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HEALTH & WELFARE PLAN LUNCH GROUP

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

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INDEX

1. Health & Welfare Benefits Monthly Update Presentation

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MONTHLY UPDATE

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0

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MONTHLY UPDATE

October 2026 Agenda

- Health Care Regulatory Update
- 2027 Enrollment Issues
- State of the state PBM laws
- MHPAEA Update
- Litigation Update

1

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1

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Health Care Regulatory Update



2

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Final Rules/Notices

- [Trump Accounts](#) (TREAS-IRS), Temporary Rule filed on 9/29/26
- [Independent Dispute Resolution Operations](#), (HHS-CMS; DOL-EBSA; TREAS-IRS), Final Rule published 6/4/26
 - [Federal Independent Dispute Resolution Operations; Correction](#), published 8/28/26
- [Patient Protection and Affordable Care Act, HHS Notice of Benefit and Payment Parameters for 2027, and Basic Health Program](#), (HHS-CMS), Final Rule published 5/20/26
- [Nondiscrimination on the Basis of Disability; Accessibility of Web Content and Mobile Applications of Recipients of Departmental Financial Assistance; Extension of Compliance Dates](#), (HHS-OCR) published 5/11/26
- [Contract Year 2027 Policy and Technical Changes to Medicare Advantage, Medicare Prescription Drug Benefit, Medicare Cost Plan, and Programs of All-Inclusive Care for the Elderly Programs](#), (HHS-CMS), Final Rule, published 4/6/2026
- [Administrative Simplification: Adoption of Standards for Health Care Attachment Transactions and Electronic Signatures](#) (CMS-HHS), Final Rule published 3/24/26.
- [Update to the Women's Preventive Services Guidelines](#) (HHS-HRSA), Notice published 1/5/26

3

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3

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Proposed Rules

- [Trump Accounts](#) (TREAS-IRS), Notice of Proposed Rulemaking filed on 9/29/26
- [Employer Contributions to Trump Accounts and Nondiscrimination Rules for Dependent Care Assistance Programs](#) (TREAS-IRS), Notice of Proposed Rulemaking published 8/11/26; comments deadline 9/25/26.
- [Electronic Disclosure by Group Health Plans Under ERISA](#) (DOL-EBSA), Proposed Rule published 7/23/26; comments deadline 9/21/26.
- [Excepted Fertility Benefits](#) (DOL-EBSA), Proposed Rule published 5/13/26; comments due by July 13, 2026.
- [Fiduciary Duties in Selecting Designated Investment Alternatives](#) (DOL-EBSA), Proposed Rule published March 30, 2026
- [Trump Accounts](#) (TREAS-IRS), Notice of Proposed Rulemaking published on 3/6/2026
- [Trump Accounts Contributions Pilot Program](#) (TREAS-IRS), Notice of Proposed Rulemaking published on 3/6/2026
- [Employee or Independent Contractor Status under the Fair Labor Standards Act, Family and Medical Leave Act, and Migrant and Seasonal Agricultural Worker Protection Act](#) (DOL-WHD), Notice of Proposed Rule published on 2/27/2026; comment deadline 4/28/26
- [Requirement to Provide Paper Statements in Certain Cases-Amendments to Electronic Disclosure Safe Harbors](#) (DOL-EBSA), Proposed Rule published on 2/25/2026
- [Improving Transparency Into Pharmacy Benefit Manager Fee Disclosure](#) (DOL-EBSA), Proposed Rule published on 1/30/26

4

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4

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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: **Definition of an "Employer" Under Section 3(5) of ERISA -- Association Health Plans** (DOL-EBSA), rec'd 8/11/26
- Final Rule: **Transparency in Coverage** (HHS-CMS), rec'd 7/27/26
- Proposed Rule: **Improving Transparency into Pharmacy Benefit Manager Fee Disclosure** (DOL-EBSA), rec'd 7/23/26
- Proposed Rule: **Loyalty and the Exclusive Purpose Rule in Selecting Plan Investments and Exercising Shareholder Rights** (DOL-EBSA), rec'd 6/30/26
- Proposed Rule: **Short-Term, Limited-Duration Insurance** (HHS-CMS), rec'd 5/30/26
- Final Rule: **HIPAA Privacy Rule: Changes to Support Coordinated Care and Individual Engagement and Reduce Regulatory Burdens**, rec'd 4/2/2026 (HHS-OCR))

5

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5

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2027 Enrollment Issues

6

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What's New?

- **HSA Limits**
 - Minimum Deductible: \$1,750 self/\$3,500 other than self-only
 - Out-of-Pocket Maximum: \$8,700 self/\$17,400 other than self-only
 - Contribution Limit: \$4,500 self/\$9000 other than self-only
- **DCAP Limits**
 - \$3,750/\$7,500
- **ACA OOP Maximum: \$12,000 for self/\$24,000 for other than self-only**

7

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7



Annual Notices

- Medicare Part D Creditable Coverage Notices
 - Best practice is to give to all participants and beneficiaries
 - Required before October 15 annually
 - Reminder:
 - *2026 Inflation Reduction Act*: Changes increased the actuarial value of the Part D standard prescription drug coverage.
 - Annual out-of-pocket (OOP) threshold is \$2,400 for 2027
 - Only the revised simplified determination methodology can be used (as opposed to old simplified methodology) to determine whether their prescription drug coverage is creditable.



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.



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

10

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10



Annual Notices

- 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>

11

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11

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MONTHLY UPDATE



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)

12

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12

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MONTHLY UPDATE



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

13

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13



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

14

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14



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

15

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15



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

16

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16



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 reduction in covered services to plan generally required within 60 days of change
 - Reminder: Mid-year changes that impact SBC require 60 days advance notice

17

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17



Electronic Distribution

- New Proposed rules for ERISA required disclosures
- 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).
- However, nothing in ERISA prohibits online enrollment! Rules in the IRC generally apply to 125 elections but no real hurdles

18

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18



Who are your enrollees?

- Newly eligible
 - Including those who qualify after a measurement period
- Employees on certain leaves (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

19

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19



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

20

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20



Elections

- Will elections carry over from 2026 into 2027?
 - 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.

21

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21

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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

22

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22

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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
 - Outline consequences of failing to provide accurate information (*e.g.*, Spousal coverage)
- 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.)

23

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23

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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

24

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24

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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

25

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State of the State PBM Laws

26

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MONTHLY UPDATE



States Continue Enacting New PBM Legislation in 2026

- Utah – HB 527, *Pharmacy Pricing Amendments* (March 19, 2026)
- Florida – HB 697, ch. 2026-4, *Drug Prices and Coverage* (March 24, 2026)
- Virginia – SB 669, ch. 36 (March 31, 2026)
- Ohio – HB 229 (March 31, 2026)
- Kansas – SB 20, ch. 81, *KS Consumer Prescription Protection and Accountability Act* (April 9, 2026)
- Tennessee – SB 2040, Pub. Ch. 1111, *FAIR Rx Act* (May 22, 2026)
- Hawaii – HB 1643, Act 39 (May 26, 2026)
- Louisiana – HB 1236, Act 913 (June 12, 2026)
- Missouri – SB 878 (July 13, 2026)

27

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27

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Recent ERISA Preemption Decisions

- Tennessee
 - *McKee Foods Corp. v. BFP Inc.*, 173 F.4th 242 (6th Cir. 2026)
- Arkansas
 - *Flowers v. Caremark PCS Health, LLC*, 180 F.4th 1084 (8th Cir. 2026)
 - *Central States, Southeast & Southwest Areas Health & Welfare Fund v. McClain*, No. 25-2727 (7th Cir. Aug. 26, 2026)

28

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28

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Pending Legal Challenges

☐	Tennessee: Fair Rx Act	
☐	Illinois: Prescription Drug Affordability Act	
☐	California: Cal. Bus. & Prof. Code § 4441(c)(2)	
☐	Minnesota: Minn. Stat. § 62W.07	
☐	Iowa: SF 383	

29

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29

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Compliance Issues to Consider



Reporting and
attestation
requirements



Provisions
applicable to self-
funded plans



Impact on mail-
order pharmacies



Potential HIPAA
concerns

30

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30

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MHPAE Update

31



The Way We Were . . .

Can it be that it was [not] so simple then . . .

- September 9, 2024, Final 2024 Rule implementing MHPAEA and the NQTL comparative analyses requirements.
- January 17, 2025, ERISA Industry Committee (ERIC) filed suit in the U.S. District Court for the District of Columbia challenging certain provisions of the 2024 Final Rule on multiple grounds, including on the grounds that they are arbitrary and capricious and contrary to law.

32

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32



The Way We Were . . .

Can it be that it was [not] so simple then . . .

- May 15, 2025, nonenforcement policy:
 - 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 [ERIC] litigation, plus an additional 18 months. This enforcement relief applies only with respect to those portions of the 2024 Final Rule that are new in relation to the 2013 final rule. The Departments note that MHPAEA's statutory obligations, as amended by the CAA, 2021, continue to have effect.

33

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FAB 2026-03 -- The Way We Were . . .

Can it be that it was [not] so simple then . . .

- EBSA reviewed its enforcement approach under MHPAEA. To preserve enforcement resources and accord with the Departments' May 2025 nonenforcement policy, EBSA will not pursue enforcement actions of those portions of the 2024 Final Rule that are new in relation to the 2013 Final Rule. Nevertheless, because MHPAEA's statutory obligations continue to apply, including the requirements added by the CAA, 2021 related to NQTL comparative analyses, EBSA will narrow its enforcement focus areas relating to requests for NQTL comparative analyses under the statute. This approach to enforcement is designed to reduce compliance burdens and to provide clarity for plans and issuers on how to meet the NQTL requirements in a balanced and even-handed manner.



Or has time rewritten every line . . .

DOL FAB 2006-3 –

- The Department has received significant input from the regulated community that prior enforcement of MHPAEA's nonquantitative treatment limitation (NQTL) comparative analyses requirements created substantial confusion and unnecessary burdens on health plans. Many stakeholders have asked for clear guidance related to MHPAEA's NQTL requirements.
- The Department is issuing this Field Assistance Bulletin to provide additional clarity on the Department's approach to enforcing the statutory and regulatory NQTL requirements. In its enforcement of these critical protections, the Department seeks to achieve the right balance to ensure that its enforcement is fair and even-handed, with advance and reasonable notice to interested parties: supporting access to comprehensive MH/SUD benefits but enforcing compliance in a practical and meaningful way that does not unnecessarily drive up compliance costs or discourage sponsors of group health plans from offering MH/SUD benefits. In sum, this updated enforcement guidance is designed to provide a streamlined and practical framework for compliance with MHPAEA's NQTL requirements.



Identifying Potential Problems: If You See the Following in Written Plan Provisions or Plan Operations, Think Twice About Possible MHPAEA Compliance Problems | U.S. Department of Labor

What should you look for when you're reviewing your plan for potential MHPAEA NQTL compliance problems?

Best Practices for Keeping MHPAEA Compliance in Mind When Selecting Health Plan Service Providers

Best Practices for Monitoring Operational Compliance for Specific NQTLs

Examples of How Plans have Addressed Concerns during NQTL Investigations

Tips for Plans Being Reviewed by DOL for NQTL Compliance

36

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36



What should you look for

- Exclusion of specific services for covered MH/SUD conditions (e.g., ABA therapy, addiction treatment, nutrition, residential treatment, etc.) without similar exclusion for M/S conditions
- Medical necessity standards and review process (prior auth, concurrent care, age limit, step therapy, etc.) applicable to MH/SUD but not M/S
- Standards for determining network adequacy, including network admission standards and provider reimbursement methodologies more burdensome for MH/SUD

37

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37



Best Practices for Compliance in Selecting Health Plan Service Providers (selected items)

- What MH/SUD benefits are offered, and what limitations apply to these services?
- How often do you review your processes and procedures for developing your network, and benefits for MHPAEA compliance?
- What do you do to review for MHPAEA compliance?
- Will you share with me any MHPAEA-specific compliance reports or compliance analyses applicable to this plan or coverage?
- Do you assist with evaluating MHPAEA compliance, including preparing a comparative analysis for each NQTL that is specific to my plan?
- Do you cover telehealth MH/SUD services?
- Are there differences between how MH/SUD claims are administered and how M/S claims are administered?
- Are there any timing differences or additional administrative burdens applied to MH/SUD claims that differ from those applicable to M/S claims prior to approval?
- What providers are available in-network for both MH/SUD and M/S? What specialties and subspecialties are available in-network for both MH/SUD and M/S?
- How do you ensure a robust MH/SUD network?

38

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38



Best Practices for Monitoring Operational Compliance for Specific NQTLs

Medical Necessity and Review (Flowchart)

Network Adequacy (Flowchart)

OON Reimbursement Methodologies

- Compare M/S vs. MH/SUD provider rates relative to a benchmark in accordance with the MHPAEA Self-Compliance Tool Appendix
- Check written plan documents and internal policies for disparities in rate-setting processes, such as rate reductions for mid-level providers that are greater for MH/SUD than for M/S.

39

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39



Examples of How Plans have Addressed Concerns during NQTL Investigations

A network adequacy parity concern was voluntarily resolved through a demonstration of proactive measures and ongoing monitoring practices . . . Which included increasing telehealth, expanding gap policies, expanding monitoring using more robust data, and increasing recruitment efforts, for MH/SUD providers.

An ABA therapy exclusion to treat autism spectrum disorder where there was no similar treatment exclusion for M/S services was corrected . . . By removing the exclusion both prospectively and retroactively, and an opportunity to resubmit claims was offered to participants potentially affected by the exclusion.

40

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40



Tips for Plans Reviewed by DOL for NQTL Compliance

- Have your documentation ready
- Establish an internal response process for communicating with DOL and key stakeholders
- Re-review your comparative analyses to refresh your memory
- Respond to requests/follow up questions from DOL
- Expect questions about apparent disparities
- Expect questions about how an NQTL is applied in practice

41

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41



Tips for Plans Being Reviewed by DOL for NQTL Compliance

- **If concerns or violations are noted**

- Ensure you understand the issues and propose appropriate corrective action. When fixing problems, consider how to address the problem going forward and whether/how participants were harmed in the past, and if so, how to address those past harms.

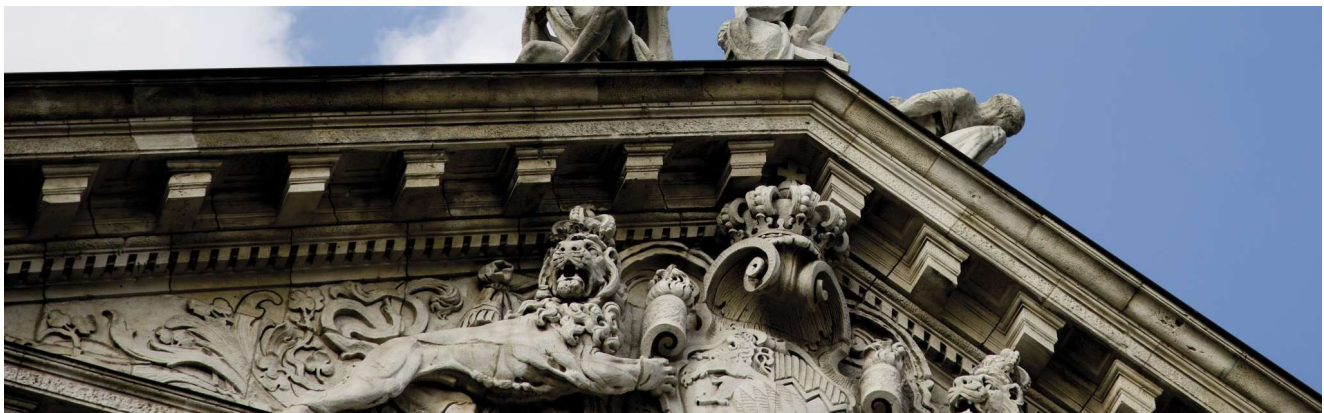
42

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42



Litigation Update



43

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43

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Litigation Update



No Surprises Act: 2nd Circuit Court of Appeals joined the 5th Circuit in holding that providers **do not** have a private right of action to enforce payment awards obtained through the IDR process in federal court.



Scope of ERISA Equitable Remedies: Full 5th Circuit Court of Appeals held oral arguments regarding whether an action for the remedy of surcharge seeks “equitable relief” within the meaning of the parties’ arbitration clause.

Amicus Curiae Brief of the U.S. Acting Secretary of Labor supports holding that surcharge is a form of “equitable relief” available against fiduciaries for breach of fiduciary duty under ERISA §502(a)(3).

44

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44

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Voluntary Benefit Litigation

- New complaints filed against insurers/brokers as plan sponsors alleging fiduciary breach and prohibited transactions in connection with offering voluntary benefits within their own benefit plans.
- Statutory and class Prohibited Transaction Exemptions (PTEs) that may be relevant:
 - For insurer plan sponsor – ERISA § 408(b)(5) or PTE 79-41
 - For broker/agent plan sponsor – PTE 79-60



45

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45

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Return of Ghost Network Claims

- California federal judge allowed ERISA and non-ERISA claims to continue against an insurer and its vendor managing the insurer's provider network.
- Claims allege that insurer maintains a "ghost" network of mental health providers that were not in network, not accepting new patients, or unreachable.
- Causes of action for plaintiffs in ERISA covered plans include:
 - Improper denial of benefits in violation of ERISA;
 - Breach of fiduciary duty under ERISA;
 - Violation of MHPAEA – judge held the allegations sufficient to support a plausible NQTL difference in access to mental health verses medical and surgical services .



46

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46

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Grab Bag

47



BCBS Settlement Payments

- Settlement payments issued from *In re: Blue Cross Blue Shield Antitrust Litigation MDL 2406*, N.D. Ala. Master File No. 2:13-cv-20000-RDP
- **Key Considerations:**
 - How settlement payments were calculated and allocated between employees vs. employer impacts use of settlement funds.
 - The portion of a settlement payment attributable to employee-paid premiums can be considered plan assets.
 - ERISA's fiduciary standards govern use of settlement proceeds that are plan assets.

Questions