Programs (EAPs)**
  - Must not provide significant medical care.
  - No coordination with other group health plans.
  - No employee premiums, contributions, or cost sharing.

BUT REMEMBER…..

- Not all fertility treatments qualify under 213(d):
  - Treatments and services for a surrogate who is not a covered person under the plan.
- Some may qualify: if preparatory to a procedure performed on a participant/spouse, or other person whose expenses are eligible for tax-free reimbursement as medical care:
  - Egg donor fees and expenses
  - Infertility treatments (*e.g.*: IVF, surgery, shots, treatments)
- Others are even more uncertain:
  - Fees for "temporary" storage of eggs, sperm, and embryo storage
  - Legal expenses that bear "a direct or proximate relationship to the provision of medical care to the taxpayer" (e.g., medical care that requires legal assistance)

Health & Welfare Benefits
MONTHLY UPDATE

Year-End Reminders

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Health & Welfare Benefits
MONTHLY UPDATE

Cost of Living Adjustments for 2026

	2025	2026
HSA contribution max for self/family	$4,300/$8,550	$4,400/$8,750
HSA additional catch-up contributions	$1,000	$1,000
HDHP annual deductible minimum self/family	$1,650/$3,300	$1,700/$3,400
Limit on HDHP OOP Max self/family	$8,300/$16,600	$8,500 ($17,000 family)
ACA limit on OOP expenses self/family	$9,200 ($18,400 family)	$10,600 ($21,200 family)
Health FSA salary reduction max	$3,300	$3,400
Health FSA carryover max	$660 (carried into 2026)	$680 (carried into 2027)
Dependent Care salary reduction max	$5,000 ($2,500 married filing separately)	$7,500 ($3,750 married filing separately)
Excepted Benefit HRAs	$2,150	$2,200
Qualified Small Employer HRAs (QSEHRAs) self/family	$6,350/$12,800	$6,450/$13,100

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MONTHLY UPDATE

Cost of Living Adjustments for 2026 (Continued)

	2025	2026
Adoption Assistance		
----Max Tax Credit	$17,280	$17,670
----Phase-out begins	$259,190	$265,080
----Phase-out ends	$299,190	$305,080
Transit and parking benefits	$325/mo.	$340/mo.

Health & Welfare Benefits
MONTHLY UPDATE

Gag Clause Attestation

- Deadline: **December 31, 2025.** Covers the period **since the last attestation** (typically the prior calendar year)
- **Where to Submit:** Submit electronically via the **CMS Health Insurance Oversight System (HIOS) Portal** on the CMS GCPCA Website.
- **Who Must File**
  - **Fully Insured Plans**: The **issuer** (carrier) typically submits on behalf of the plan
  - **Self-Insured Plans**: The **plan sponsor** is legally responsible (may delegate filing to a **TPA** via written agreement)
- **What's New in 2025**
  - **Downstream Agreements**: Must ensure TPAs or vendors do **not** enter into contracts with third parties that restrict access to cost, quality, or claims data
  - **Discretionary Clauses**: Agreements that allow data sharing only at the **discretion of TPAs or providers** are considered prohibited gag clauses
  - **Reporting Non-Compliance**: If prohibited clauses remain, **attestation must still be submitted**, with details provided in the "Additional Information" section of the form.
- **Action Steps for Plan Sponsors**
  - **Review contracts** with TPAs, PBMs, and other vendors for prohibited gag clauses
  - **Confirm** that no downstream agreements restrict data access
  - **Coordinate** with TPAs or carriers to determine who will submit the attestation
  - **Document** any efforts to remove prohibited clauses
  - **Submit attestation** or ensure your TPA/carrier does so by **Dec. 31, 2025**

Health & Welfare Benefits
MONTHLY UPDATE

Massachusetts HIRD Form

- **Purpose of the HIRD Form:**
  - Collects data on **employer-sponsored insurance (ESI)** offerings
  - Helps **MassHealth** identify members eligible for the **Premium Assistance Program**
- Filing window opens November 15; deadline is **December 15.**
- **Who Must File**
  - **All employers** (in-state or out-of-state) with **6 or more employees** in Massachusetts during the past 12 months.
  - Includes **full-time, part-time, and temporary employees**
  - Employee count is based on **quarterly wage reports** submitted to the **Department of Unemployment Assistance (DUA)**
- No major changes reported for 2025
- **Action Steps for Employers**
  - **Log in** to your MassTaxConnect account
  - **Gather plan details** from your Summary of Benefits
  - **Complete and submit** the HIRD form by **Dec. 15**
  - **Coordinate** with payroll vendors if they assist with filing
  - **Retain confirmation** of submission for your records

Health & Welfare Benefits
MONTHLY UPDATE

Updates: Health Resources and Services Administration (HRSA)

- **Effective for New Plan years in 2026:**
  - Additional imaging (e.g., MRI, ultrasound, mammography) or pathology required after initial screening.
  - Patient navigation services added: For breast and cervical cancer screening and follow-up, as relevant, to increase utilization of screening, based on patient's needs for navigation services. Patient navigation services involve person-to-person (e.g., in-person, virtual, hybrid models) contact with the patient.

Health & Welfare Benefits
MONTHLY UPDATE

HIPAA Part 2: Notice of Privacy Practices (NPP)

- February 16, 2026: deadline to update NPP for HIPAA Part 2
  - In general, Part 2 protects Substance Use Disorder (SUD) information obtained by any federally assisted program.
- What updates need to be made to the HIPAA NPP for HIPAA Part 2?
  - A statement that such records (or related testimony) **cannot be used in legal proceedings** against the patient without **written consent** or a **court order** with notice and opportunity to be heard.
  - If used for **fundraising**, individuals must be given a **clear opt-out option**.
- HHS promised model language, which has not yet been issued.

Questions

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Employee Benefits & Executive Compensation Advisory | Health & Welfare Benefits Update: 2025 Year-End Roundup

December 1, 2025

Advisories

By: John R. Hickman, Ashley Gillihan, Amy Heppner, Laurie Kirkwood

This year kicked off with a new administration heralding big policy changes in areas that affect employee health & welfare benefits. This year's Roundup is packed with the latest legislative and regulatory developments that matter most to health benefit plan sponsors and service providers. From significant consumer-directed health legislative changes in telehealth and health savings accounts to pivotal court decisions impacting mental health parity, reproductive health privacy, and wellness program benefits, we break down what's new, what's paused, and what's next for employer health plans.

Legislative Spotlight

Big bill, big changes: The OBBBA's impact on your benefit plans

The One Big Beautiful Bill Act (OBBBA) made headlines with its ambitious consumer-directed health proposals, but only a few provisions made it into law. Agencies are feverishly working on additional guidance for those provisions.

- **HDHP/HSA Exception for Telehealth and "Remote Care."** The Senate's version made permanent the exception for pre-deductible telehealth coverage and extended the exception to "other remote care," which means telehealth or "other remote care" coverage before satisfaction of the high-deductible health plan's (HDHP) deductible will not disqualify participants from health savings account (HSA) eligibility for plan years beginning after December 31, 2024. This retroactive effective date bridges the gap that would have otherwise followed the sunset date of the last telehealth extension at the end of 2024.

  > Consider: When is care telehealth or remote care? For example, there are some who hope that the exception may apply beyond services to durable medical equipment or prescription drugs obtained through telehealth providers. Agency guidance may address this issue.

- **Bronze and Catastrophic Exchange Plans / HSA Compatibility.** Beginning in 2026, bronze and catastrophic Exchange plans will qualify as HSA-compatible HDHPs.

> Consider: Exchange plans cannot be pre-tax funded under a cafeteria plan, but the premiums can be reimbursed through an individual coverage health reimbursement arrangement (ICHRA).

- **Direct Primary Care Arrangements.** Direct primary care (DPC) arrangements that meet certain requirements will also be HSA compatible. The fee for a compatible DPC will also qualify as an eligible expenditure for HSA purposes (up to $150/month for individuals, $300/month for families).

> Consider: The OBBBA failed to answer a few critical questions. Can annual payments be prorated? Can the DPC be funded on a pre-tax basis by the employer or employee (through a cafeteria plan)? What is the scope of allowable DPC "primary care" services? Can a DPC be integrated with an employer's HDHP coverage? Agency guidance is welcomed on these points.

Many House-proposed health benefit reforms, such as expanded HSA eligibility and ICHRA codification, were not included in the final law. But perhaps we may see further activity on some of these provisions in the future.

The OBBBA also included changes for other types of employee benefits:

- **Dependent Care Assistance Program.** Dependent care assistant program (DCAP) limits have increased to $3,750 for individuals (and married filing separately) and $7,500 for families in 2026. Be aware that increasing pre-tax salary reduction limits can adversely impact the DCAP 55% average benefits nondiscrimination test.
- **Student Loan Benefits.** The student loan repayment assistance benefit is now permanent, with annual limits adjusted for inflation after 2026.
- **Commuter Benefits.** The bicycle commuter benefit, which was frozen January 1, 2017 through December 31, 2025, is now permanently eliminated after December 31, 2025.
- **Trump Accounts.** This investment vehicle is similar to an individual retirement account for parents to set up for their minor children. Beginning in 2026, parents can contribute up to $5,000 per child, and employers can contribute up to $2,500 annually, indexed and tax-free. Employer contributions must be made under the terms of a written plan document that complies with rules similar to those for DCAPs.

Regulatory Update

2024 MHPAEA Rule: Agency enforcement paused, comparative analysis still required

Federal agencies have paused enforcement of the 2024 final rule under the Mental Health Parity and Addiction Equity Act (MHPAEA) due to ongoing litigation (*ERISA Industry Committee (ERIC) v. HHS*) and a presidential Executive Order directing regulatory review.

What's Next. The departments will not enforce the 2024 final rule or otherwise pursue enforcement actions if a plan fails to comply before a final decision in the litigation, plus an additional 18 months. The departments are considering whether to issue a notice of proposed rulemaking rescinding or modifying the regulation through notice and comment rulemaking.

What Plan Sponsors Need to Know. Plan sponsors must still comply with the 2013 final rule and the Consolidated

Appropriations Act of 2021, including maintaining written comparative analyses for nonquantitative treatment limitations. Private litigation under the MHPAEA from plan participants remains a risk for all MHPAEA requirements.

Federal court vacates HIPAA reproductive health privacy protections

A federal district court in Texas in *Purl v. HHS* vacated most provisions of the HIPAA Reproductive Health Privacy Rule. Covered entities are no longer required to comply with the new federal privacy requirements for reproductive health information, such as the prohibition on certain uses and disclosures and the attestation requirement for law enforcement requests.

What's Next. The Department of Health and Human Services (HHS) has not appealed the decision and attempts by other states to intervene and appeal the decision were unsuccessful.

What Plan Sponsors Need to Know.

- Plans that took compliance action before the rule was vacated should consult with legal counsel on next steps.
- The court's decision does not affect new HIPAA Notice of Privacy Practices (NPP) requirements for substance use disorder records under 42 C.F.R. Part 2. Plan sponsors must still update NPPs to address these changes by February 16, 2026. NPPs must still be updated for HIPAA Part 2. Model language had been promised, but none has been issued.
- Monitor state activity for any applicable non-preempted state laws that may provide additional privacy protections for reproductive health information.

Court vacates interpretation of "sex" as "gender identity" under Section 1557

In October a federal court in Mississippi vacated the expanded definition of sex discrimination to include gender identity under the 2024 final rule for Affordable Care Act (ACA) Section 1557, holding that HHS exceeded its statutory authority. The opinion listed the specific provisions that were vacated. (*State of Tennessee v. HHS*)

What's Next. The outcome of the Mississippi order aligns with the first Trump Administration's version of gender identity under the final rule under Section 1557, making an appeal less likely. Section 1557 litigation is still pending in other jurisdictions.

What Plan Sponsors Need to Know. This outcome could have broad implications for other Section 1557 cases. See the Litigation Update section for more information on gender identity litigation and benefits.

ACA contraceptive religious and moral exemption vacated

A Pennsylvania district court in *Pennsylvania v. Trump* vacated two federal regulations—the Religious Exemption Rule and the Moral Exemption Rule—that had allowed a broad range of employers, including for-profit entities, to opt out of providing contraceptive coverage under the ACA based on religious or moral objections. The court found these rules to be "arbitrary and capricious" under the Administrative Procedure Act.

What's Next. The Trump Administration appealed, though briefing has been delayed due to the government shutdown. Unless stayed on appeal, the Religious and Moral Exemption Rules are vacated, reverting the contraceptive coverage framework to the pre-2017 accommodation regime.

What Plan Sponsors Need to Know. Plan sponsors already covering all ACA-mandate preventive services are not affected by this ruling. However, employer health plans that were relying on either exemption to not offer the full range of contraceptive

coverage required under the ACA should consult legal counsel.

Preventive Services and Fertility Benefits

Supreme Court upholds ACA preventive services mandate

In June 2025 the U.S. Supreme Court issued its decision in *Kennedy v. Braidwood Management Inc.*, affirming the constitutionality of the U.S. Preventive Services Task Force (USPSTF) appointment process and upholding the ACA's requirement that employer-sponsored group health plans cover preventive services receiving an A or B recommendation from the USPSTF without cost-sharing. These services include screenings for breast, cervical, and colorectal cancers, as well as screenings for sexually transmitted diseases and PrEP for HIV prevention.

What's Next. The case now returns to the lower courts to consider challenges to the authority of two other advisory bodies, the Health Resources and Services Administration (HRSA), and Advisory Committee on Immunization Practices (ACIP). The HRSA makes recommendations on contraceptive coverage for women and other types of preventive services for women and children. The ACIP is the advisory committee that recommends vaccines, including the schedule for childhood vaccines.

HRSA expands women's preventive services

Finalized Updates for 2026. In December 2024, the HRSA approved recommendations to add additional imaging (such as MRI, ultrasound, and mammography) and pathology after initial screening to the HRSA-supported Women's Preventive Services Guidelines. Plans are required to cover these updates for plan years beginning in 2026.

Proposed Updates. In late September 2025, the HRSA proposed additional updates to screening for cervical cancer. These proposed changes include updates to screening recommendations for women ages 30 to 65, the option of patient-collected hrHPV testing for the same age group, and coverage of additional testing (such as cytology, biopsy colposcopy, extended genotyping, and dual stain) and pathologic evaluation, if indicated, for women of all screening ages. Plan coverage for these proposed updates for cervical cancer screening, if finalized, would become effective for plan years beginning on or after one year after the recommendation or guideline is officially issued.

Infertility coverage gets federal spotlight—tax rules still tricky

The new administration is committed to increase access and reduce cost for infertility treatment (see Executive Order 14216 and Fact Sheet). In October the Departments of Labor, Health and Human Services, and the Treasury published guidance for stand-alone benefit packages to employees interested in coverage for treatment of infertility, including IVF (see ACA FAQs Part 72). Although this guidance did not alter current rules, it explained that employer plan sponsors have two main pathways to offer fertility benefits as "excepted benefits" under federal law:

- **Noncoordinated excepted benefit.** First, fertility coverage can be provided as an independent, noncoordinated excepted benefit—for example, through a specified disease or illness policy (such as infertility-only insurance) or hospital indemnity coverage. To qualify, these benefits must be offered under a separate insurance policy, certificate, or contract, with no coordination between the excepted benefit and any group health plan maintained by the same sponsor. Importantly, these policies cannot be self-funded; they must be fully insured. Employees do not need to enroll in the employer's traditional group health plan to access these benefits, and enrollment in such coverage does not disqualify participants from contributing to an HSA if they otherwise meet HSA eligibility requirements.
- **EBHRAs and EAPs.** Second, employers may offer fertility benefits as a limited excepted benefit—most commonly through an excepted benefit health reimbursement arrangement (EBHRA) or certain employee assistance programs (EAPs). EBHRAs must be offered alongside a traditional group health plan, must have annual limits ($2,150 for 2025),

and cannot reimburse premiums for major medical coverage. EAPs may provide coaching or navigator services related to fertility but cannot offer significant medical care or be coordinated with other group health plans.

What's Next. The departments are considering future rulemaking to expand options for fertility benefits and may adjust the value limits for supplemental coverage.

What Plan Sponsors Need to Know. Although not discussed in the FAQs, certain fertility treatments or services may not meet the current definition of "medical care" under U.S.C. § 213(d) for purposes of tax-favored treatment. Employers need to remain mindful of the IRS guidance limit on infertility treatments. The table below summarizes some of the treatments and services that have been addressed in sources other than formal rulemaking:

Expense Type	Deductible?	IRS Guidance/Letter Rulings
IVF for taxpayer/spouse	Yes	Must be necessary to overcome inability to have children
Egg/sperm donor fees	Sometimes	If preparatory to procedure for employee/spouse/dependent
Surrogacy expenses	No	Surrogate is not a dependent; reimbursement and benefits are only permitted for employees and their tax dependents
Storage of eggs/sperm	Yes (temporary)	Must be for imminent use and necessary due to a medical condition
Legal fees	Sometimes	If directly related to the provision of medical care

Litigation Updates

Legal landscape shifts for gender-affirming coverage

Recent federal court decisions have reshaped the legal landscape for gender-affirming care, with significant implications for employer health plan sponsors. In *United States v. Skrmetti*, the Supreme Court upheld Tennessee's ban on gender-affirming medical care for minors, holding that such laws do not trigger heightened scrutiny under the Equal Protection Clause because they classify based on age and medical use, not sex or transgender status. The Court declined to extend the Title VII reasoning of *Bostock v. Clayton County* to constitutional claims, emphasizing that state bans on gender-affirming care for minors are subject only to rational basis review. This decision is now binding nationwide and signals a restrictive approach to constitutional challenges against similar state laws.

A mix of circuit courts and district courts have also addressed federal nondiscrimination protections this year. In *Lange v. Houston County*, the Eleventh Circuit, sitting en banc, reversed a district court and held that employer health plan exclusions for "sex change" services are not facially discriminatory under Title VII, echoing the Supreme Court's logic in *Skrmetti*. Meanwhile, in September a federal district court in Washington in *L.B. v. Premera Blue Cross* found that a categorical exclusion of gender-affirming chest surgery for minors violated Section 1557 of the ACA, but acknowledged that the Supreme Court's recent decisions could affect the outcome if appealed.

However, in October, the regulatory efforts to expand gender-identity protections under Section 1557 faced setbacks when the Southern District of Mississippi in *State of Tennessee v. HHS* vacated specific regulatory provisions that expand the definition of sex discrimination to include gender identity, holding that HHS exceeded its statutory authority. Then, in mid-November, the Ninth Circuit in *C.P. v. BCBSIL* vacated a lower court's ruling for summary judgment that favored the transgender plaintiffs who sued a third-party administrator (TPA) of a self-insured plan for denying coverage for gender

dysphoria, remanding the case back to the lower court to reconsider the analysis of sex discrimination under Section 1557 in light of Skrmetti. In its analysis, the Ninth Circuit invoked *Loper Bright* to set aside a set of 2020 regulations that would have excluded the TPA from Section 1557.

What's Next.

- On September 15, 2025, Premera filed an appeal to the Ninth Circuit. It is unclear if the ruling in the Mississippi district court will have any impact in the Ninth Circuit.
- The Western District of Washington will revisit its Section 1557 sex discrimination analysis under *Skrmetti* to determine whether a TPA impermissibly applied an exclusion for gender-affirming care.
- The Eleventh Circuit remanded *Lange v. Houston County* back to the district court for claims turning on the intent of the exclusion for sex-change procedures.

Tobacco surcharge litigation heats up

A new wave of litigation is targeting tobacco wellness programs, but they are not one size fits all. For example, some offer only prospective removal of the surcharge upon completion of a tobacco cessation program, while others impose time restrictions on when a participant can qualify for retroactive reimbursement while offering prospective removal. In short, the crux of the plaintiffs' claims is that employer health plans must offer full retroactive reimbursement of all tobacco surcharge payments any time a participant completes a tobacco cessation program and that certain plan disclosures do not contain specific information they allege is required.

Courts are divided on whether plaintiffs state a plausible violation of the law by alleging an employer health plan fails to retroactively reimburse tobacco surcharges. For example, in *Williams v. Bally's Management Group LLC* , the plaintiff alleged that Bally's violated the law by offering only prospective removal of the tobacco surcharge upon completion of a tobacco cessation program. The Rhode Island federal court declined to read a retroactive reimbursement requirement into the law, and found that Bally's was not required to provide retroactive reimbursement of the tobacco surcharge. Other courts, however, have found the opposite.

What Plan Sponsors Need to Know. The case law for tobacco wellness programs is evolving rapidly. There are numerous unresolved legal issues in these cases, and with over 40 cases filed in the last couple of years, we are sure to see further development. Programs that offer retroactive reimbursement after completion of a tobacco cessation program have fared better on motions to dismiss. We recommend consulting with counsel experienced in the nuances of this litigation and the law and monitoring the law in your jurisdiction.

PBM litigation

In 2025, two pivotal lawsuits targeted the use of pharmacy benefit managers (PBMs) under ERISA. The plaintiffs alleged that employers failed to properly select and monitor PBMs, resulting in excessive drug costs and higher participant expenses, but federal courts dismissed these claims due to lack of standing, finding the alleged injuries too speculative or not directly linked to employer actions. In one of the cases, the court noted that the employer retained sole discretion in the plan document to set participants' contributions, which also factored into the court's view that the connection between PBM fees and drug pricing and participant cost was speculative.

What's Next. The courts permitted the plaintiffs to file amended complaints that are subject to renewed motions to dismiss.

TCPA lawsuits spike—HIPAA compliance isn't enough

HIPAA compliance does not shield plans from Telephone Consumer Protection Act (TCPA) liability, which carries steep statutory damages for each violation—up to $500–$1,500 per violation—making it a source of litigation risk for health plans Litigation under the TCPA surged in 2025, especially after the Supreme Court clarified that courts are not bound by the Federal Communications Commission's interpretations in *McLaughlin Chiropractic Associates Inc. v. McKesson Corp.* Health plans and TPAs face risk for automated calls/texts without proper consent and for failing to honor opt-outs.

Plan sponsors will want to be mindful of the following:

- Have outbound communications (calls, texts, faxes) been evaluated for TCPA compliance, not just HIPAA?
- Have proper consents been obtained for all automated or prerecorded messages? Which party is responsible for obtaining them?
- Are opt-out mechanisms clear, easy to use, and honored promptly?
- What does the TPA or vendor agreement say about TCPA compliance? Which party obtains any required consent and indemnification for TCPA failures?

No Surprises Act: Ongoing legal battles and new FAQs

Litigation over the federal independent dispute resolution (IDR) process under the No Surprises Act remains unsettled, with key cases shaping the landscape for employer plan sponsors and TPAs. In *Guardian Flight v. Health Care Service Corp.*, the Fifth Circuit held that providers cannot enforce IDR awards in federal court but must rely on administrative enforcement through HHS. This aligns with district court decisions in New York and Florida, while a District of Connecticut decision reached a different conclusion, creating a divide that may require Supreme Court review.

Ongoing litigation in the Fifth Circuit led by the Texas Medical Association (TMA) also challenges the use of the qualifying payment amount (QPA) in arbitration. The departments issued two FAQs this year to address some of these issues:

- FAQ Part 69 (Jan 2025) introduced a new extension policy for providers that miss IDR deadlines due to delayed or missing QPA disclosures. Providers can now request deadline relief from the Centers for Medicare & Medicaid Services (CMS) with supporting documentation.
- FAQ Part 71 (July 2025) extended enforcement discretion for QPA calculations through February 1, 2026 and clarified that plans must still certify that QPAs were calculated in compliance with applicable rules.

What's Next.

- A petition for certiorari was filed in October for the *Guardian Flight* case.
- The full Fifth Circuit heard arguments in the TMA case in September, but no opinion has been issued.
- CMS and the Employee Benefits Security Administration both listed federal IDR operations on their semi-annual regulatory agendas published in September, and a new final rule is anticipated.

ACA 4980H penalties: Court says IRS can't act without HHS certification

In *Faulk Company Inc. v. HHS*, the Northern District of Texas addressed whether the IRS properly assessed the employer shared responsibility payment (ESRP) penalty under IRC § 4980H for failing to offer minimum essential coverage required by the ACA. The court found that under the statutory framework, only HHS—not the IRS—has authority to provide the required certification to employers before the IRS can assess the ESRP. The IRS's practice of sending Letter 226-J as certification was deemed improper because it did not originate from HHS and did not provide adequate notice of liability or appeal rights as required by ACA Section 1411. The court ordered the IRS to refund the over $200,000 penalty paid by Faulk and set aside the

regulation (45 C.F.R. § 155.310(i)) that allowed the IRS to issue certifications.

What's Next. HHS has not appealed.

What Plan Sponsors Need to Know.

- ESRP penalty assessment must be preceded by proper certification and notice from HHS.
- An IRS Letter 226-J alone does not meet the HHS certification requirement.
- Employers that have been assessed a Section 4980H penalty under the ACA or have already paid a penalty should consult with legal counsel. Refund requests are typically required within two years of paying the penalty. Those assessed a penalty in the future may have a defense if HHS certification hasn't been received for employees identified as triggering a penalty.

Prescription Drug Coverage

State regulation of PBMs—Patchwork rules complicate administration

Although there is a lot of talk in D.C. about regulating PBMs at the federal level, so far no nationwide laws have been enacted. In 2025, numerous states enacted laws aimed at regulating PBMs, leaving a patchwork of varying requirements for national employers with self-funded ERISA plans.

Several state laws faced legal challenges in 2025, particularly over ERISA preemption that limits states from regulating self-funded employer health plans. Below are some highlights:

- In July a court ordered a preliminary injunction of an Iowa PBM law on several provisions (*Iowa Association of Business & Industry v. Ommen*). Iowa appealed to the Eighth Circuit.
- Oklahoma's Patient's Right to Pharmacy Choice Act was struck down by the Tenth Circuit in *PCMA v. Mulready*. The Tenth Circuit found that provisions regulating network adequacy, any-willing-provider mandates, and restrictions on mail-order incentives were preempted by ERISA because they interfered with plan administration. The Supreme Court declined to review the case, leaving the Tenth Circuit's decision in place.
- In Tennessee, a federal district court held in *McKee Foods Corp. v. BFP Inc.* that the state's any-willing-provider provisions that applied to self-funded plans were preempted by ERISA. The court agreed with the Tenth Circuit in *Mulready* that the scope of a plan's pharmacy network is a key aspect of how the plan structures and designs benefits and that Tennessee's restrictions "require providers to structure benefit plans in particular ways." The court issued a permanent injunction against enforcement of these provisions for McKee Foods Corporation's self-funded plan. Tennessee filed an appeal to the Sixth Circuit with oral arguments scheduled for December.
- Conversely, a federal court in *Illinois in Central States v. Arkansas Insurance Department* upheld Arkansas's Rule 128, ruling that its reporting and dispensing fee requirements did not "relate to" ERISA plans and were not preempted. The court emphasized that the law regulated PBMs and not ERISA plans directly. Notice of appeal was filed on September 30, 2025.

Additional PBM laws have been enacted in many other states. It will likely take years for the preemption challenges to be fully resolved.

What Plan Sponsors Need to Know.

- **Legal Uncertainty Persists.** Courts continue to interpret ERISA preemption differently, especially when state laws

regulate PBMs but affect plan design. Several appeals have been filed.

- **State-by-State Compliance.** Laws targeting PBMs may still impact self-funded ERISA plans, particularly in areas like network composition and cost-sharing. Sponsors should monitor state legislative and judicial developments and consult legal counsel to assess exposure and compliance strategies.

GLP-1s: Plan sponsors should tread carefully

GLP-1 drugs for diabetes and weight loss are prompting employers to use medical management strategies, exclusions, and condition-based limits to control expenses. However, plan sponsors must ensure that any limitations comply with the Americans with Disabilities Act (ADA), HIPAA nondiscrimination rules, and the ACA's essential health benefits requirements. Moreover, the summary of benefits and coverage and summary of material modification rules will impact when such changes may be effective and how soon they must be communicated.

What Plan Sponsors Need to Know. There is no federal mandate requiring self-insured ERISA plans to cover GLP-1 drugs for weight loss or obesity, and state insurance mandates do not apply to self-funded plans due to ERISA preemption. Plan sponsors should work with counsel to ensure compliance and keep the following in mind:

- **Nondiscrimination Issues.** Eligibility criteria should be evidence-based and applied uniformly to avoid discrimination claims. Review midyear changes carefully. Talk to counsel about whether the changes should instead be made at the start of a new plan year.
- **ADA.** If a limitation or exclusion of GLP-1 is tied to a specific condition, will the condition be considered a disability under the ADA?
- **ACA.** If annual or lifetime dollar limits are imposed on GLP-1 drugs, will the drugs be considered essential health benefits?

Year-End Reminders

Cost of living updates

Provisions	2025	2026
HSA contribution max for self/family	$4,300/$8,550	$4,400/$8,750
HSA additional catch-up contributions	$1,000	$1,000
HDHP annual deductible minimum self/family	$1,650/$3,300	$1,700/$3,400
Limit on HDHP OOP max self/family	$8,300/$16,600	$8,500/$17,000
ACA limit on OOP expenses self/family	$9,200/$18,400	$10,600/$21,200
Health FSA salary reduction max	$3,300	$3,400
Health FSA carryover max	$660 (carried into 2026)	$680 (carried into 2027)
Dependent care salary reduction max	$5,000 ($2,500 married filing separately)	$7,500 ($3,750 married filing separately)
Excepted benefit HRAs	$2,150	$2,200

Provisions	2025	2026
Qualified small employer HRAs (QSEHRAs) self/family	$6,350/$12,800	$6,450/$13,100
Adoption assistance: Max tax credit	$17,280	$17,670
Adoption assistance: Phase-out begins	$259,190	$265,080
Adoption assistance: Phase-out ends	$299,190	$305,080
Transit and parking benefits	$325/mo.	$340/mo.

1095-C reporting to individuals

- Automatic distribution of ACA statements (Forms 1095-B and 1095-C) is no longer required under the Paperwork Burden Reduction Act. Plan sponsors must instead provide a clear and accessible notice informing individuals they can request a copy of their statement. If requested, the statement must be furnished by January 31 of the following year or within 30 days of the request, whichever is later.
- Filing requirements with the IRS remain unchanged—plan sponsors must still submit all required ACA returns.
- Employers that have been assessed a Section 4980H penalty under the ACA should consult with legal counsel to determine if proper HHS certification was provided. Employers that have already paid this penalty should consult with legal counsel to determine if they may be entitled to a refund.

Gag clause attestation

- Due December 31, 2025
- Submit via CMS HIOS portal
- Review contracts for prohibited data restrictions
- Self-insured plans: sponsor is responsible for reporting (but can delegate to a TPA)

Massachusetts HIRD form

- Filing window: November 15–December 15
- Required for employers with six or more employees in Massachusetts
- File via MassTaxConnect

HRSA preventive services update

- New guidelines for breast/cervical cancer screening and patient navigation
- Effective for new plan years beginning in 2026

HIPAA Part 2 notice of privacy practices

- Update required by February 16, 2026
- Must include new protections for substance use disorder records
- Awaiting model language from HHS

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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