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2025: Third Quarter

Compliance Digest

Compliance Bulletins Released July to September

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Texas Potentially Eases Premium Liability

Issued date: 07/02/25

On May 21, 2025, Senate Bill 1332 ("SB 1332") went into effect. The new legislation gives insurers the discretion to waive premium liability in cases where the employer submits a late termination of eligibility notice, but only if no covered services were used after the employee's eligibility ended.

Background

Texas Senate Bill 51 ("SB 51"), which went into effect in 2006, requires plan sponsors to pay a participant's premiums through the end of the month in which the plan sponsor notifies the carrier that an individual is no longer eligible. However, if an individual ceases to be eligible during the last seven days of a month, the employer must notify the insurer no later than the third day of the following month (not including Saturdays, Sundays, and legal holidays).

This requirement applies to Texas residents covered under insured plans offering the following benefits:

- PPO and HMO medical;
- PPO vision (but not dental); and
- HMO vision and dental (single service).

It is not applicable to self-funded plans.

Missing the deadline results in the employer being charged a full additional month of premiums, even if the employee used no covered services and did not elect COBRA or Texas state continuation. This can be particularly problematic because many employers and insurance carriers now rely on Electronic Data Interchange ("EDI") feeds, which typically transmit weekly. Under SB 51, if a termination of benefits occurs during the last week of the month but the EDI feed does not transmit by the third day of the following month, the employer can be held financially responsible for an entire extra month of premium without recourse. And sometimes there are simply unforeseen administrative errors.

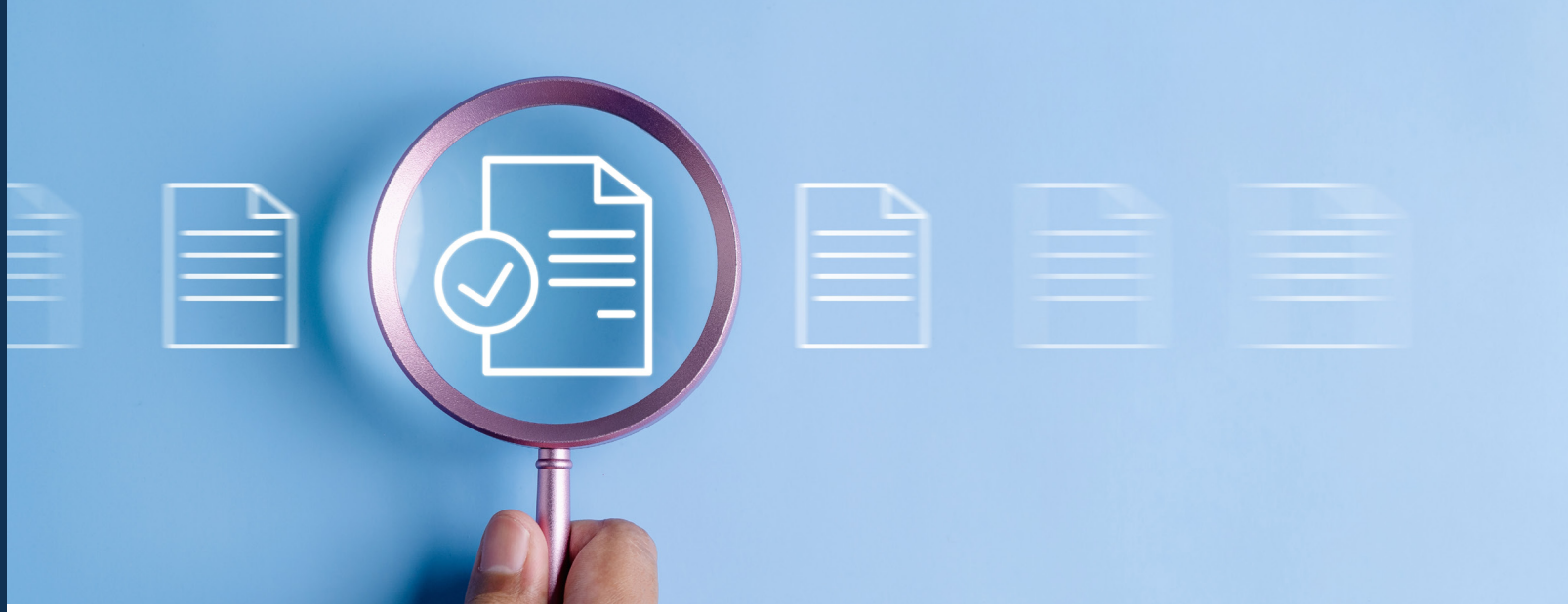
SB1332

The new legislation eases the administrative burden of SB 51 by giving insurers the discretion to waive premium liability in cases where the employer submits a termination of benefits notice late, but only if no covered services were used after the employee's eligibility ended.

While Governor Greg Abbott signed the bill on May 30, 2025, the supermajority passage meant that even if unsigned, the bill automatically became law. Thus, the law became effective in time for retroactive group health plan terminations processed as soon as June 2025 (for terminations in late May 2025).

Employer Action

Coordination with carriers and EDI service providers is still recommended to determine the best administrative processes for ensuring timely notices of termination. While in many cases carriers will be able to waive premiums for months following late-submitted terminations, such waiver is at the discretion of the carrier and employers will still be liable if covered services were used after the employee's eligibility ended.



Proposed Changes to Machine-Readable File Requirement

Issued date: 07/08/25

As previously reported, on February 25, 2025, President Trump signed an Executive Order (EO 14221) directing federal agencies to update the existing health care price transparency guidance and enforcement efforts, including those addressing machine-readable files ("MRFs"). In response, on May 23, 2025, the Departments of Labor, Health and Human Services, and the Treasury (collectively, "the Departments") released some FAQs signaling their improvement of the MRF disclosure process and issued a request for information ("RFI") for how best to report prescription drug information.

Background

Under the Transparency in Coverage ("TiC") final rules, group health plans and health insurance carriers must make public MRFs that disclose:

1. In-network rates;
2. Out-of-network allowed amounts and billed charges; and
3. Negotiated rates and historical net prices for covered prescription drugs.

While (1) and (2) above went into effect on July 1, 2022, the prescription drug MRF was delayed. In FAQ 61, the Departments announced that the enforcement deferral for the prescription drug MRF was rescinded, and that additional guidance would be issued in order for plans and carriers to comply with this requirement.

Improving Efficiency

The latest FAQs indicate that the Departments have identified several areas for strengthening disclosure requirements. The Departments intend to address concerns regarding the MRFs related to accessibility due to file size, data integrity, and a lack of critical context that limits full transparency. The Departments intend to release schema version 2.0, which will implement revised technical requirements for the in-network file and out-of-network allowed amount and billed charges file. In particular, schema version 2.0 will reduce file size by requiring exclusion of duplicative data, reducing unnecessary data

fields, and will include updates to better contextualize the data, making it more meaningful to ultimately achieve greater transparency. The Departments intend to finalize schema version 2.0 on October 1, 2025, with compliance being required by February 2, 2026.

The Departments are also considering rulemaking to further refine and improve upon the MRF requirements.

Prescription Drug Reporting

The RFI is intended to gather input from the public regarding implementation of the machine-readable file disclosure requirements as to prescription drugs in particular. The Departments previously deferred enforcement of this requirement.

Questions concern topics such as how to:

- Identify more meaningful data elements;
- Avoid unnecessary or irrelevant disclosures; and
- Capture rebate amounts.

Employer Action

At this time, there are no immediate action items for employers. As a reminder, with respect to the transparency requirements currently in effect:

- **Fully insured plans:** Health insurance carriers remain responsible for compliance with transparency requirements. Employers should obtain written confirmation that the carrier posts this information on behalf of the plan.
- **Self-funded plans:** Employers are responsible for ensuring compliance but may contract with third-party administrators (TPAs) and pharmacy benefit managers (PBMs) to fulfill these obligations.

It is important to note that generally, an employer sponsoring a self-funded plan can satisfy the MRF disclosure requirements by entering into a written agreement under which a TPA posts the MRFs on its public website on behalf of the plan. However, if the TPA fails to do so, the plan is liable. Employers without such a written agreement should post a link to the TPA's MRFs.

When the Departments provide their guidance, employers should engage with their carriers, TPAs, and PBMs to understand how they plan to comply with the new transparency requirements and whether updates to service agreements may be necessary. We will continue to monitor these developments and provide updates as new information becomes available.

One Big Beautiful Bill Act Signed into Law

Issued date: 07/11/25

On Friday, July 4, 2025, President Trump signed into law the One Big Beautiful Bill Act ("OBBBA"), which encompassed much of the President's desired domestic policies for his term. Importantly for employers, the bill does not alter or eliminate the tax exclusion for employer sponsored health insurance.

There are several provisions in OBBBA that amend the Internal Revenue Code ("the Code") and impact employer sponsored plans.

The following highlights some of the key changes.

Telehealth and Direct Primary Care Are Okay Before the Minimum HDHP Deductible

Most notably, certain types of coverage will no longer preclude individuals enrolled in a qualified high-deductible health plan ("HDHP") from contributing or receiving contributions to a Health Savings Account ("HSA").

Telehealth

For plan years beginning after December 31, 2024, an HDHP will not be disqualified by failing to have a deductible for telehealth and other remote care services. This means that an employer can provide telehealth on a no-cost (or reduced cost) basis for HDHP participants, and the individuals will still be able to make and receive contributions to their respective HSAs.

The retroactive effect of this provision means that if telehealth or other remote care services were provided for free (or at a reduced cost before the deductible) in 2025, that coverage is not considered disqualifying and employers will not need to adjust the tax treatment of any potential employee or employer HSA contributions made earlier this year.

Direct Primary Care

Beginning on January 1, 2026, HDHP participants can make and receive HSA contributions while covered under a direct primary care service arrangement ("DPC"). Previously, free (or reduced cost) DPC services provided before the minimum

HDHP deductible is satisfied would disqualify individuals from making HSA contributions.

To qualify as a DPC, the program must:

- Consist solely of primary care services provided by primary care practitioners, and
- Have a monthly fee of $150 or less for self-only coverage and $300 or less for coverage other than self-only. These amounts will be indexed annually.

For this purpose, the statute states that the following services are specifically excluded from treatment as primary care:

- Any procedures that require the use of anesthesia,
- Prescription drugs (other than vaccines), and
- Lab services that are not typically administered in an ambulatory primary care setting.

Additionally, HSA account holders can pay for a DPC out of their HSA, but only if the arrangement is less than or equal to $150/month for an individual ($300/month for a family) as indexed.

> It is important to note that this change allows for the DPC fees to be reimbursed by an HSA. It does not appear to allow for reimbursement from other types of accounts like a Health Reimbursement Arrangement ("HRA") or a Flexible Spending Account ("FSA"). However, further guidance would be welcome.

Increase to the Dependent Care Account

Previously, Section 129 dependent care assistance programs (also known as "dependent care FSAs" or "DCAPs") were limited to reimbursing up to $5,000 annually ($2,500 if married filing separately) of qualified child and dependent care expenses incurred for the taxpayer to seek employment or work.

For taxable years beginning after December 31, 2025, DCAPs can reimburse up to $7,500 annually ($3,750 if married filing separately). No other amendments were made, so the new maximum is still not indexed for inflation and is subject to meeting certain nondiscrimination requirements provided by the Code.

> Please note that while the increased dollar limit for DCAPs is a welcome development, employers should be mindful that such an increase could impact their nondiscrimination testing results if highly compensated or key employees benefit more from this higher limit.

Permanent Changes to Qualified Education Assistance Plans

Employers may contribute up to a maximum of $5,250 towards educational assistance for an employee in a calendar year and those amounts will be excludable from the individual's taxable income.

An educational assistance program can include payments for expenses incurred by or on behalf of an employee for the education of the employee, as well as payments to the employee or a lender of principal and/or interest on any qualified educational loan incurred by the employee for education of the employee.

The student loan provision was set to expire at the end of 2025, but the provision is now extended permanently.

Additionally, the $5,250 maximum will now be indexed moving forward to account for inflation.

Permanent Changes to Transportation Fringe Benefits

OBBBA permanently eliminates the bicycle commuting reimbursement exclusion.

In addition, the bill adjusts the methodology for calculating inflation when indexing the maximum amount of fringe benefits excludable for parking or public transit.

Extension and Enhancement of the Tax Credit for Paid Family and Medical Leave

OBBBA makes permanent paid family medical leave tax credits under Code § 45S, with three modifications:

- Expands the credit allowing employers to claim the credit for a portion of paid family and medical leave insurance premiums.
- It makes the credit available in all states.

Establishment of Trump Accounts and Employer Contributions

For tax years beginning after December 31, 2025, the law establishes a new type of retirement account called a "Trump Account," which will be treated in a similar manner to Individual Retirement Accounts ("IRAs") but is specifically designed for minors. The accounts are subject to various rules, including:

- The account must be established for the exclusive benefit of an eligible individual under the age of 18 or the individual's children under the age of 18.
- Contributions are limited to up to $5,000 per year (indexed for inflation for years after 2027), and funds must be invested in "eligible investments." Contributions can begin July 4, 2026.
- With limited exceptions, the amounts in the Trump Account must not be distributed before the first day of the year that the beneficiary turns 18.

Employers may contribute up to $2,500 (indexed for inflation for years after 2028) to an employee's Trump Account or that of their dependent(s). Amounts contributed by an employer are excludable from the employee's taxable income provided they are made in accordance with a separate, written plan document and subject to nondiscrimination requirements like those that apply to DCAPs.

Employer Action

Employers should review the benefit related provisions of OBBBA. Employers may want to consider:

- With respect to HDHP/HSA plans, whether to offer:
    - Free or reduced cost telehealth (or other remote care services).
    - A DPC arrangement.
- Increasing the DCAP limit for 2026 to reflect the larger salary reduction of $7,500.
- Whether to take advantage of other tax favored offerings, including:
    - A qualified education assistance program that will permanently include student loan payments; or
    - Contributions to employees' own (or their dependents') Trump Account for future investment (available beginning July 4, 2026).

New York City Issues Guidance for Prenatal Leave

Issued date: 07/16/25

New York became the first state in the nation to enact paid prenatal leave that became effective January 1, 2025. New York employers must provide 20 hours of paid prenatal leave for covered healthcare services in a 52-week period that is measured from the first time the employee uses paid prenatal leave. The New York City ("NYC") Department of Consumer and Worker Protection ("DCWP") amended its interpretive rules for the NYC Earned Safe and Sick Time Act ("ESSTA") to incorporate New York state's prenatal leave guidance.

The NYC amended rules were effective July 2, 2025, and while the rules attempt to align the city's ESSTA with the state's paid prenatal leave guidance, there are some notable differences as summarized below.

	New York State Paid Prenatal Leave	New York City Amendments to DCWP Interpretive Rules
Failure to file Form 5500	Employers may not request medical records or ask employees to disclose confidential information about their health condition when requesting paid prenatal leave	After three consecutive workdays of leave, employers can require employees to submit reasonable documentation to substantiate that paid prenatal leave was used appropriately
Employee Notice Requirements	Employees should request time off in accordance with existing notification/request procedures within their workplaces and are encouraged to provide advance notice of such leave requests, when possible	Employers can require an employee to provide reasonable notice of the need to use safe/ sick time or paid prenatal leave for "foreseeable" absences

Use of Paid Prenatal Leave	Allows employees to take paid prenatal leave in hourly increments	Permits an employer to set a minimum increment of paid prenatal leave at “one hour per day” suggesting that an employer has flexibility to establish a different minimum leave increment
Employer Notice and Recordkeeping Requirements	Employers are not required to separately identify paid prenatal leave on employee paystubs but are encouraged to keep accurate records	Requires employers to report an employee’s available paid prenatal leave balance each pay period in which an employee uses the leave (on the pay statement following the use or other written documentation)

Employer Action

NYC employers should review the paid prenatal leave interpretive rules with counsel to ensure compliance with all relevant guidance. It remains to be seen whether the NYC differences to the state paid prenatal leave provisions are applicable absent amendments to the ESSTA.

Privacy Rule Addressing Reproductive Health Vacated

Issued date: 07/21/25

On June 18, 2025, the amendment to the Health Insurance Portability and Accountability Act ("HIPAA") Privacy Rule concerning reproductive protected health information was vacated.

Background

In April 2024, the Department of Health and Human Services ("HHS") issued a final rule to strengthen the HIPAA Privacy Rule by prohibiting the use or disclosure of protected health information ("PHI") to investigate or prosecute patients, providers, and others involved in the provision of legal reproductive health care, including abortion care ("rPHI"). The rule resulted from concerns that pregnant women who live in a state where elective abortion is illegal seeking an abortion in a state where elective abortion is legal may have their records sought for the purpose of conducting criminal, civil, or administrative investigations following the Supreme Court's overturning of Roe v. Wade in the Dobbs case.

Purl v. HHS

An order out of a federal district court in Texas blocked the final rule on a nationwide basis.

The court ruled against the regulations based on the following:

1. HHS went further than HIPAA allows under standards set forth in the Loper Bright case and cannot restrict state rights to regulate abortion, as granted by the Dobbs decision. This is under the major questions doctrine which indicates that if an agency seeks to decide an issue of major national significance, its action must be supported by clear congressional authorization.
2. Defining "person" as excluding an unborn human conflicts with the Dictionary Act.
3. HIPAA cannot curtail state powers such as the power to create state child abuse and public health reporting laws.

It seems unlikely that HHS, under the current Administration, will appeal the decision.

Result

The Purl order immediately resets the compliance requirements for HIPAA-regulated entities, removing the additional protection HHS imposed on the sharing of rPHI. The general HIPAA Privacy Rule remains in effect. Under the general HIPAA privacy rules, a disclosure of PHI related to abortion without court order is prohibited, but that disclosure related to abortion with a court order does not require authorization.

Further Litigation

Texas has filed a separate lawsuit challenging the 2024 rPHI rule as well as the final 2000 rule, which is pending in federal court in Lubbock. Texas argues that the rule violates the Administrative Procedure Act ("APA") which governs how federal agencies develop and issue regulations. HHS, in a court filing last month, said the Administration is evaluating its position in this case.

Employer Action

Plan Sponsors who amended their HIPAA privacy policies and any other HIPAA-related documents addressing rPHI should remove those references and note that law enforcement is not required to use the model attestation.

California Delays Implementing Mandated Fertility Benefits

Issued date: 07/23/25

The effective date of California Senate Bill 729, which expands fertility coverage for fully insured plans, has been delayed. Originally set to be in effect for contracts issued, amended, or renewed on or after July 1, 2025, the law is now effective for fully insured health policies and HMO contracts **issued, amended, or renewed on or after January 1, 2026.**

Background

California Senate Bill 729 ("SB 729"), signed into law on September 29, 2024, requires large group policies and HMO contracts to cover the diagnosis and treatment of infertility and fertility services, including a maximum of three completed in-vitro fertilization treatments. Small group health insurance policies and HMO contracts are required to offer the employer (or other policyholder) the option to cover these same services but are not mandated to provide this coverage automatically. In California, "small group" is generally defined as a plan covering an employer that employs at least one, but not more than 100, full-time equivalent employees on at least 50% of its working days during the preceding calendar quarter or preceding calendar year, the majority of whom were employed in California.

The new state law applies to every health insurance policy that is issued, amended, or renewed to residents of California, regardless of the situs of the contract. It does not apply to self-funded group health plans or to health insurance policies or HMO contracts maintained by a "religious employer."

The law was originally set to be effective for insurance policies and HMO contracts issued, amended, or renewed on or after July 1, 2025. The new state law does not apply to health plans and policies with CalPERS (the benefit system for state employees) until July 1, 2027.

What's New

Upon signing SB 729, Governor Newsom requested the California Legislature to delay the implementation date from July 1, 2025, to January 1, 2026.

The extension became official on June 30, 2025, when Governor Newsom signed Assembly Bill 116 ("AB 116"), the health omnibus trailer bill, as part of the 2025-2026 state budget. AB 116 included a provision extending the implementation date of SB 729 for both large and small group plans to January 1, 2026. It also gave the Department of Insurance and the Department of Managed Health Care until January 1, 2027, to issue compliance guidance.

The benefit mandate will now take effect for fully insured group health insurance policies and HMO contracts that are **issued, amended, or renewed on or after January 1, 2026.**

Employer Action

Large employers with fully insured plans should be aware of the new fertility requirements that will take effect for plan years beginning on or after January 1, 2026.

Large employers with fully insured policies written outside of California, but providing coverage to California residents, should discuss compliance with the insurance carrier.

Small employers with fully insured plans should determine whether to opt in to the fertility coverage with the first renewal on or after January 1, 2026.

HHS Revises Out-of-Pocket Maximum Limits for 2026

Issued date: 07/28/25

The Department of Health and Human Services ("HHS") released final regulations on the Affordable Care Act ("ACA") Marketplace Integrity and Affordability. While the regulations generally affect Marketplace Coverage, it did include a revision to the out-of-pocket maximum limits for plan years that begin on or after January 1, 2026. This revision is due to an updated methodology to better align with premium trends. The revised limits are as follows:

- $10,600 for self-only coverage (revised from $10,150)
- $21,200 for coverage other than self-only (revised from $20,300).

It is important to note that the out-of-pocket maximum limits for non-grandfathered group medical plans are different (and generally higher) than the out-of-pocket maximum limits required for high-deductible health plans ("HDHPs") that are compatible with health savings account ("HSA") eligibility. For 2026, the out-of-pocket maximum limits for HSA-compatible HDHPs are $8,500 (up from $8,300 for 2025) for self-only coverage and $17,000 (up from $16,600 for 2025) for coverage other than self-only.

In addition, the rule finalized that carriers subject to essential health benefit requirements ("EHBs") (generally non-grandfathered individual and small market group health plans) may not cover specified sex-trait modification procedures
as an EHB. This policy will not prohibit carriers subject to EHB requirements from voluntarily covering specified sex-trait modification procedures, nor will it prohibit states from requiring coverage of such services, subject to the rules related to state-mandated benefits.

Employer Action

- Ensure out-of-pocket maximum limits for 2026 do not exceed the revised maximums.

Deal Reached To Simplify Prior Authorizations

Issued date: 07/30/25

On June 23, 2025, Health and Human Services (“HHS”) Secretary Robert F. Kennedy, Jr. and Centers for Medicare & Medicaid Services (“CMS”) Administrator Dr. Mehmet Oz met with health insurers to discuss their pledge to streamline and improve the prior authorization processes.

Companies represented at the roundtable included Aetna, Inc., AHIP, Blue Cross Blue Shield Association, CareFirst BlueCross BlueShield, Centene Corporation, The Cigna Group, Elevance Health, GuideWell, Highmark Health, Humana, Inc., Kaiser Permanente, and UnitedHealthcare.

Participating health insurers have pledged to:

- Standardize electronic prior authorization submissions using Fast Healthcare Interoperability Resources (FHIR®)-based application programming interfaces.
- Reduce the volume of medical services subject to prior authorization by January 1, 2026.
- Honor existing authorizations during insurance transitions to ensure continuity of care.
- Enhance transparency and communication around authorization decisions and appeals.
- Expand real-time responses to minimize delays in care with real-time approvals for most requests by 2027.
- Ensure medical professionals review all clinical denials.

For patients, these commitments are intended to result in faster, more direct access to appropriate treatments and medical services with fewer challenges navigating the health system. For providers, these commitments are intended to streamline prior authorization workflows, allowing for a more efficient and transparent process overall, while ensuring evidence-based care for their patients.

Employer Action

This agreement between HHS and insurance companies is a pledge and, at this time, not related to any proposed or final rules around prior authorization processes. It remains to be seen how this will play out in practice, particularly in the commercial market.

No employer action is necessary.

IRS Announces 2026 ACA Affordability Indexed Amount

Issued date: 08/04/25

The IRS recently announced that the Affordable Care Act ("ACA") affordability indexed amount under the Employer Shared Responsibility Payment ("ESRP") requirements will be 9.96% for plan years that begin in 2026. This is a significant increase from the 2025 percentage amount (9.02%), jumping above the original 9.5% threshold.

Background

IRS Revenue Procedure 2025-25 establishes the indexed "required contribution percentage" used to determine whether an individual is eligible for "affordable" employer-sponsored health coverage under Section 36B (related to qualification for premium tax credits when buying ACA Marketplace coverage). However, the IRS explained in IRS Notice 2015-87 that a percentage change under Section 36B will correspond to a similar change for affordability under section 4980H ESRP requirements.

Determining Affordability in 2026

An employer will not be subject to a penalty with respect to an ACA full-time employee ("FTE") if that employee's required contribution for 2026 meets one of the following safe harbors.

1. **The W-2 safe harbor.**

The employee's monthly contribution amount for the self-only premium of the employer's lowest cost coverage that provides minimum value is affordable if it is equal to or lower than 9.96% of the employee's W-2 wages (as reported on Box 1 of Form W-2). Application is determined after the end of the calendar year and on an employee-by-employee basis. Box 1 reflects compensation subject for federal income taxes, which would exclude amounts such as employee contributions to a 401(k) or 403(b) plan, and towards other benefits through a cafeteria plan.

2. Rate of pay safe harbor.

The employee's monthly contribution amount for the self-only premium of the employer's lowest cost coverage that provides minimum value is affordable if it is equal to or lower than 9.96% of the employee's computed monthly wages. For hourly employees, monthly wages are equal to 130 hours multiplied by their rate of pay. For salaried employees, monthly wages are equal to their monthly salary.

For example, an hourly employee has a $10/hour rate of pay. For a 2026 plan year, coverage is "affordable" for the employee if the employee's cost for self-only coverage does not exceed $129.48/month (($10 x 130 hours) x 0.0996).

3. Federal Poverty Level ("FPL") safe harbor.

Coverage is affordable if it does not exceed 9.96% of the FPL.

For a 2026 calendar year plan, coverage is affordable under the FPL safe harbor if the employee monthly cost for self-only coverage in the lowest cost plan that provides minimum value is not more than $129.89 (48 contiguous states), $162.26 (Alaska), or $149.31 (Hawaii). Note, this amount may increase (or decrease) when the 2026 FPL guidelines are issued.

Employer Action

Employers budgeting and preparing for the 2026 plan year should review these affordability safe harbors when analyzing employee contribution amounts for the coming year.

Update on the End of Indiana's 2025 Legislative Session

Issued date: 08/05/25

As is typical at the end of a legislative session, there was a flurry of activity and passage of multiple bills in Indiana. Two bills touching on benefits have become law; this article summarizes key aspects of each. Overall, the day-to-day impact of these bills to plan sponsors is minimal. However, we anticipate that the bills will allow plan sponsors to:

- Have more options when selecting pharmacy benefit managers ("PBMs"), especially for self-funded plans, and
- Hold PBMs and third-party administrators ("TPAs") more accountable by extending the same fiduciary duties to those entities.

Senate Bill 3 – Now Public Law 69

Effective July 1, 2025, Public Law 69 extends state fiduciary duties to TPAs and PBMs "acting on behalf of a plan sponsor." The law defines plan sponsor as "an employer or organization that offers health insurance coverage to its employees or members through an insurer or a self-funded health benefit plan" and therefore, the law appears to apply to both fully insured and self-funded ERISA plans. The four key fiduciary duties that TPAs and PBMs must follow are:

1. Act with loyalty and care in the best interests of the plan sponsor;
2. Ensure that all fees, costs, and commissions are reasonably and fully disclosed;
3. Avoid self-dealing and conflicts of interest; and
4. Maintain transparency in all financial and contractual arrangements related to the plan sponsor's health insurance coverage, including prescription drug benefits.

Senate Bill 140 – Now Public Law 189

Public Law 189 applies broadly to insurers and pharmacy benefit managers. It sets forth requirements relating to network adequacy, fee/compensation disclosures, cost/reimbursement guidelines, and some contractual limitations. These requirements are effective for any policies or contracts delivered, entered into, renewed, or amended after December 31, 2025.

Network Adequacy

The law mandates that any insurer, PBM, or other administrator of pharmacy benefits "ensure that the network is reasonably adequate and accessible." There are two key requirements to be considered adequate:

1. Offer an adequate number of accessible pharmacies that are not mail-order pharmacies; and
2. Provide convenient access to pharmacies that are not mail-order pharmacies within a reasonable distance of not more than 30 miles from each insured's residence, to the extent that pharmacy or pharmacist services are available.

It is important to note that the distance is based upon the individual employee's address – not the employer's location.

General Restrictions for PBMs

PBMs or TPAs administering pharmacy services are prohibited from engaging in the following behaviors:

- Preventing a pharmacy or pharmacist from selling or providing information about a lower cost alternative;
- Imposing limits, including quantity limits or refill frequency limits, on an insured's access to medication from a pharmacy that is more restrictive than those existing for a pharmacy affiliate;
- Requiring a pharmacy or pharmacist to enter into an additional contract with an affiliate of the insurer, pharmacy benefit manager, or other administrator of pharmacy benefits as a condition of entering into a contract with this insurer, pharmacy benefit manager, or administrator; or
- Requiring a pharmacy or pharmacist to, as a condition of contract, agree to payment rates for any affiliate of the insurer, pharmacy benefit manager, or other administrator of pharmacy benefits that is not a party to the contract.

These restrictions should help expand the inclusion of independent pharmacies as being in-network for plans and thus expand network availability and adequacy to improve participant experience.

Contracting with a Particular PBM or Pharmacy Prohibited for Self-Funded Plans

The law prohibits a TPA from requiring a plan sponsor to:

- Require as a pre-condition or condition of a contract with the TPA that the plan sponsor contract with a particular PBM; or
- Charge a different rate or fee for services if the plan sponsor based upon the plan sponsor's PBM selection.

Employer Action

- Employers should review policies and procedures relating to monitoring of vendors and update any questions relating to:
    - Rates and commissions,
    - Network adequacy, and
    - Conflicts of interest.
- Continue to monitor for further communications from TPAs and PBMs regarding, as applicable, their compensation, rebates, conflicts of interest, and updated contractual terms.

Texas Legislature Extends Period for Newborn Enrollment

Issued date: 08/14/25

On June 20, 2025, Senate Bill 896 ("SB 896") was signed into law. The new legislation extends the automatic period that newborns are covered and gives parents 60 days to request a continuation of that coverage under a Texas medical plan. The legislation applies to plans issued or renewed on or after January 1, 2026.

Background

Under existing law, a Texas plan automatically covers a newborn child of a covered employee beginning on the date of birth and ending on the 32nd day after the date of the child's birth unless, not later than the 31st day after the date of birth, the carrier receives:

1. notice of the birth; and
2. any required additional premium.

This means that a newborn is automatically covered for 31 days with no notice or premium required. To continue coverage past that date, the employee must timely provide notice and any additional premium.

This rule does not apply to self-funded plans other than multiple employer welfare arrangements ("MEWAs").

SB 896

Key points about the new Texas insurance mandate for newborns:

- **Purpose of the law:** The law aims to give parents more time to enroll their newborns and ensures they have continuous coverage.
- **Covered Plans:** The law applies only to:
    - fully insured plans issued in Texas; and

    - MEWAs as to Texas residents only.
- **Extended Enrollment Period:** The law extends the automatic period for newborn enrollment from 31 to 60 days.
- **Notification and Premium Payment:** The carrier must receive notice of the birth and any required additional premium within those 60 days to maintain coverage beyond the 60 days.
- **Effective Date:** The law applies to plans delivered or renewed on or after January 1, 2026.

Employer Action

Carriers are responsible for compliance and must include this mandate in certificates of coverage for plans issued on or after January 1, 2026. Note that they may go further than the law requires, including children other than newborns.

As employees are entitled to rights under this law, plan sponsors are responsible for understanding it and passing on any notice and additional premium from the employee to the carrier. Plan sponsors must also amend their cafeteria plans for this change before it goes into effect (by December 31, 2025, for a 2026 calendar year plan).

New Texas Mandated Benefits for 2026

Issued date: 08/15/25

The Texas legislature wrapped up its 89th legislative session in June, having passed a number of bills related to health insurance. Below are the bills signed into law that relate to employer-sponsored plans. They apply to insured medical plans written out of Texas only and, where applicable, pharmacy benefit managers ("PBMs") operating in Texas, and are effective for health plans delivered or renewed on or after January 1, 2026, unless otherwise noted below.

Summary

Senate Bill 896 – Extends the automatic enrollment period for newborns from 31 to 60 days following birth.

House Bill 388 – Requires the creation and use of a standardized coordination of benefits questionnaire to streamline the billing process, effective February 1, 2026.

House Bill 1052 – Requires health benefit plans to cover telemedicine, teledentistry, and telehealth services provided from locations outside Texas on the same basis as those provided within the state, as long as the patient primarily resides in Texas and the provider is licensed or authorized to provide services in Texas and maintains a physical office in Texas.

House Bill 2254 – Permits preferred and exclusive provider benefit plans to contract with primary care physicians and physician groups on a risk basis, including capitation or other risk-sharing arrangements. Participation in these arrangements is voluntary, and insurers cannot discriminate against physicians or groups who opt out.

House Bill 3057 – Requires health benefit plans that provide coverage for chimeric antigen receptor T-cell therapy (CAR T) to cover medically necessary CAR T therapy when administered by qualified, FDA-certified providers within the plan's network.

House Bill 3233 – Prohibits PBMs from storing or processing patient data for a Texas resident in a location outside of the United States or its territories. Effective for contracts entered into on or after September 1, 2025.

House Bill 3812 – Extends the duration of preauthorization exemptions from six months to one-year, includes additional claims in preauthorization exemption evaluations, and prohibits the physician supervising utilization management at a

health plan from holding an administrative license.

Senate Bill 493 – Prohibits PBMs from including gag clauses in contracts with pharmacies that would prohibit a pharmacist from informing an enrollee of any difference between the patient's out-of-pocket cost for a prescription drug using the PBM benefit and the out-of-pocket price when paying cash. Effective for contracts entered into on or after September 1, 2025.

Senate Bill 527 – Prohibits a health benefit plan covering general anesthesia from excluding medically necessary general anesthesia services relating to dental services for a covered individual, provided that: (1) the individual is younger than 13 years of age and unable to undergo the dental service without general anesthesia due to a documented physical, mental, or medical reason; and (2) a qualified provider of anesthesia services performs the anesthesia.

Senate Bill 815 – Restricts health plans from utilizing artificial intelligence or algorithms for claim denials. However, such systems may still be used for administrative support or fraud detection purposes.

Senate Bill 916 – Extends protections against surprise billing for ground ambulance services in Texas through September 1, 2027. Grants DSHS expanded authority to suspend or revoke the licenses of emergency medical service providers who either intentionally give false information or repeatedly break payment rules with respect to insurance coverage for out-of-network emergency care.

Senate Bill 926 – Permits HMOs and insurers to provide incentives, such as adjusted deductibles, copayments, coinsurance or other cost-sharing mechanisms or to use a tiered network to encourage enrollees or insureds to utilize specific physicians or providers. Prevents plans from using these incentives to limit medically necessary services or provide lower quality of care.

Senate Bill 1236 – Permits pharmacists an opportunity to refuse a proposed modification to a network contract and voids modifications that are not approved and signed by the pharmacist under most circumstances. With some exceptions, under this bill, a health benefit plan could only recoup the dispensing fee and not the cost of the drug or any other cost. Also requires pharmacy benefits to include on the health insurance card a unique identifier that indicates whether the plan is subject to regulation by TDI.

Senate Bill 1257 – Requires plans that have ever provided gender transition coverage to provide broad coverage for adverse consequences, management, reversal or follow up related to gender transition procedure or treatment.

Senate Bill 1332 – Allows health plans to waive premiums when a health plan receives late notification of an employee's departure from a company if the employee did not receive covered services following their departure. It applies to fully insured PPO/EPO and HMO businesses.

Senate Bill 2544 – Out-of-network providers, health benefit plan issuers or administrators may request mandatory mediation for health benefit claims involving out-of-network facilities no later than 180 days after the provider receives an initial payment for the relevant service or supply. Effective June 20, 2025. Currently, there is no deadline.

Employer Action

For the most part, employers with insured medical plans written out of Texas should be aware of the above changes and no employer action is required. However, employers should amend their cafeteria plans for Senate Bill 896 before it goes into effect (by December 31, 2025, for a 2026 calendar year plan).

North Carolina Enacts PBM Law

Issued date: 08/18/25

On July 10, 2025, North Carolina Governor Josh Stein signed the Act Supporting Community Retail Pharmacies and Improving Transparency ("the SCRIPT Act") into law. The SCRIPT Act is the latest in a series of state laws that seek to regulate the business practices of pharmacy benefit managers ("PBMs"). The Act imposes new reporting obligations on PBMs, limits their ability to steer patients to certain pharmacy providers, and requires rebates and discounts to be passed directly to participants. Most SCRIPT Act provisions go into effect October 1, 2025, while others are not effective until 2026 or 2027.

Summary

The pharmacy choice provisions of the Act prohibit PBMs from:

- Prohibiting insured participants from selecting a pharmacy that has agreed to participate in the health plan,
- Denying a pharmacy that has agreed to the terms of reimbursement the opportunity to participate as a contract provider,
- Imposing any cost sharing on any covered benefit that is not equally imposed on contract providers,
- Imposing any monetary incentive that would affect an insured's choice of provider,
- Reducing reimbursement for insured pharmacy services where the participant selects a pharmacy of his or her choice, and
- Requiring participants to purchase pharmacy products through a mail-order pharmacy.

The pharmacy choice provisions apply to insurance contracts entered into on or after October 1, 2025.

Pharmacy Services Administrative Organizations

The SCRIPT Act regulates pharmacy services administrative organizations ("PSAOs"), which are organizations that represent independent pharmacies in negotiations with PBMs and other third-party payers. The Act prohibits PSAOs

from requiring independent pharmacies to buy more expensive drugs from certain wholesalers and to disclose ownership interests to the state. The PSAO provisions are effective for contracts entered into or renewed on or after October 1, 2026.

Reporting Requirements

The Act adopts new reporting requirements for PBMs. Among other things, the Act requires PBMs to report to the Commissioner of Insurance the aggregate amount of rebates paid, amounts retained through spread pricing, the aggregate amount of fees imposed on contracted pharmacies, and the aggregate amount of rebates passed on to the insurer or insured participant. The reporting requirements are effective for contracts entered into on or after October 1, 2025.

Pharmacy Reimbursement Rates

The Act prohibits PBMs from reimbursing pharmacies less than the amount it reimburses its affiliate pharmacies for the same item or service. This provision is effective for pharmacist services dispensed on or after October 1, 2025.

Additionally, PBM contracts may not require independent pharmacies and those in pharmacy deserts to be reimbursed at rates lower than acquisition cost.

PBM Rebates Shared with Consumers

The Act requires that 90% of all rebates received in connection with dispensing a drug be used to offset the patient's cost-sharing. This means that 90% of all rebates will be required to be passed along to consumers at the point of sale. This provision will require insurers to submit an attestation of compliance by January 1 of each year to the Commissioner of Insurance. The consumer rebate provisions apply to prescription drugs purchased on or after January 1, 2027.

Prescription Drug Transparency

For prescription drugs priced at $100 or more for a 30-day supply, the Act requires manufacturers to notify interested parties by January 1 of each year as to price increases of 15% or greater that occurred in the prior calendar year. Drug manufacturers must also notify interested parties of the price of any new prescription within 3 days after it is made available for purchase. The requirement to notify interested parties of cost increases is effective January 1, 2026; the requirement to notify of costs of new drugs is effective immediately.

Applicability

The SCRIPT Act applies to health benefit plans in the state, which means accident and health insurance policies, nonprofit hospital service corporation contracts, health maintenance organizations, multiple employer welfare arrangements, or other benefit arrangements, to the extent permitted under ERISA. While fully insured coverage written in the state will be subject to the new requirements, it is not yet clear which provisions, if any, will apply to self-funded plans.

In 2020, the U.S. Supreme Court held in *Rutledge v. Pharmaceutical Care Management Association* that state PBM laws that merely regulate reimbursements to pharmacies are not preempted by ERISA. However, state laws that regulate the structure of employee health benefit plans will generally be preempted. In 2023, the 10th Circuit Court of Appeals found an Oklahoma law that regulated PBM networks to effectively regulate benefit plan design and was partially preempted by ERISA. In June of 2025, the Supreme Court declined to review the appeal, so the 10th Circuit opinion stands.

To the extent that state laws and regulations are preempted under ERISA, they will not apply to self-funded plans, whether they are established in North Carolina or any other state. Given the evolving ERISA preemption landscape, it is not clear which provisions of the SCRIPT Act will apply to self-funded plans.

Employer Action

Employers who sponsor fully insured plans can expect their insurance carrier to comply with the new requirements and do not need to take any action. Sponsors of self-insured plans should reach out to their TPA or PBM to determine if the North Carolina law requires any benefit design changes.

Departments Extend Enforcement Relief for the No Surprises Act

Issued date: 09/08/25

On July 30, 2025, the Departments of Labor, Health and Human Services, and the Treasury ("the Departments") released FAQ Part 71, which confirms:

- Enforcement relief for following prior guidance related to the Qualified Payment Amount ("QPA") for items and services furnished before February 1, 2026; and
- The changes to the out-of-pocket maximum ("OOPM") limits for plan years beginning on or after January 1, 2026.

Background

The No Surprises Act ("NSA") was part of the Consolidated Appropriations Act, 2021 ("the CAA"). The NSA protects participants, beneficiaries, and enrollees in group health plans and individual health insurance from certain surprise out-of-network services.

As previously reported, the independent dispute resolution ("IDR") process under the NSA has been subject to extensive litigation. Specifically, the presumption in favor of the QPA and the requirement that the IDR entity should choose the payment amount closest to the QPA has been the focus of much of the litigation. As a result of various court decisions, the Departments have released prior guidance indicating that the Departments will exercise enforcement discretion for plans and insurance issuers relying on prior guidance issued in 2021 on how the QPA should be calculated. This prior guidance was effective for items or services furnished prior to August 1, 2025.

What's New?

NSA

As a court decision is still pending on the latest legal challenge to the QPA, the FAQ confirms that plans, issuers, and providers may continue to rely on the older 2021 QPA calculation methodology for items and services furnished before February 1, 2026, without risk of federal enforcement. States are encouraged to adopt a similar approach.

Plans must still provide related QPA disclosures and certify that the QPA was determined in compliance with applicable requirements, even if using the 2021 methodology.

OOPM

In addition, the FAQ restated both the premium adjustment percentage and the OOPM for 2026 plan years. The maximum annual limitation on cost sharing for the 2026 plan year will be $10,600 for self-only coverage, and $21,200 for other than self-only coverage.

Employer Action

Employers should ensure OOPM limits for 2026 do not exceed the maximums. For fully insured plans, carriers are responsible for the IDR process. For self-funded plans, employers should ensure their TPA is supporting compliance with the NSA, including the IDR process.

2025 MLR Rebate Checks to Be Issued Soon to Fully Insured Plans

Issued date: 09/09/25

As a reminder, insurance carriers are required to satisfy certain medical loss ratio ("MLR") thresholds. This generally means that for every dollar of premium a carrier collects with respect to a major medical plan; it should spend 85 cents in the large group market (80 cents in the small group market) on medical care and activities to improve health care quality. If these thresholds are not satisfied, rebates are available to employers in the form of a premium credit or check.

If a rebate is available, carriers are required to distribute MLR checks to employers by September 30, 2025.

Importantly, employers must distribute any amounts attributed to employee contributions to employees and handle the tax consequences (if any).

This does not apply to self-funded plans.

What to Do with this MLR Rebate Check?

The rules around rebates are complex and require careful review with ERISA counsel. Among other things, an employer receiving a rebate as a policy holder will need to determine:

- who receives a rebate (e.g., current participants v. former participants);
- the form of the rebate (e.g., premium reduction v. cash distribution);
- the tax impacts of any such rebate (on both the employer and participants receiving the rebate); and
- what, if any, communication to provide participants regarding the rebate.

The following questions and answers are designed to provide information as to what employer action may be necessary.

What will the rebate amount be?

Carriers determine MLR on a state basis by market segment (individual, small group, or large group). Carriers do not disaggregate by type of plan within these markets (e.g., PPO v. HMO v. HDHP) or by policyholder so the carrier will have to let you know the amount.

A carrier is not required to provide a rebate to an enrollee if the total rebate owed is less than $20 per subscriber ($5.00 when a carrier pays the rebate directly to each subscriber). This rule regarding de minimis amounts only applies to the carrier, not to employers refunding amounts to participants.

Will there be any communication?

Yes.

For each MLR reporting year, at the time any rebate of premium is provided, a carrier must provide the policyholder and each current enrollee who was also enrolled in the MLR reporting year in a form prescribed by HHS.

Employers do not have to notify employees, but they may want to address the notices being distributed by the carriers. Language similar to the following provides a starting point for such a notice:

> Employees should have received a notice of rebate from [carrier]. In short, [Employer] received a rebate check in the amount of $_____. Amounts attributable to participant contributions will be used to [reduce premium amounts] for [currently enrolled employees] in accordance with legal requirements. These amounts will be reflected in the [September ___] paychecks.

What will the form of rebate to the employer be?

Carriers may issue rebates in the form of either a premium credit (i.e., reduction in a premium owed), a lump-sum payment, a lump-sum reimbursement to the account used to pay the premium if an enrollee paid the premium using a credit card or direct debit, or a "premium holiday," if this is permissible under state law.

When will the rebate be issued?

Rebates must be paid by **September 30** each year. A carrier that fails to timely pay any rebate must additionally pay the enrollee interest at the current Federal Reserve Board lending rate or 10% annually, whichever is higher, on the total amount of the rebate, accruing from the date payment was due.

Do employers have to give some or all of the rebate to participants?

Yes, unless they paid 100% for all tiers of coverage.

Carriers will generally send rebate checks to employers and employers must mete out any amounts attributed to employee contributions to employees and handle the tax consequences.

There is no one formula for employers to use, but guidance has been provided to aid employers.

<u>ERISA-covered group health plans</u>

To the extent that rebates are attributable to participant contributions, they constitute plan assets. Plan assets must be handled in accordance with the fiduciary responsibility provisions of Title I of ERISA.

If the employer is the policyholder, determining the plan's portion, if any, may depend on provisions in the plan or the policy or on the manner in which the plan sponsor and the plan participants have shared in the cost of the policy. If the plan

or its trust is the policyholder, in the absence of specific plan or policy language to the contrary, the entire rebate would constitute plan assets, and the policyholder would be required to comply with ERISA's fiduciary provisions in the handling of rebates that it receives.

The HHS regulations and related DOL guidance for ERISA plans leave to the policyholder the decision as to how to use the portion of a rebate that constitutes plan assets, subject to ERISA's general standards of fiduciary conduct. The DOL notes that, in choosing an allocation method, "the plan fiduciary may properly weigh the costs to the plan and the ultimate plan benefit as well as the competing interests of participants or classes of participants provided such method is reasonable, fair and objective." An allocation does not necessarily have to exactly reflect the premium activity of policy subscribers. A plan fiduciary may instead weigh the costs to the plan and the competing interests of participants or classes of participants when fashioning an allocation method, provided the method ultimately proves reasonable, fair, and objective. If the fiduciary finds that the cost of passing through the rebate to former participants would exhaust most of those rebates, the proceeds can likely be allocated to current participants.

Guidance does not address how to handle an MLR rebate where the amount is inconsequential (e.g., a dollar per participant). Taking a cue from DOL Field Assistance Bulletin No. 2006-01, a fiduciary may be able to conclude, after analyzing the relative costs, that no allocation is necessary, when the administrative costs of making correction far exceed the amount of the allocation.

If a plan provides benefits under multiple policies, the fiduciary is instructed to allocate or apply the plan's portion of a rebate for the benefit of participants and beneficiaries who are covered by the policy to which the rebate relates provided doing so would be prudent and solely in the interests of the plan according to the above analysis. But, according to the DOL, "the use of a rebate generated by one plan to benefit the participants of another plan would be a breach of the duty of loyalty to a plan's participants."

Plans that are neither covered by ERISA nor are governmental plans (e.g., church plans)

With respect to policyholders that have a group health plan but not a governmental plan or a plan subject to ERISA, carriers must obtain written assurance from the policyholder that rebates will be used for the benefit of current subscribers or otherwise must pay the rebates directly to subscribers.

The final rule issued on February 27, 2015, provides that subscribers of non-federal governmental or other group health plans not subject to ERISA must receive the benefit of MLR rebates within three (3) months of receipt of the rebate by their group policyholder, just as subscribers of group health plans subject to ERISA do.

When do rebates need to be made to participants?

As soon as possible following receipt and, in all cases, within 3 months of receipt.

What is the form of rebate to participants?

There is no one way to determine this, but guidance has been provided to aid employers.

Reductions in future premiums for current participants is probably the best method.

If proceeds are to be paid to participants in cash, the DOL is likely to require that payments go to those who participated in the plan at the time the proceeds were "generated," which may include former employees. An option that may be easier to administer is to keep the proceeds in the plan and provide a "premium holiday" (suspension of required premiums) or a reduction in the amount of employee-paid premiums.

The interim final regulations for non-ERISA governmental plans require that rebates be used to reduce premiums for all health plan options for subscribers covered when the rebate is received, to reduce premiums for current subscribers to the option receiving the rebate, or as a cash refund to current subscribers in the option receiving the rebate. In each case, the regulations allow the rebate to be allocated evenly or in proportion to actual contributions to premiums. Note that the rebate

is to be used to reduce premiums for (or pay refunds to) employees enrolled during the year in which the rebate is actually paid (rather than the MLR reporting year on which the rebate was calculated).

To recap, here are some options to consider:

- Reduce future premiums for current plan participants. This is administratively easy with limited tax issues with respect to participants.
- Cash payments to current participants. This is administratively burdensome and results in tax consequences to participants.
- Cash payments to former participants. This is administratively burdensome and results in tax consequences to former participants.

The employer could also consider, with counsel, whether providing benefit enhancements or payment of reasonable plan expenses would be considered permissible.

What are the federal tax implications to employees?

Pre-Tax Premium Payments

When employees pay their portion of the premiums for employer-sponsored health coverage on a pre-tax basis under a cafeteria plan, MLR rebates will be subject to federal income tax and wages. Briefly:

- For rebates that are distributed as a reduction in premium (thus reducing an individual's pre-tax premium payment during the year), there is a corresponding increase to the employee's taxable salary that is also wages taxable for employment tax purposes.
- Rebates that are distributed as cash will result in an increase in taxable income that is also wages subject to employment taxes.

The result is the same regardless of whether the MLR rebates are provided only to employees participating in the plan both in the year employees paid the premiums being rebated and the year in which the MLR rebates are paid, or to all employees participating in the plan during the year the MLR rebates are paid (even if some employees did not participate in the plan during the year to which the rebate applies.)

After-Tax Premium Payments

When employees pay their portion of the premiums on an after-tax basis, MLR rebates generally are not subject to federal income tax or employment taxes. This applies when the rebate is provided as a reduction in premiums or as a cash. The result is the same regardless of whether the MLR rebates are provided only to employees participating in the plan both in the year employees paid the premiums being rebated and the year in which the MLR rebates are paid, or to all employees participating in the plan during the year the MLR rebates are paid (even if some employees did not participate in the plan during the year to which the rebate applies).

What are the tax implications to employers?

Employers should review the tax implications of a rebate with tax advisors. Generally, amounts used for benefits (e.g., to pay premiums with respect to insured plans) should not be taxable.

When employees pay premiums on a pre-tax basis, does reducing a participant's premiums mid-year allow them to make election changes?

Probably not.

If employee contributions are paid on a pre-tax basis and there is a mid-year rate change, the cafeteria plan must determine whether such a change is permitted under the Section 125 rules.

If the plan incorporates the permitted election change rules, the relevant issue is whether this change in cost is permitted under the regulations.

- If there is an insignificant decrease[1], there can be an automatic adjustment.
- If there is a significant decrease, employees may make a corresponding change including commencing participation in the cafeteria plan for the first time for the option with a decrease in cost.

Generally, MLR rebates are expected to be fairly low dollar amounts and may not rise to the level of a significant change. Employers should consider either taking the position that the cost change is insignificant or that the cost change is significant and the "corresponding change" is to simply allow the reduction or increase. The cafeteria plan document should be consistent with the employer's position.

[1]There is little guidance in the regulations on what constitutes a "significant change." An example relating to dependent care assistance program benefits indicates that, under the particular facts, a 12.5% change in the cost of care (from $4,000 to $4,500) may be significant. However, this 12.5% threshold should not be viewed as a safe harbor. Consequently, employers will need to make the "significant vs. insignificant" determination based upon all the facts and circumstances.

Connecticut Expands Leave to Certain School Employees

Issued date: 09/16/25

Connecticut Governor Ned Lamont recently signed HB 7288 which, among other things, expands job-protected unpaid leave under the Connecticut Family Leave Act ("CTFMLA") and the Connecticut Paid Leave Act ("CTPLA") to certain non-certified school employees. Beginning October 1, 2025, the bill amends CTFMLA and CTPLA to cover employees that are employed by "public school operators" in a position that does not require a professional certification under Chapter 166 of the Connecticut General Statutes. These public school operators are now required to register with the Connecticut Paid Leave Authority (the "Authority"), deduct the 0.5% contributions from eligible employees' wages, and remit those contributions quarterly to the Authority.

Employer Action

Public school operators should work with employment and labor counsel to review their leave policies and procedures to ensure they are compliant with the new requirement effective October 1, 2025. In addition, employers should monitor the Connecticut Department of Labor ("CTDOL") and CTPLA websites for additional guidance and regulations. We will continue to monitor this issue as well and will keep employers updated as applicable.

Delaware Amends Paid Family and Medical Leave Law

Issued date: 09/17/25

On July 30, 2025, Governor Matt Meyer signed HB 128 ("the Act") into law, amending Delaware's paid family and medical leave law ("PFML"). The Act was effective immediately once it was signed into law.

Background

Delaware's PFML law, the Healthy Delaware Families Act, requires certain employers to provide their covered employees with up to $900 per week in paid leave for parental, family caregiving, medical, and qualified military exigency leave. Contributions to the state plan began on January 1, 2025, and benefits will begin on January 1, 2026.

The Act amends several provisions of the PFML law, specifically the following:

- The coordination of an employer's other paid leave with PFML leave;
- An employer's ability to require a covered employee to use other paid time off ("PTO") prior to using PFML leave;
- The annual deadline for applying for a private plan; and
- Private plan claims documentation requirements.

Paid Leave Coordination with PFML

The Act clarifies that PFML is the primary payor of benefits and that an employer may offset other employer paid leave policies (e.g., short-term disability policies) based on an employee's receipt of PFML benefits. This offset must be conveyed in the terms of the policy.

Required Use of PTO No Longer Allowed

The law previously allowed employers to require an employee to use any accrued but unused PTO prior to receiving PFML benefits and that the use of such PTO could be counted toward the length of benefits received under PFML. This is no longer the case as the Act has amended the law so that an employer may NOT require that an employee use accrued but unused PTO prior to accessing PFML benefits. In addition, the employer and a covered employee must now agree for an employee to use accrued but unused PTO to supplement PFML benefits.

Private Plan Application Deadlines

If an employer wishes to comply with the PFML law by using a private plan, the law previously required the employer to annually apply to the Delaware Department of Labor ("DOL") between September 1 and December 1 of each year. The Act amends the law so that the DOL must now accept private plan applications on a rolling basis with effective dates for approved private plans now being January 1, April 1, July 1, and October 1.

Private Plan Claims Documentation

Employers utilizing a private plan are no longer required to provide claim documentation to the DOL unless the claim is subject to an appeal, complaint, audit, or specific inquiry from the Department.

Employer Action

- Employers providing other forms of income replacement to employees covered under Delaware's PFML law should ensure that their policies permit them to offset these benefits by any PFML benefits received.
- Employers should review, and amend as necessary, all PTO policies to ensure that they do not require covered employees to use accrued but unused PTO prior to the receipt of PFML benefits.
- Employers should adjust as necessary any timelines for application for a private plan with the DOL.

San Francisco HCSO Expenditures and Reporting Update for 2026

Issued date: 09/18/25

The San Francisco Health Care Security Ordinance ("HCSO") minimum expenditure rates for 2026 have been released, and the HCSO Annual Reporting Form for calendar year 2025 is due on April 30, 2026.

2026 Minimum Expenditure Rates

Under the HCSO, covered employers must make minimum health care expenditures at the following rates for each hour worked by covered employees in San Francisco:

Employer Size	Number of Employees	2025 Health Care Expenditure Rate	2026 Health Care Expenditure Rate
Large	All employers with 100 or more employees	$3.85 per hour payable	**$4.11** per hour payable
Medium	Businesses with 20-99 employees Nonprofits with 50-99 employees	$2.56 per hour payable	**$2.74** per hour payable
Small	Businesses with 19 or fewer employees Nonprofits with 49 or fewer employees	Exempt	Exempt

The hours payable under the HCSO for each employee are capped at 172 hours per month. Therefore, for 2026 the maximum required health care expenditure for a covered employee of a large employer is $709.92 per month ($4.11/hour x 172 hours). For a medium-sized employer, the maximum required expenditure for a covered employee is $471.28 per month ($2.74/hour x 172 hours).

Managerial, supervisory, or confidential employees who earn more than a specified amount are exempt from the minimum health care expenditures requirement under the HCSO. For 2025, the earnings threshold for these employees to be exempt from the HCSO is $125,405 per year (or $60.29 per hour). As of January 1, 2026, the new threshold will be $128,861 per year (or $61.95 per hour).

Annual Reporting Form

Covered employers must submit an online report each year that summarizes how they complied with the HCSO. The web-based HCSO Annual Reporting Form for the prior calendar year is typically available on the San Francisco Office of Labor Standards Enforcement ("OLSE") HCSO website by April 1 and must be submitted by April 30. For example, the HCSO Annual Reporting Form for calendar year 2025 is expected to become available on the HCSO website by April 1, 2026, and is due by April 30, 2026.

Employer Action

Covered employers should ensure that they will be making the required minimum health care expenditures in 2026 at the new rates for employees in San Francisco and maintain records showing compliance with the HCSO requirements.

The 2026 version of the HCSO poster, which must be posted in all workplaces with covered employees, is expected to become available by December 2025. Covered employers should monitor the San Francisco HCSO website (linked below) to obtain and post the 2026 version of the poster by January 1, 2026.

www.sf.gov/information--health-care-security-ordinance

Covered employers should also be prepared to submit the HCSO Annual Reporting Form for calendar year 2025 no later than April 30, 2026.

Washington Expands PFML Protections

Issued date: 09/19/25

Washington's Paid Family and Medical Leave ("WA PFML") program, administered by the Employee Security Department ("ESD"), provides partial wage replacement benefits to employees on leave for certain family and medical reasons. With the passage of HB 1213, various WA PFML employee protections will be expanded effective January 1, 2026.

Background

Effective January 1, 2020, all employers with at least one (1) employee performing services in Washington must provide paid family and medical leave benefits through the state insurance fund or an approved voluntary plan. WA PFML benefits are funded by premiums paid by employer and employee contributions. Employees may receive wage replacement benefits of up to 90% of weekly wages up to the maximum. Employers are also required to report employee wages and hours when premiums are remitted to ESD.

Employees are eligible for leave benefits if they worked at least 820 hours for any WA employer during a qualifying year. Employees may be eligible for up to 12 weeks of medical or family leave. WA PFML leave can run concurrently with the federal Family and Medical Leave Act ("FMLA"). Based on employer size and depending on their eligibility, employees may be entitled to job protection and benefits continuation during their period of leave.

HB 1213

On May 17, 2025, HB 1213 was signed into law. HB 1213 expands several employee benefits and protections under WA PFML. The changes become effective January 1, 2026.

Notable changes follow.

Minimum leave increments

The minimum leave increment is reduced from eight (8) to four (4) hours.

Significant changes to job protection provisions

- Smaller employers will be required to provide job protection to employees taking WA PFML as follows:
    - 25 or more employees from January 1, 2026 to December 31, 2026
    - 15 or more employees from January 1, 2027 to December 31, 2027
    - Eight (8) or more employees on or after January 1, 2028
- The minimum hours worked for employees to qualify for job protection is removed
- Benefits continuation is now required during any leave when an employee is eligible for job protection

Leave stacking

Currently, employees can "stack" FMLA and WA PFML leave by claiming leave under FMLA first without applying for leave under WA PFML. Stacking makes it possible for an employee to take 12 weeks of leave under FMLA and then the full amount of available WA PFML, potentially providing an employee with up to 30 weeks of protected leave.

HB 1213 now provides a maximum period of job protection of 16 weeks in a 52-week period when an employee takes FMLA that is also eligible for WA PFML. The maximum job protection period requires the employer to provide notice to the employee containing the following information:

- That the FMLA leave is counting against any period of job protection under WA PFML
- That the use of unpaid FMLA leave does not affect the employee's eligibility for benefits under WA PFML

The maximum period of job protection that is available to an employee requires the employee to exercise their right to restoration of employment by the earlier of:

- First scheduled workday following the period of leave; or
- First scheduled workday following a continuous or intermittent period of 16 weeks.

This means an employee's job protection expires after the 16-week period even if the employee is still off work on approved WA PFML, making it possible for the employer to avoid job restoration and discontinue benefits continuation. Employers should be sure to confirm whether an employee in this situation should be offered COBRA.

Small employer grants

HB 1213 also changes the grants available to assist small employers with costs related to WA PFML

- Only employers with 50 to 150 employees will be eligible for existing grants
- A new $3,000 grant is available to employers with fewer than 50 employees that can be used for:
    - Costs related to hiring a temporary worker for more than seven (7) days; or
    - Significant additional wage related costs due to an employee's leave
- Any employer receiving a grant will be assessed for all premiums for three (3) years

Employer Action

Employers will need to become familiar with the additional rights and responsibilities imposed by HB 1213. While the changes related to employee leave stacking are welcomed, employers should update existing leave policies to account for the changes related to job protection and benefit continuation. Additionally, employers should consider updating leave and benefit continuation policies to account for possible required COBRA continuation coverage offered during WA PFML leave. Employers will likely need to confirm processes with COBRA administrators to ensure compliance.

ESD may provide sample notices that can be used to satisfy the notice obligation that allows an employer to limit the maximum period of job protection and benefit continuation.

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