ALSTON & BIRD

HEALTH & WELFARE PLAN LUNCH GROUP

April 2, 2026

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Health Benefits Update

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April 2026 Agenda

- Health Care Legs and Regs
- HIPAA and Privacy Refresher
- Litigation Update
- Litigation Defense Strategies

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Health Care Legs and Regs

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Published in the Federal Register

- Fiduciary Duties in Selecting Designated Investment Alternatives (DOL-EBSA), Proposed Rule, issued March 30, 2026
- Administrative Simplification: Adoption of Standards for Health Care Attachment Transactions and Electronic Signatures (CMS-HHS), Final Rule published on 3/24/26.
- Trump Accounts (TREAS-IRS), Notice of Proposed Rulemaking published on 3/6/2026, Comment deadline 5/8/2026
- Trump Accounts Contributions Pilot Program (TREAS-IRS), Notice of Proposed Rulemaking published on 3/6/2026, Comment deadline 4/8/2026 [Note these are due one month earlier than comments for Trump Accounts]s
- 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. Comment due by 4/17/26.
- Improving Transparency Into Pharmacy Benefit Manager Fee Disclosure (DOL-EBSA), Proposed Rule published on 1/30/26; Comments due 4/15/26 (extended)
- Update to the Women's Preventive Services Guidelines (HHS-HRSA), Notice published on 1/5/26
- Delinquent Filer Voluntary Compliance Program (DOL-EBSA), Notice published on 12/30/25
- Transparency in Coverage (HHS-CMS, TREAS-IRS, DOL-EBSA), Proposed Rule published on 12/23/25

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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:

- Final Rule: **Patient Protection and Affordable Care Act, HHS Notice of Benefit and Payment Parameters for 2027**; and Basic Health Program, rec'd 4/1/2026 (HHS-CMS))
- Proposed Rule: **Amendments to Excepted Benefits**, rec'd 3/27/26 (DOL-EBSA)
- Final Rule: **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**, rec'd 2/18/2026
- Final Rule: **Independent Dispute Resolution Operations**, rec'd 1/29/2026 (HHS-CMS)

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Proposed Legislation

- S.3549 (H.R.6837)- **PBM Fiduciary Accountability, Integrity, and Reform (FAIR) Act:** To amend the Employee Retirement Income Security Act of 1974 to ensure that pharmacy benefit managers are considered fiduciaries, and for other purposes. Introduced 12/17/2025.
- **Appropriations Committee releases Consolidated Appropriations Act, 2026** : Increasing funding for mental health and substance use treatment and prevention. For a summary related to DOL, HHS, and related agencies appropriations, click here.
- **S.3097 – Health Information Privacy Reform Act ("HIPRA"):** The press release states that the legislation is aimed at protecting "Americans' private health data by expanding health privacy protections to account for new technologies that are not currently required to have privacy protections, such as smartwatches and health apps." Introduced 11/4/2025 by Bill Cassidy (R-LA).

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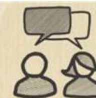
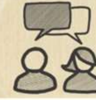


Independent Dispute Resolution Update

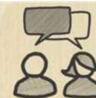
- Final Rule for Independent Dispute Resolution (IDR) Operations is under review at OMB. Proposed rule was released in 2023.
- Calculation of the Qualifying Payment Amount (QPA) for purposes of patient cost sharing, providing required disclosures with an initial payment or notice of denial of payment, and providing required disclosures and submissions under the Federal IDR process:
  - According to ACA FAQs Part 71 issued in July 2025, plans and issuers must calculate QPAs using a good faith, reasonable interpretation of the 2023 methodology until the Fifth Circuit issues its *en banc* decision in the Texas Medical Association (TMA) litigation.
    - TMA litigation still pending. Briefs filed in January 2026.
  - In ACA FAQs Part 73, the Departments extended the enforcement discretion, originally provided in FAQs Part 62 and extended in FAQs Parts 67, 69, and 71, for any plan or issuer, or party to a payment dispute in the Federal IDR process, that uses a QPA calculated in accordance with the 2021 methodology, for items and services furnished on or after February 1, 2026, and before October 1, 2026.



IDR: 2023 Proposed Rule

The Departments published proposed regulations on November 3, 2023 addressing the following areas—will the Final Rule reflect the prior administration's proposals?

- Mandatory use of CARCs/RARCs for out-of-network remittance advice
- New Federal IDR registry for plans and issuers
  - Plans and issuers would be required to provide identifying and contact information, including plan/issuer identity, plan type, applicable state-law/All-Payer Model status, open negotiation contact information, identifiers such as HIOS or EIN/plan number, and fee-collection information.
- Open negotiation becomes more formalized
  - The initiating party would have to submit an open negotiation notice with required supporting information to both the other party and the Departments through the Federal IDR portal.
- IDR initiation becomes more structured
  - The non-initiating party would be required to submit a notice of IDR initiation response within 3 business days after receipt.
- Certified IDR entity selection timeline changes
- Eligibility review process is expanded
  - Certified IDR entities would have more time to make eligibility determinations.
  - In periods of strain or extenuating circumstances, the Departments could conduct eligibility review themselves instead of the certified IDR entity.
- New withdrawal rules
- New batching and bundled-payment rules
- Administrative fee collection changes



IDR: What the Numbers Tell Us

- A February 2026 Congressional Research Service (CRS) Report analyzes NSA/IDR **emergency service outcomes** relative to **in-network rates** across 14 states.
- **IDR Outcomes for Emergency Services Can Increase Plan Costs**
  - Over 95% of IDR emergency service disputes resulted in payments above the median in-network rate for providers who also contract in-network.
  - The median prevailing IDR award was ~312% of the median in-network rate, meaning plans frequently pay 3x what they pay for the same services in-network.
  - Emergency services comprised >50% of IDR determinations in 2023, and ~45% in 2024.
- **Providers Win Most Emergency IDR Cases**
  - Providers initiated nearly all IDR disputes and prevailed in ~80% of cases in 2023, and ~85% of cases in 2024 and exceed 90% in some states (e.g., Utah, New Mexico, Nevada)
- **IDR Awards Exceed Not Only QPAs, but Also Actual Market Rates**
  - CRS compared IDR outcomes to actual negotiated in-network rates (from Transparency in Coverage data), not just to QPAs. Key findings:
    - The median QPA was close to (or slightly above) median in-network rates overall.
    - By contrast, provider offers and prevailing awards were far higher than both QPAs and in-network rates.
- **State-Level Variation Is Significant**
  - Nevada & California: IDR awards close to in-network rates (~**118–129%**).
  - Colorado: median IDR award **619%** of the median in-network rate.
  - 9 of 14 states saw IDR awards exceed **300%** of in-network rates.

IDR: Provider Win Rates Across 14 States (for ER)

Table I from the CRS Report:

State	Provider Win Percentage
Utah	100%
New Mexico	94.7%
Nevada	93.4%
Washington	90.0%
Florida	89.7%
Arizona	86.2%

State	Provider Win Percentage
Alabama	85.5%
Colorado	83.6%
Texas	81.2%
Louisiana	80.3%
Idaho	78.8%
Michigan	78.6%
California	77.4%
Connecticut	55.3%

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IDR: Dispute Characteristics Across 14 States

Table B-1. IDR Dispute Characteristics

Characteristic	Number of Disputes	Median QPA	Median Prevailing Offer
Total Disputes	82,119	$226	$627
CPT Code			
99281	9	$24	$75
99282	149	$82	$548
99283	11,804	$157	$310
99284	43,299	$216	$555
99285	26,858	$260	$781
State			
Alabama	1,327	$159	$525
Arizona	9,454	$173	$507
California	1,174	$190	$450
Colorado	122	$265	$1,099
Connecticut	47	$201	$283
Florida	21,198	$274	$579
Idaho	189	$216	$455
Louisiana	2,349	$150	$742
Michigan	826	$160	$509
New Mexico	431	$167	$724
Nevada	6,697	$167	$458
Texas	37,997	$231	$736
Utah	17	$382	$1,761
Washington	291	$211	$636
Individual Provider/Facility			
Individual Provider	71,573	$203	$578
Facility	10,546	$1,163	$2,526

Source: CRS analysis of Departments of Health and Human Services, Labor, and the Treasury, Federal Independent Dispute Resolution (IDR) Public Use File (PUF) for 2024, Q1, Federal IDR PUF for 2024, Q2.

Notes: IDR = independent dispute resolution process.

IDR: Litigation Against Provider Intermediaries

In an amicus brief filed with a California district court in litigation involving the IDR process and provider intermediaries filing disputes on behalf of providers, the ERISA Industry Committee (ERIC) and American Benefit Council:

- Argue that the IDR process has increased costs rather than reducing them, citing that providers initiated over 1.2 million disputes in the first half of 2025 alone;
- Suggest that eligibility policing is ineffective: plans reported identifying up to 39% of disputes as ineligible in 2024, but IDR entities dismissed only 17% of cases as ineligible in the first half of 2025;
  - As noted in the June 2025 guidance, IDR entities spend far more time than originally anticipated on eligibility determinations. The IDR entity does not get to keep its fee if a dispute is ineligible for the IDR process.
- Highlight that the bulk of IDR disputes initiated in 2025 were brought by a handful of provider intermediaries;
- Express a practical concern for the fee structure: the brief notes that under the statute, the losing party pays the full arbitration fee, and because providers allegedly prevailed in 88% of IDR cases in the first half of 2025, those fees "fall predominately on the shoulders of payers."

IDR: Plan Sponsors and TPA Takeaways/Reminders

- IDR Outcomes Can Affect Network Negotiations
  - Directly, through inflated OON emergency payments; and
  - Indirectly, by giving providers leverage in future in-network rate negotiations.
- Plan sponsors of self-insured ERISA plans are ultimately responsible for NSA/IDR compliance
- TPAs cannot base the median contracted rate on their entire book of business.
- IDR process has several deadlines, and eligibility disputes should be raised early.
- June 2025 Guidance outlines the process for reopening a closed dispute for certain types of errors described in the guidance.
  - According to the June 2025 guidance, the Departments' position is that deadlines for payment determinations are not tolled by a request to reopen a closed dispute.

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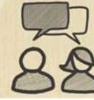

MHPAEA: Big Changes to the 2024 Final Rule on the Way?

- In a Joint Status Report in *ERIC v. HHS et al*, HHS, DOL, and Treasury stated:

> *"The Departments have determined that, rather than defend the Rule in this proceeding, they will issue a new proposed rule, including anticipated significant revisions to the provisions of the Rule that ERIC has challenged in this lawsuit. The Departments intend to include a rulemaking on this topic on the 2026 Spring Regulatory Agenda, and to issue a notice of proposed rulemaking no later than December 31, 2026."*

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HIPAA and Privacy Refresher

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HIPAA Basics

- HIPAA Applies to . . .
  - All health plans including medical, vision, dental, EAP, wellness programs and . . .
    - All third party administered health FSAs
    - All third party administered HRAs
    - All other health plans (e.g., LSAs)
- HIPAA Does not Apply to
  - Dependent care FSAs, Transit, non-health LSAs
  - HSAs
- But does arrangement have/need access to PHI??

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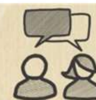

HIPAA Quick Check for TPAs and Plan Sponsors

- Do you have business associate agreements in place with all service providers and contractors
- Have all plan sponsor clients issued privacy notices and updated them (reminder notice every three years).
- Do plan sponsors have . . .
  - Privacy and Security Policy and Procedures document
  - WRITTEN security risk assessment
- Does TPA have . . .
  - Privacy and Security Policy and Procedures document
  - WRITTEN security risk assessment
- Is any consideration being received for use of PHI (including enrollment info)

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HIPAA and Privacy/Data Breach Generally

- Recent large "big data" breaches for health plans and HSA providers
- Not every data breach is subject to HIPAA
  - Only healthcare data is PHI
  - Think: health plan, dental plan, EAP, HRA, health FSA, ICHRA, wellness programs, etc.
- Some data breaches relate solely to personal identifiable information (PII)
  - Think: HSAs, parking/transit, dependent care and related card transactions
- Federal (HIPAA, GLB), State, and Local requirements often overlap
  - In some cases applicability of HIPAA may mitigate some state law reporting obligations

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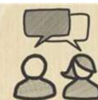

Breach Reporting - US

- **All 50 states have state data breach notification statutes.**
  - Updates to these laws over recent years have, among other things, expanded the definition of personal information and reporting obligations to state regulators.
- **FTC:**
  - The FTC stated that Section 5 of the FTC Act ("unfair or deceptive practices") creates a "de facto breach disclosure requirement" in a May 2022 blog post.
  - On December 9, 2021, the FTC published a notice of proposed rulemaking to the Federal Register including a reporting requirement for financial institutions of certain cybersecurity events to the FTC.
    - 16 of the 2019-2024 FTC actions involved data security in violation of the "unfair or deceptive practices" prohibition or the GLBA Safeguards Rule for failing to provide reasonable information security.

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Cyber Incident Reporting - US

- Insurance companies are required to report material cyber incidents for an increasing number of states that have adopted a version of the NAIC Data Security Model Law.
  - While versions of the Model Law vary in the 30 states that have adopted it, in general incidents must be reported to the chief insurance regulatory official of the state within **72 hours** of determining a qualifying incident occurred.
- Banking organizations are required to report computer security incidents to their primary federal regulator.
  - Reporting must occur "as soon as possible" and no later than **36 hours** of determining that the event has crossed the "notification incident" materiality threshold, meaning a computer-security incident that has or is reasonably likely to disrupt or degrade the banking organization's business lines or ability to carry out operations.

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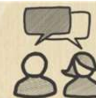

State Privacy Laws, GLBA, and Supplier Management

- Develop and use a standard data processing agreement ("DPA")
- The DPA should include CCPA-compliant service provider terms
  - These are specific contract provisions mandated by the California Consumer Privacy Act (the "CCPA") to classify your supplier as a "service provider."
  - This is required for a supplier agreement not to result in "sales" of personal information under state law.
  - Include GLBA terms if NPI is in scope (Strict data use limits; Safeguards Rule compliance)
- Develop minimum DPA standards to negotiate when the supplier insists on its own form.
- Include AI governance and risk management terms, including limits on using data to train AI models.

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State Privacy Laws and GLBA: Tracking Pixels and SDKs

- Providers of tracking pixels, SDKs (software development kits), and other tracking technologies for websites and mobile apps should also be subject to CCPA-compliant service provider terms.
- These tracking technologies are common and useful tools for websites and mobile apps, but can create significant unexpected risks and liabilities for health plans and TPAs.
- If not deployed carefully, use of tracking pixels and SDKs may result in privacy compliance issues, state law wiretapping claims, and data breaches that raise issues under HIPAA, state data breach laws, and the FTC Act.

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State Privacy Laws and GLBA: Supplier Contract Red Flags

- Right to “aggregate and anonymize” your data.
- Risk-shifting
  - Restriction on providing personal information or sensitive information to the supplier
  - Mutual obligations to comply with privacy laws
- Right to use your data to train AI models.

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Litigation Update

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Litigation Update

- **Transgender Care**
  - *Anderson v. Crouch,* 2026 U.S. App. LEXIS 7026 *, __ F.4th __, (March 10, 2026, 4th Cir.) on remand from the U.S. Supreme Court, held that West Virginia's Medicaid exclusion of surgical treatment for gender dysphoria does not violate the Equal Protection Clause, ACA section 1557, or the Medicaid Act.
  - EEOC decision in *Sam T. v. Kuper* (March 24, 2046), rejected claims from governmental employees that OPM's exclusion of gender affirming care violated Title VII and the Rehabilitation Act based on *Skrmetti.* Overturns a 2024 EEOC decision, *Lawrence v. OPM,* which held that denying health care coverage for gender affirming care violated Title VII.
  - *Oregon v. Kennedy,* on March 19, 2026, the U.S. District Court for the District of Oregon partially vacated a declaration issued by HHS Secretary Robert F. Kennedy Jr. in December 2025 that gender affirming care procedures for minors are (i) not safe and effective; and (ii) fail to meet professionally recognized standards of care. Several States and the District of Columbia led by Oregon filed a lawsuit seeking declarative and injunctive relief that the declaration exceeds HHS' authority and violates notice-and-comment rulemaking requirements.

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Litigation Update

- **ACA Section 1557**
  - U.S. District Court in Nevada allowed a disability discrimination class action to proceed against a self-funded medical plan TPA for the underlying plans' failure to cover hearing aids.
    - Follows 9th Circuit precedent holding that a TPA can be liable for violating ACA Section 1557, even when implementing plan terms drafted by a plan sponsor.
  - 1st Circuit upheld dismissal of a complaint against an insurer for disability discrimination for failure to cover weight loss drugs.
- **Wellness**
  - Tobacco surcharge complaints- new allegations surrounding whether disclosure is required in *all* plan materials.
  - Regulations currently do not require disclosure in plan materials that merely mention such program is available w/o disclosing all its terms.

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Litigation Update

- **Prescription Drugs – Fiduciary Duty Claims**
- Current and former employees sued the plan sponsor in the U.S. District Court for the SDNY alleging that plan sponsor breached its fiduciary duties and engaged in prohibited transactions (PTs) by mismanaging the prescription-drug component of the self-funded employee health plan.
- Court dismissed the fiduciary breach claims that the plan sponsor imprudently failed to negotiate terms with the PBM to protect the Plan from excessive costs.
  - Court stated that the allegations focused less on administration and more on the plan sponsor's decisions regarding the design and structure of the Plan's pharmacy benefit arrangements, which the Court held were settlor rather than fiduciary functions.

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Litigation Update

- **Prescription Drugs –Prohibited Transaction Claims**
- Court allowed the PT claims to proceed against the plan sponsor.
- Plan sponsor acted as a fiduciary when entering into and/or renewing the PBM agreement and making related payments to the PBM.
- PBM was a party in interest because it provided services to the plan.
- Employees allege that the Plan paid the PBM $3 million annually in administrative fees along with spread pricing and retained rebates. Employees assert that, taken together, this compensation was excessive and therefore unreasonable.
- Employees' allegations were sufficient to assert a plausible PT claim at this juncture pursuant to the Supreme Court's recent opinion in *Cunningham v. Cornell University* – plaintiffs need to do no more than plead a violation of ERISA section 406(a)(1) – that the defendants caused the Plan to exchange property between the plan and a party in interest.

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Litigation Defense Strategies

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Litigation Defense Strategies

Plan documents can provide an effective starting point for litigation defense

Can plan ahead by reviewing applicable provisions now

Consider whether to add or revise provisions based on current law

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Choose the best forum for litigation.

- Most courts will permit and enforce **forum selection clauses**.
- Can specify a single federal district or include several options, such as the districts where the plan is administered, where the breach took place, or where the defendant resides.
- Considerations:
  - Legal standard in the jurisdictions
  - Evidentiary concerns
  - Convenience

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Set the clock and let it run

- **Statute of limitations provisions** can help limit the scope of liability.
- An ERISA plan's stated deadline for bringing a lawsuit controls unless it is unreasonable.
- Courts generally enforce three-year limitations and, in some cases, one-year limitations or less.
  - Must allow enough time for claims and appeals.
  - Ambiguous language is construed against the drafter.
- Notice required.

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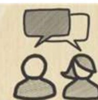

Ensure the plan gives the right decisionmakers authority.

- **Discretionary language:** Plan document should expressly provide that the decisionmaker has discretionary authority to interpret and administer the plan and make factual determinations.
- Ensure that the provision identifies the appropriate decisionmaker.
- Grant discretionary authority to delegates of the plan decisionmaker where appropriate.
- Should ideally be included in both the plan document and SPD.
- Check for consistency across all written documents and materials.

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Clearly state and follow claims and appeals procedures.

- Can proscribe the method and time limits for filing claims.
- Clear and consistent:
  - Should be clearly stated in the plan document.
  - Should be consistent across other documents and communications.
- Ensure the procedures outlined in the plan document are realistic and consistent with the actual practices.
  - Courts will enforce deadlines against both parties – failure to comply with the process can jeopardize discretionary review.

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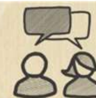

Ensure claimants are required to follow claims process.

- **Exhaustion requirement:** courts generally require claimants to complete administrative process before filing a lawsuit for a claim for benefits.
- But may not enforce exhaustion requirement if it is not clearly stated in the plan document.
- Consider including a statement about the need for a claimant to exhaust the claim and appeal process before filing a lawsuit.

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Double check that defined terms mean what you want them to.

- Ensure it is clear whether something is a requirement for coverage or an exclusion.
- Check how courts have interpreted similar language, particularly in the jurisdiction for chosen forum, if applicable.
- Consider having limitations written out in the plan document.

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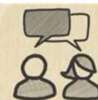

Allow the plan to seek recovery.

- Recoupment:
  - Provisions explicitly permitting recoupment of overpayment
- Subrogation and reimbursement:
  - Provisions addressing the right to seek reimbursement of recovery from a third party
  - Create an equitable lien by agreement
  - Consider common fund and make whole doctrines

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Clarify who can seek recovery from the plan.

- Anti-assignment clauses
- Provisions for appointing authorized representatives

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Agree to specific procedures for resolving disputes.

- Class action waivers
- Arbitration provisions
- Jury trial waivers

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Questions

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