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Compliance Digest

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2025 Compliance Bulletins: Fourth Quarter

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Washington State Expands EHBs Starting January 1, 2026

Issued date: 10/10/25

Under the Affordable Care Act ("ACA") individual and small group health plans are required to provide coverage for 10 categories of essential health benefits ("EHB"). For plan years after January 1, 2020, states are permitted to set the specific coverage requirements for the EHBs in the state's benchmark plan. For plan years beginning on or after January 1, 2026, Washington has added new coverage requirements to their EHB benchmark plan.

Background

The ACA established the EHB requirement for individual and small group plans to ensure plans provided comprehensive items and services in ten categories of benefits. States are permitted to update the specific coverage requirements in their benchmark plan with approval by CMS.

Importantly, self-funded and large group plans are not required to provide coverage for any particular EHBs. However, to the extent the plan (including self-funded and large group fully insured plans) covers an EHB then:

1. Lifetime and annual dollar limits may not be imposed (in-network and out-of-network); and

2. In-network cost sharing accumulates to deductible and maximum out-of-pocket ("MOOP").

As states are permitted to determine which items and services are included as EHBs in the state's benchmark plan, self-funded group plans are permitted to select their benchmark plan. For this purpose, self-funded group health plans may select any state's benchmark plan.

New Essential Health Benefits

In late 2024, Washington state expanded the list of EHBs that would be included in the state benchmark plan as of January 1, 2026. The specific items and services included will be considered EHBs for any self-funded plan that selects Washington state's benchmark plan. This means lifetime and annual limits and cost sharing aggregation rules apply to any items and services included in the state benchmark plan for any self-funded plan that selects the Washington benchmark plan.

The new EHBs include the following:

- **Hearing aids**
    - New hearing aid benefit that includes an annual hearing exam and one hearing aid per ear with hearing loss every three years.
    - No lifetime or annual dollar limit.
    - Generally, not subject to the deductible except in qualified high-deductible health plans ("HDHPs") to preserve eligibility to contribution to a health savings account ("HSA").
- **Donor human milk**
    - Coverage for human milk for inpatient use, when an infant is unable to receive maternal milk or when the parent is unable to produce maternal milk in sufficient quantities or caloric density.
- **Artificial insemination**
    - Coverage for artificial insemination in vivo, a fertilization treatment in which fertilization occurs internally as opposed to externally and in a lab.

Impact on Employer Sponsored Health Plans

Small group insurance

- Employers purchasing a small group insured health plan in Washington will have these new EHBs included as part of that coverage for plan years beginning on or after January 1, 2026.

Large group insurance

- A large insured group health plan is not required to cover any EHBs. To the extent it does and includes these new EHBs, the plan will be required to comply with the annual/lifetime limit prohibition and cost-sharing aggregation. The changes take effect for plan years beginning on or after January 1, 2026.

Self-funded group health plans

- If a self-funded group health plan includes the above benefits and the plan is benchmarked to WA, then the plan will be required to comply with the annual/lifetime limit prohibition and cost sharing aggregation for any EHBs, including these new benefits. The changes take effect for plan years beginning on or after January 1, 2026.
    - Self-funded plan sponsors may need to confirm with their TPA which state benchmark plan is applicable.
- Self-funded plan sponsors may select any of the 50 benchmark plans from any state. A plan sponsor that does not want to treat the expanded list of items and services as EHBs will need to work with their TPA to select the appropriate benchmark plan. Additionally, the benchmark plan should be identified in the SPD so amendment or updates to the SPD may be required.

- Self-funded plan sponsors that selected the Washington benchmark plan and provide fertility services through a third party may need to comply with these requirements as it relates to artificial insemination (i.e., no annual/lifetime dollar limit, cost-sharing aggregation). Employers should discuss this discuss this with the vendor.

- There is likely no issue for a plan that excludes coverage for the EHB.

2026 Cost of Living Adjustments

Issued date: 10/14/25

The IRS has released cost of living adjustments for 2026 under various provisions of the Internal Revenue Code ("Code"). Some of these adjustments may affect your employee benefit plans.

Cafeteria Plans – Health Flexible Spending Arrangements

Annual contribution limitation

For plan years beginning in 2026, the dollar limitation under Code Section 125(i) for voluntary employee salary reductions for contributions to health flexible spending arrangements ("health FSAs") increased from $3,300 to $3,400.

Annual maximum carryover

For cafeteria plans that permit the carryover option, the maximum unused amount from a health FSA that can be carried over to the following plan year is $680 for plan years beginning in 2026 (up from $660 in 2025).

Qualified Transportation Fringe Benefits

For calendar year 2026, the monthly exclusion limitation for transportation in a commuter highway vehicle ("vanpool") and any transit pass (under Code Section 132(f)(2)(A)) and the monthly exclusion limitation for qualified parking expenses (under Code Section 132(f)(2)(B)) increased from $325 to $340.

The Consolidated Appropriations Act of 2016 permanently changed the pre-tax transit and vanpool benefits to be at parity with parking benefits.

Highly Compensated

The compensation threshold for a highly compensated employee or participant (as defined by Code Section 414(q)(1)(B) for purposes of Code Section 125 nondiscrimination testing) for testing in calendar year 2026 is $160,000 in the prior year, 2025.

Under the cafeteria plan rules, the term *highly compensated* means any individual or participant who for the preceding plan year (or the current plan year in the case of the first year of employment) had compensation in excess of the compensation amount as specified in Code Section 414(q)(1)(B). *Prop. Treas. Reg. 1.125-7(a)(9).*

Key Employee

The dollar limitation under Code Section 416(i)(1)(A)(i) concerning the definition of a key employee for testing in calendar year 2026 is $230,000 in the prior year, 2025.

For purposes of cafeteria plan nondiscrimination testing, a *key employee* is a participant who is a key employee within the meaning of Code Section 416(i)(1) at any time during the preceding plan year. *Prop. Treas. Reg. 1.125-7(a)(10).*

Non-Grandfathered Plan Out-of-Pocket Cost-Sharing Limits

As previously reported, the 2026 maximum annual out-of-pocket limits for all non-grandfathered group health plans are $10,600 for self-only coverage and $21,200 for family coverage.

These limits generally apply with respect to any essential health benefits ("EHBs") offered under the group health plan. For coverage other than self-only (e.g., family coverage), the self-only annual out-of-pocket limit applies to each covered individual.

Health Reimbursement Arrangements

Qualified Small Employer Health Reimbursement Arrangements

For tax years beginning in 2026, to qualify as a qualified small employer health reimbursement arrangement ("QSEHRA") under Code Section 9831(d), the arrangement must provide that the total amount of payments and reimbursements for any year cannot exceed $6,450 ($13,100 for family coverage), which increased from $6,350/$12,800 in 2025.

Excepted Benefit Health Reimbursement Arrangements

For plan years beginning in 2026, to qualify as an excepted benefit health reimbursement arrangement ("EB HRA") under Treas. Reg. Section 54.9831-1(c)(3)(viii), the maximum amount that may be made newly available for the plan year for an excepted benefit HRA is $2,200 (increased from $2,150 in 2025).

Health Savings Accounts

As previously reported, the inflation adjustments for health savings accounts ("HSAs") for 2026 were provided by the IRS in *Rev. Proc. 2025-19.*

HSA annual contribution maximum

For calendar year 2026, the maximum HSA contribution amount for an individual with coverage under an HSA-compatible HDHP is:

- $4,400 for self-only coverage (up from $4,300 for 2025)
- $8,750 for coverage other than self-only (up from $8,550 for 2025)

Note that Individuals who are age 55 or older and covered by an HSA-compatible HDHP may make an additional HSA catch-up contribution of $1,000 each year until they enroll in Medicare. This catch-up contribution amount has not increased since 2009.

HSA-compatible high-deductible health plan

For calendar year 2026, an HSA-compatible HDHP is a health plan:

- for which the maximum annual out-of-pocket expenses (deductibles, co-payments, and other amounts, but not premiums) do not exceed:
    - $8,500 for self-only coverage (up from $8,300 for 2025)
    - $17,000 for coverage other than self-only (up from $16,600 for 2025), and
- with a minimum annual deductible that is not less than:
    - $1,700 for self-only coverage (up from $1,650 for 2025)
    - $3,400 for coverage other than self-only (up from $3,300 for 2025)

      Note that if family HDHP coverage includes an embedded individual deductible, for 2026 that embedded individual deductible cannot be less than $3,400 (the statutory minimum deductible for family HDHP coverage).

Non-calendar year plans: In cases where the HSA-compatible HDHP renewal date is after the beginning of the calendar year (e.g., a fiscal year plan), any required changes to the annual deductible or out-of-pocket maximum may be implemented as of the next renewal date. See IRS Notice 2004-50, Q/A-86 (Aug. 9, 2004), https://www.irs.gov/pub/irs-drop/n-04-50.pdf.

Employer Action

Employers with plan years beginning on or after January 1, 2026, should ensure the correct limits are applied to respective benefit plan options.

Immunization Schedule Updated by the CDC

Issued date: 10/16/25

On October 7, 2025, the Centers for Disease Control and Prevention ("CDC") updated its immunization schedule regarding COVID-19 and chickenpox vaccinations. Based on the new recommendations from the Advisory Committee on Immunization Practices ("ACIP"), the CDC is now recommending application of individual-based decision making to COVID-19 vaccination and that toddlers receive protection from varicella (chickenpox) as a standalone immunization.

Background

The CDC's ACIP is a federal advisory committee that makes formal recommendations as to adult and child vaccinations. The ACIP recommendations become official CDC policy once they are adopted by the CDC's Director.

The Patient Protection and Affordable Care Act ("ACA") requires group health plans and carriers to provide coverage for certain preventive services without imposing out of pocket costs, including immunizations recommended by the ACIP and adopted by the CDC.

A high-deductible health plan ("HDHP") used in connection with a health savings account ("HSA") generally must provide ACA mandated preventive care without cost-sharing. In addition, other types of preventive care (including adult and child immunizations), may be treated as preventive care and provided first dollar without affecting an individual's HSA contribution eligibility.

Updated Recommendations for Vaccines

The ACIP voted on the below actions, which were adopted by the CDC's Acting Director:

- to recommend that the COVID-19 vaccination for individuals over the age of six (6) months be based on individual-based decision making (between a health care provider and patient);
- against requiring a prescription to receive the COVID-19 vaccination; and

- to recommend that children ages 12-23 months receive the chickenpox vaccine separately, rather than in combination with measles, mumps and rubella vaccination.

The CDC's immunization schedule was formally updated on October 7, 2025.

Under the CDC's new recommendation for individual based decision-making, plans and carriers should allow coverage for COVID-19 vaccinations without imposing cost sharing requirements when provided in-network. This means that any COVID-19 vaccination received by an individual based on individual decision making would be considered an ACA preventive service, including for those with HDHP coverage.

According to a press release, the Department of Health and Human Services ("HHS") will examine all insurance coverage implications following this new recommendation. At the time of publication, no additional guidance has been issued.

Employer Action

For current plan years, prior ACIP recommendations continue to apply.

For plan years beginning after the ACIP recommendation changes (e.g., a plan year beginning January 1, 2026), non-grandfathered group health plans must provide the COVID-19 vaccine in-network and without cost sharing based on individual decision making.

- *Fully insured health plans.* Carriers are generally responsible for complying with preventive service coverage requirements and making updates as to these recommendations. Plan sponsors should not need to take any action at this time.

    - Note that some states may choose to require or recommend coverage for the COVID-19 vaccine under the prior ACIP recommendation. For example, California passed AB 144 in response to the changes to the ACIP recommendation, codifying the prior federal recommendations that were in effect as of January 1, 2025, and allowing the California Department of Public Health to supplement those recommendations. Insured health plans and HMOs in California are required to cover preventive care items and services, including immunizations, under the recommendations. State insurance mandates generally do not apply to ERISA governed self-funded health plans.

- *Self-funded health plans.* TPAs are generally responsible for complying with preventive service coverage requirements and making updates as to these recommendations. Plan sponsors should discuss any questions as to coverage changes with TPAs.

Gag Clause Attestation Due December 31, 2025

Issued date: 10/27/25

As previously reported, insurance carriers and plan sponsors of group health plans must submit information annually to the Centers for Medicare and Medicaid Services ("CMS") attesting that their plans do not include prohibited gag clauses by December 31st each year. The next attestation is due by **December 31, 2025**.

A gag clause is a contractual term that directly or indirectly restricts specific data and information that a plan or issuer can make available to another party. These clauses may be found in agreements between a plan or carrier and any of the following parties:

- A health care provider;
- A network or association of providers;
- A third-party administrator ("TPA"); or
- Another service provider offering access to a network of providers.

A gag clause may also be found in the downstream agreements of the service provider.

Carriers and TPAs are notifying clients how they intend to comply with the Gag Clause Prohibition Compliance Attestation ("GCPCA"). Similar to last year, it seems there is no uniformity as to how the various carriers/TPAs will address the attestation requirements.

Fully Insured Plans

If the group health plan is fully insured, the plan and the carrier both have the obligation to file an attestation; however, if the carrier submits the attestation on behalf of the fully insured arrangement, no further action should be required by the plan. Plan sponsors should not assume the carrier will submit the attestation on their behalf. The carrier may request information from the employer to enable submission on the employer's behalf or may decline to submit and place the obligation on the employer to file the attestation.

While we anticipate many carriers will file the attestation on behalf of fully insured group health plans, it is important to confirm your particular carrier's approach.

Self-Funded Plans

A self-funded plan (including level-funded) is responsible for the attestation; however, the plan sponsor may enter into a written agreement with the provider (TPA, PBM) to submit the attestation on behalf of the plan. TPAs may request information from the employer to enable submission on the plan's behalf. That said, some TPAs have indicated they will not submit the attestation for the plan. If that is the case, plan sponsors will need to submit the attestation for their plans and should obtain written confirmation from the TPA and other service providers that the contractual arrangements (including any downstream agreements) do in fact satisfy the gag clause prohibition requirements.

Plan sponsors who will need to file an attestation will submit their attestation via the webform by selecting the link for "Gag Clause Prohibition Compliance Attestation" at hios.cms.gov/HIOS-GCPCA-UI.

Plan sponsors should carefully review any communication provided by the carrier or TPA to ascertain what approach they will undertake for the December 31, 2025 submission.

Illinois PBM Law Takes Effect January 1, 2026

Issued date: 10/28/25

New legislation, the Prescription Drug Affordability Act (the "Act"), expands requirements on pharmacy benefits in Illinois. The law joins a trend across the country in regulating pharmacy benefit managers ("PBMs") to prevent certain common industry practices, including spread pricing, steering to PBM owned or affiliated pharmacies, as well as retention of prescription drug rebates. In addition, the law imposes a new fee on PBMs that is likely to be passed on to carriers and employer-sponsored group health plans.

The provisions of the Act are summarized below. Unless stated otherwise, all the reforms take effect for all plans that are amended, delivered, issued, or renewed on or after January 1, 2026.

Prohibition on Spread Pricing

Spread pricing is a practice where a pharmacy benefit manager supplies prescription drugs to a retail pharmacy for one price and then charges the health plan a greater price. The difference between the two prices, or the "spread" is retained by the PBM as a revenue stream. The Act prohibits PBMs from engaging in spread pricing. A violation of this provision is considered an unfair and deceptive practice and may be subject to civil penalties and/or license revocation.

Steering Prohibited

At times, PBMs and health insurers will offer more advantageous pricing to plans and members to fill prescriptions at pharmacies that are owned or affiliated with the PBM. This can negatively impact independent and rural pharmacies by reducing their volume. Under the Act, insurers and PBMs are prohibited from requiring participants to fill prescriptions exclusively through a mail-order or specialty pharmacy that is affiliated with the PBM, designating drugs as specialty medications solely for the purpose of limiting access, and requiring individuals to use a PBM-affiliated retail pharmacy if it would result in an increased cost to participants.

Prescription Rebates

Many prescription drug manufacturers issue rebates to PBMs when their brand name drug is filled, making the brand drug relatively more attractive and competitive when compared to a generic therapeutic equivalent. Depending on market segment and contract, the PBM may not pass through all of the rebates to the health insurer or the plan sponsor, retaining those rebates as an additional revenue stream. The Act requires the PBM to remit 100% of all prescription drug manufacturer rebates to the health benefit plan sponsor, covered individual, or employer. Records demonstrating compliance must be remitted to the Illinois Department of Insurance annually.

Transparency Rights and Reporting

All contracts between a PBM and a plan sponsor or an insurer must now contain a term that permits the sponsor or insurer the right to audit compliance with the terms of the contract at least once per year. The PBM must pay for the cost of the audit. The audit may be performed by an auditor selected by the plan sponsor, the insurer, or a designee. The plan must then give a copy of the audit to the PBM, which will remit a copy to the IL Department of Insurance within 60 days.

In addition, PBMs must annually submit reports to the IL Department of Insurance, health benefit plan sponsors, and each insurer no later than September 1st. The report must include the following information, amongst other data:

- List of drugs including therapeutic class, brand name, generic name, or specialty drug name;
- Number of covered individuals;
- Number of drug-related claims;
- Average wholesale acquisition cost per drug;
- Amount received by the plan in rebates, fees, or discounts related to drug utilization or spending;
- Total gross and net spending by health benefit plan;
- Any information collected by drug manufacturers pertaining to copayment assistance;
- And any compensation paid to brokers, consultants, advisors or any other individual or firm for referrals, consideration, or retention by the health benefit plan.

If the PBM fails to provide all required elements to the Department of Insurance, a fine up to $10,000 per day, per offense may apply.

Tax

On or before September 1st, 2025, and annually thereafter, all PBMs licensed to do business in Illinois must remit the IL Department of Insurance $15 (or an alternate amount determined by the Director of the Department of Insurance) per covered individual enrolled by the pharmacy benefit manager in Illinois. These amounts will be placed in a Prescription Drug Affordability Fund in the State Treasury. The first $25m collected annually shall be placed into a Department of Commerce and Economic Opportunity Projects Fund for grants to pharmacies. While the fee per covered individual must be paid by the PBM, it is likely that those amounts will be passed on to plans or insurers for reimbursement.

Who Does the Act Apply To?

These new requirements apply to PBMs that administer both fully insured and self-funded programs in Illinois.

Certain aspects of this PBM law could be preempted as to self-funded plans under ERISA (for example the prohibition on steering). ERISA preempts state laws that have a substantial impact on employer-sponsored health plans. At this time, there do not seem to be any legal challenges to this law, but we will continue to monitor developments.

ERISA does not apply to plans administered by state or local governments or church plans.

Employers should discuss the implication of these new requirements with carriers, third-party administrators, and PBMs.

Illinois Mandates Fertility Benefits & Dependent Coverage for Parents

Issued date: 10/29/25

The Illinois legislature enacted two new laws impacting certain health benefits plans. These provisions take effect for policies issued, amended, delivered or renewed in Illinois on or after January 1, 2026.

Briefly, these Illinois benefit mandates:

- Broaden benefits related to infertility treatment, and
- Expand dependent coverage to include the tax dependent parent (or stepparent) of the insured.

These provisions apply to fully insured group health plans issued in Illinois. ERISA covered self-funded health plans are not required to comply.

Mandatory Fertility Benefits

The new law broadens mandatory coverage of infertility and provides that no group policy of accident and health insurance that provides pregnancy-related benefits may be issued, amended, delivered, or renewed in Illinois on or after January 1, 2026, unless the policy contains coverage for the diagnosis and treatment of infertility, including specified procedures. Covered plans must also include coverage for the procedures necessary to screen or diagnose a fertilized egg before implantation.

State insurance mandates are generally pre-empted by ERISA and apply to fully insured group health plans with Illinois as their situs state. However, since the law also amended the County, Municipal, and School Codes, the mandates also apply to non-ERISA self-funded group health plans sponsored by Illinois state or local governmental entities as well as public schools.

Additionally, any group policy that covers more than 25 employees that is amended, delivered, issued, or renewed on or after January 1, 2026, shall provide, for individuals 45 years of age and older, coverage for an annual menopause health visit without any cost-sharing applied to the insured member.

Dependent Parent and Stepparent Coverage

The Illinois Insurance Code was amended so that a group or individual policy of accident and health insurance issued, amended, delivered, or renewed after January 1, 2026, which provides dependent coverage, shall make that dependent coverage available to the parent or stepparent of the insured if the parent or stepparent:

- Meets the definition of a qualifying relative under 26 U.S.C. 152(d); and
- Lives or resides within the accident and health insurance policy's service area.

The expanded definition does not apply to specialized health care service plans, Medicare supplement insurance, hospital-only policies, accident-only policies, or specified disease insurance policies that reimburse for hospital, medical, or surgical expenses.

Generally, to satisfy the definition of a "qualifying relative" the parent or stepparent must have:

1. Gross income for the calendar year in which such taxable year begins that is less than $5,200 for 2025 (*as indexed for inflation*); and
2. The taxpayer (the primary insured) provide over one-half of the individual's support for the calendar year in which such taxable year begins.

This Illinois state insurance mandate is generally preempted by ERISA and would only apply to fully insured group health plans with Illinois as their situs state.

Employer Action

Carriers issuing and renewing group health plan policies in Illinois should be making the necessary changes to the plan designs to comply with the law.

Self-funded non-ERISA plans employers should work with their TPAs and stop loss carriers to comply with new fertility requirements.

If applicable, employers should amend plan documents to make sure to include dependent parent/stepparent eligibility language.

New York Paid Family Leave 2026 Contributions and Benefits

Issued date: 10/31/25

The New York State Department of Financial Services has announced the contribution rate under the New York Paid Family Leave ("PFL") law effective January 1, 2026, will be set at **0.432%** of weekly wages, an 11.31% increase from last year.

Employee contributions for PFL are calculated as a percentage of an employee's gross wages per pay period up to the maximum contribution based on the *annualized* New York State Average Weekly Wage ("NYAWW"). For 2026:

- NYAWW in effect will be $1,833.63, an increase of 4.3% from the 2025 NYAWW of $1,757.19. The *annualized* NYAWW is $95,348.76.
- The maximum annual employee contribution will be $411.91 ($354.53 in 2025).

The PFL benefit is 67% of an employee's Average Weekly Wage (up to the NYAWW) payable for 12 weeks. For 2026:

- The maximum weekly PFL benefit will be $1,228.53 ($1,177.32 in 2025).
- The maximum annual PFL benefit payable for 12 weeks will be $14,742.36 ($14,127.84 in 2025).

The following should be noted:

- The maximum amount of PFL and disability leave under the New York Disability Law ("DBL") that may be taken in a *52-consecutive week period* is limited to 26 weeks.
- If an employee begins continuous leave in 2025 and the leave extends into 2026, the benefit is based on the rate in effect on the first day of leave (i.e., in 2025) and is not recalculated at the 2026 rate.
- If an employee begins intermittent leave in 2025 and the leave extends into the following year and there is at least a three-month lapse in days taken under New York PFL, the leave is considered a new claim under the law in 2026, and the benefit is calculated at the 2026 rate.

Employer Action

Employers should prepare for the 2026 New York PFL contribution and benefit changes that begin in January. PFL coverage will typically be added as a rider on an employer's existing disability insurance policy, although benefits can be provided through a self-funded plan approved by the New York Workers' Compensation Board.

Fertility Services as Excepted Benefits

Issued date: 10/31/25

The expansion of access to infertility treatment and specifically IVF has been a priority of the Trump Administration. On October 16, 2025, the Departments of Labor, Health and Human Services, and the Treasury (collectively, "the Departments") issued FAQs about Affordable Care Act Implementation Part 72 ("FAQ 72") to provide new guidance that allows employers to offer coverage to employees for fertility treatments as excepted benefits.

Background

Under the Affordable Care Act ("ACA"), group health plans ("GHPs") offered to employees must satisfy various market reform provisions or risk significant penalties. There are four categories of benefits that are not subject to the ACA market reforms if they meet stringent requirements to qualify as excepted benefits. They are:

1. Benefits that are generally not health coverage – e.g., automobile insurance, liability insurance, and workers' compensation insurance.

2. Limited excepted benefits – e.g., limited scope dental and vision insurance, long term care, and nursing home care.

    - Pursuant to subsequent rule making, the following benefits may qualify as limited excepted benefits: certain employee assistance programs ("EAPs"), and excepted benefit health reimbursement arrangements ("EBHRAs").

3. Independent, non-coordinated excepted benefits – e.g., coverage for a specified disease or illness, hospital indemnity, and other fixed indemnity insurance.

4. Supplemental excepted benefits – e.g., Medigap, CHAMPVA, or similar coverage that is supplemental to GHP coverage.

FAQ 72 provides a mechanism for certain fertility benefits to be provided as independent, non-coordinated excepted benefits (3) or limited excepted benefits (2) above.

Independent Non-Coordinated Excepted Benefits

Coverage for specified diseases or illnesses, such as cancer-only policies, or hospital indemnity or other fixed indemnity coverage, can be excepted benefits when they satisfy the following conditions:

- The benefits are provided under a separate policy, certificate, or contract of insurance,
- There is no coordination between the provisions of such benefits and any exclusion of benefits under any GHP maintained by the same employer, and
- The benefits are paid with respect to an event regardless of whether there is other coverage under any GHP offered by the same employer, or individual coverage offered by the same carrier.

Based on FAQ 72, employers may now offer fertility benefits that satisfy the above conditions as excepted benefits. This includes employers that do not offer a traditional GHP with major medical coverage, as well as coverage for employees that are not enrolled in major medical coverage offered by their employer.

Importantly, to qualify as an excepted benefit under this definition the benefit must be provided under an insurance policy. A self-funded fertility benefit will not meet this definition. Additionally, there can be no coordination between the benefits provided by the excepted fertility benefits and any exclusion of benefits under any GHP offered by the same plan sponsor.

It should be noted that, currently, there may not be options in the insurance market to purchase fertility coverage that meets the requirements to qualify as an excepted benefit. It will be interesting to see whether the market develops specific disease/illness insurance policies that provide fertility benefits.

HSA Contribution Compatibility

Employees covered on a high-deductible health plan (“HDHP”) may not have other impermissible coverage in order to maintain eligibility to make or receive HSA contributions. However, additional coverage for a specific disease or illness is permitted. FAQ 72 makes clear that fertility treatment coverage offered as a non-coordinated excepted benefit can be provided to employees with HDHP coverage with no impact on their eligibility to make or receive HSA contributions.

Limited Excepted Benefits

Under the limited excepted benefits rules, employers may offer an EBHRA that satisfies the following conditions:

- Other GHP coverage that is not limited to excepted benefits is made available by the plan sponsor
- Benefits are limited in amount – $2,200 for plan years beginning in 2026 and indexed annually
- The HRA may not reimburse premiums for other individual coverage, group coverage, or Medicare coverage that are not excepted benefits
- The HRA must be offered on the same terms to all similarly situated individuals

EBHRAs must comply with ERISA notice requirements and provide notice including the following:

- A description of eligibility conditions to receive benefits,
- Annual or lifetime dollar limits,
- Other limits on benefits under the plan, and

- A description or summary of the benefits

If the above conditions are satisfied, an employer may provide coverage for fertility services via an EBHRA that reimburses out of pocket costs related to fertility services.

It is important to note that, while this relief is helpful, the annual EBHRA benefit limit ($2,200 for 2026) may not be enough to cover the out-of-pocket costs associated with fertility expenses.

Employee Assistance Programs

The guidance further allows employers to include coaching and navigator services to help employees understand their fertility options under an EAP that qualifies as a limited excepted benefit. The FAQ makes clear that the addition of fertility-related coaching or navigator services to an EAP will not risk the EAP's status as an excepted benefit.

Importantly, the FAQ notes that an EAP cannot qualify as an excepted benefit if it:

- Offers any fertility benefits that are significant benefits for medical care,
- Coordinates benefits with any GHP,
- Requires employees to pay premiums for coverage, or
- Imposes any cost sharing

Penalties

If fertility benefits are not integrated with major medical coverage or do not meet the definition of an excepted benefit (as described above), these benefits may not satisfy the ACA's market reforms and risk a penalty equal to $100 per person per day ($36,500 annually).

Many employers integrate the fertility benefits/program into a major medical group health plan that otherwise satisfies the ACA market reforms.

Employer Action

Many vendors provide fertility services through programs that are not structured to qualify as excepted benefits. Usually, the fertility benefits are integrated into the major medical plan coverage (which otherwise meets the ACA's market reforms).

Importantly, the guidance does not limit employers to providing fertility benefits through these excepted benefits options. Rather, the FAQ is providing clarity on additional avenues through which an employer may provide fertility services as excepted benefits to avoid risking ACA market reform violations.

Employers currently offering fertility benefits should discuss FAQ 72 with their vendor to determine if the program currently qualifies as an excepted benefit or whether any changes are needed. Again, a self-funded fertility benefit will not be able to qualify as an independent non-coordinated excepted benefit.

Employers considering adding fertility benefits should carefully review the guidance to determine whether providing fertility services as an excepted benefit meets their needs.

Employers sponsoring EAPs that would like to add fertility coaching or navigator services should reach out to the EAP provider to ensure these services are provided within the boundaries of the guidance.

Reminder: Massachusetts HIRD Reporting Due December 15, 2025

Issued date: 11/03/25

As a reminder, Massachusetts employers must file the annual Health Insurance Responsibility Disclosure ("HIRD") form through the MassTaxConnect ("MTC") web portal. The HIRD reporting will be available to be filed starting November 15th and must be completed by December 15th.

The HIRD form collects employer-level information about employer-sponsored health insurance ("ESI") offerings. The HIRD form assists MassHealth in identifying members with access to qualifying ESI who may be eligible for the MassHealth Premium Assistance Program.

State law requires every employer with six or more employees in Massachusetts to annually submit a HIRD form. If you are an employer who currently has (or had) six or more employees in any month during the past 12 months preceding the due date of this form (December 15 of the reporting year), you are required to complete the HIRD form.

- An individual is your employee if you, as the employer, included such individual in your quarterly wage report to the Department of Unemployment Assistance ("DUA") during the past 12 months. You are required to complete the HIRD form if you reported six or more employees (includes all employment categories) in any DUA wage report during the past 12 months.

- If you are an out-of-state employer that is not required to file a quarterly wage report to the DUA, an individual is your employee if they are hired for a wage or salary in Massachusetts to perform work, regardless of full-time or part-time status.

For HIRD FAQs, visit: www.mass.gov/info-details/health-insurance-responsibility-disclosure-hird-faqs.

For more information about the Premium Assistance Program and additional employer resources, visit the MassHealth Premium Assistance web page: www.mass.gov/info-details/masshealth-premium-assistance-pa.

Massachusetts Paid Family Leave 2026 Contributions and Benefits

Issued date: 11/04/25

The Massachusetts Department of Family and Medical Leave ("DFML") has recently announced the contribution rate, the State Average Weekly Wage, and the maximum weekly benefit amount for the Massachusetts Paid Family and Medical Leave ("PFML") program effective January 1, 2026. The DFML has also published the FY2025 Annual Report for the PFML program.

Contributions

The 2026 contribution rate on eligible wages will be 0.88% (the contribution rate remains unchanged since 2024). Individual contributions are capped by the Social Security income limit. The 2026 Social Security income limit is expected to be released later in October and will likely be significantly higher than the 2025 limit which is currently set at $176,100.

If an employer has at least 25 covered individuals (i.e., employees and 1099 contractors in MA), both the employer and the employee share in the cost of medical leave benefits. The employee is responsible for the entire cost of family leave benefits. The following illustrates the PFML contribution breakdown for 2026:

- Medical Leave Contribution: **0.70%** of eligible wages allocated as follows:
    - Employer: At least 60% of the medical leave cost is paid by the employer (0.42%)
    - Employee: No more than 40% of medical leave can be deducted from the employee's wages (0.28%).
- Family Leave Contribution: 0.18% of eligible payroll deduction
    - May be paid entirely from employee wages (no employer contribution required).

If the employer has fewer than 25 covered individuals in Massachusetts, the employer is not required to contribute toward the medical or family leave portions of the benefit. The employee's 2026 contribution for medical and family leave benefits is 0.46% of eligible wages.

Amount of Benefit

The weekly benefit amount for employees and self-employed individuals on family or medical leave is determined as follows:

- the portion of an employee's or self-employed individual's average weekly wage ("AWW") that is equal to or less than 50 percent of the state average weekly wage ("MAAWW") is replaced at a rate of 80 percent; and
- the portion of an employee's or self-employed individual's AWW that is more than 50 percent of the MAAWW is replaced at a rate of 50 percent, up to the maximum allowed benefit amount.

For 2026:

- The MAAWW will be $1,922.48, an increase of 5.1% from the 2025 MAAWW of $1,829.13.
- The maximum weekly PFML benefit will be $1,230.39, an increase of 5.1% from the maximum weekly benefit of $1,170.64 in 2025

FY2025 Annual Report

As required by the Family and Medical Leave Law, the DFML has issued its annual report containing information on benefits, applications, and certain characteristics of applicants during Fiscal Year 2025.

Employer Action

Employers should prepare for the 2026 PFML contribution and benefit requirements by working with payroll processors, approved private plan vendors and employment counsel to ensure their leave policies and procedures are compliant by January 2026. Updated workplace posters and notifications for the 2026 contribution rates and benefit amounts will be available to employers on the PFML website soon.

New PCOR Fee Announced

Issued date: 11/07/25

On November 3, 2025, the IRS released Notice 2025-61, announcing that the adjusted applicable dollar amount used to determine the PCOR fee for plan years ending on or after October 1, 2025, and before October 1, 2026, is $3.84.

The PCOR filing deadline is **July 31, 2026**, for all self-funded medical plans (including level-funded) and some HRAs (including ICHRAs) for plan years (including short plan years) ending in 2025. Carriers are responsible for paying the fee for insured policies.

PCOR fee due July 31, 2026:

Plan Years Ending on	Amount of PCOR Fee
January 31, 2025	$3.47/covered life/year
February 28, 2025	$3.47/covered life/year
March 31, 2025	$3.47/covered life/year
April 30, 2025	$3.47/covered life/year
May 31, 2025	$3.47/covered life/year
June 30, 2025	$3.47/covered life/year
July 31, 2025	$3.47/covered life/year
August 31, 2025	$3.47/covered life/year
September 30, 2025	$3.47/covered life/year
October 31, 2025	**$3.84/covered life/year**
November 30, 2025	**$3.84/covered life/year**
December 31, 2025	**$3.84/covered life/year**

Employer Action

For now, no action by employers with self-funded health plans (or an HRA) is required. It is important to note that we have seen increased enforcement activity from the IRS around missing PCOR fees. Specifically, the IRS is issuing notices to employers who appear to have missed a prior year PCOR fee filing, requesting payment (including interest and penalties).

For the Form 720 and Instructions, visit www.irs.gov/forms-pubs/about-form-720. The Q2 Form 720 for 2025 which is used to file and pay this fee is typically not available until April of the filing year.

California Enacts PBM Reform Law

Issued date: 11/07/25

A recently enacted California law establishes extensive new requirements for pharmacy benefit managers ("PBMs") doing business in the state. The law is intended to increase regulatory oversight, enhance transparency, and address the revenue-generating abilities of PBMs. Effective dates vary by provision, with many going into effect on January 1, 2026.

Senate Bill 41

On October 11, 2025, California Governor Gavin Newsom signed Senate Bill 41 ("SB 41") into law. SB 41 covers a wide range of topics relating to PBMs. This update summarizes key provisions that could affect employer-sponsored health plans, and is not intended to cover all details of the law.

Price and Compensation

- No spread pricing. PBMs are prohibited from including spread pricing in contracts starting January 1, 2026. Spread pricing is a model of prescription drug pricing in which the contracted price charged for a drug by a PBM differs from the amount paid to the pharmacy. Spread pricing terms in existing contracts will be void on or after January 1, 2029.

- Passthrough pricing required. PBMs must use a passthrough model of pricing for prescription drugs. Under this model, payments made by a health care service plan or health insurer to a PBM for a prescription drug must equal the payments the PBM makes to a pharmacy for the drugs, including dispensing fees.

- 100% rebate passthrough. The law requires PBMs to direct 100% of manufacturer rebates received to be passed through to the payer or program for the sole purpose of offsetting cost sharing and reducing premiums for plan participants.

- Cost sharing cannot exceed the "actual rate" paid or "net price" paid. Health care service plan contracts or health insurance policies issued, amended, or renewed on or after January 1, 2026, are generally prohibited from calculating an insured's cost sharing for a prescription drug (including deductibles and copayments) at an amount that is greater than the "actual rate" paid by the plan for the drug or, if the contract includes disclosure of the "net price," the "net price" paid by the PBM for the drug.

- Note that these cost-sharing requirements appear to only apply to fully insured plans issued in California. They are not applicable to ERISA self-funded plans.

- Limitations on PBM compensation. PBMs cannot derive income from PBM services provided to a payer other than a defined service fee for those services. The amount must be defined in the agreement between the PBM and payer and cannot be tied to drug prices or patient cost sharing. The law permits performance bonuses to PBMs based on savings, depending on what the bonus is based.

- Other pharmacy pricing protections.

  - PBMs cannot reduce payments for pharmacist services under a reconciliation process to achieve certain reimbursement rates.

  - PBMs cannot retroactively deny or reduce pharmacy claims after adjudication except in limited circumstances (e.g., the claim was submitted fraudulently).

  - PBMs can reverse and resubmit claims from a contract pharmacy only: (1) with prior written notification; (2) with just cause or after attempting to first reconcile the claim; and (3) within 90 days of the claim being adjudicated.

  - PBMs cannot charge a pharmacy a fee to process claims electronically.

Limitations on Manufacturer Exclusivity and Treatment of Nonaffiliated Pharmacies

- Limitations on exclusivity with manufacturers. PBMs cannot enter exclusive arrangements with manufacturers on or after January 1, 2026, unless it can be demonstrated that the arrangements result in the lowest cost to the payer and the lowest cost sharing for the plan participant.

- Limitations on favorable treatment of affiliated pharmacies over nonaffiliated pharmacies. PBMs are prohibited from denying a nonaffiliated pharmacy the opportunity to participate in their network if the pharmacy is willing to accept the same terms and conditions established for affiliated pharmacies. The law also limits certain "steering" actions by PBMs that favor affiliated pharmacies over nonaffiliated pharmacies (e.g., requiring a plan participant to use only an affiliated pharmacy if there are nonaffiliated pharmacies in the network). PBMs are prohibited from discriminating against a nonaffiliated pharmacy in connection with dispensing drugs. PBMs also cannot enter into contracts that restrict or impose exclusivity on nonaffiliated pharmacies' ability to contract with employers and payers, beginning January 1, 2026.

Regulatory Oversight, Transparency, and Ethical Obligations

- Licensure requirement. For PBM contracts issued, amended, or renewed on or after January 1, 2027, the PBM must be licensed and in good standing with the California Department of Managed Health Care ("DMHC").

- Ethical and fiduciary obligations. PBMs must exercise good faith and fair dealing and must inform a purchaser in writing of any activity, policy, or practice presenting a conflict of interest. PBMs owe a fiduciary duty to a self-insured employer plan, as well as a payer client, which includes a duty to be fair and truthful toward the client, to act in the client's best interests, to avoid conflicts of interest, and to perform its duties with care, skill, prudence, and diligence.

- Disclosure and reporting requirements. PBMs must provide detailed disclosures to a purchaser, including drug pricing, rebate, administrative fee, drug utilization, and pharmacy financial arrangement information, quarterly upon request. PBMs must also submit financial statements to the DMHC. The DMHC may conduct periodic routine and nonroutine surveys of a PBM.

Scope and Applicability

SB 41 aims to regulate PBMs conducting business in California, which will affect fully insured group health plans that contract with PBMs in the state.

While SB 41 specifically excludes a "self-insured employee welfare benefit plan" subject to ERISA from the definition of a PBM, it is unclear how much of the law intends to apply to PBMs working with self-insured plans. Certain provisions regulating PBM practices are drafted in a way that may affect PBM contracts more broadly, including those with self-funded ERISA plans. The law also specifically addresses a PBM's fiduciary obligation to self-insured employer plans, as well as to payer clients.

State PBM laws that are merely regulating PBM reimbursement practices to pharmacies are not preempted by ERISA. Indeed, SB 41 appears to have been drafted with an intent to avoid ERISA preemption. However, given the evolving ERISA preemption landscape with respect to state PBM laws, it is not yet clear which provisions of SB 41 will be preempted by ERISA and therefore not apply to self-funded ERISA plans.

Additional guidance from the California Department of Insurance (DOI) and DMHC is expected and we will continue to monitor this issue as more information and regulations become available.

The law specifically does not apply to a collectively bargained Taft-Hartley self-insured plan under ERISA or to a PBM's provision of PBM services pursuant to that Taft-Hartley plan.

Employer Action

Employers that sponsor fully insured plans contracting with PBMs in California can expect their insurance carrier to work with the PBMs to comply with the new requirements and do not need to take any action at this time.

Employers that sponsor self-funded plans contracting with PBMs in California should reach out to their TPA and/or PBM to determine if the new law requires any benefit design changes.

Final 2025 ACA Reporting Instructions and Forms Issued

Issued date: 11/10/25

The IRS released final instructions and forms for calendar year 2025 ACA reporting, including Forms 1094-C, 1095-C, 1094-B, and 1095-B. As a reminder, it is important to ensure the forms are accurate, timely furnished to participants and filed with the IRS as good faith relief from penalties is no longer available.

There are no significant changes to the 2025 forms.

Forms 1094-C/1095-C

Applicable large employers ("ALEs") must furnish Form 1095-C to full-time employees and file Form 1094-C and all 1095-Cs with the IRS. ALEs offering a self-insured group health plan must also furnish Forms 1095-C to covered employees or other primary insured individuals in the self-funded health plan (e.g., covered part-time employees, COBRA qualified beneficiaries).

It is important to note that self-funded health plans include level-funded arrangements and individual coverage health reimbursement arrangements ("ICHRAs").

The calendar year 2025 Form 1095-C must be furnished to full-time employees and other individuals by March 2, 2026. The Form 1094-C and all Forms 1095-C must be filed with the IRS electronically by March 31, 2026.

ALEs, in coordination with their payroll or other reporting vendors, should have records to determine each employee's status as an ACA FTE or not an ACA FTE for each month during 2025 in preparation to complete, furnish and file these forms for 2025.

Forms 1094-B/1095-B

Employers that are not ALEs and offer self-funded group health plan coverage, including level-funded plans and ICHRAs, must furnish and file forms regarding minimum essential coverage. Specifically, as the provider of the self-funded plan, the employer reports to the IRS and all covered individuals (e.g., employees, COBRA qualified beneficiaries, spouses,

dependents) the coverage they had during the calendar year. To meet this requirement, employers use Forms 1094-B and 1095-B.

The calendar year 2025 Form 1095-B must be furnished to covered individuals by March 2, 2026. Form 1094-B and all Forms 1095-B must be filed with the IRS electronically by March 31, 2026.

Employers should coordinate with payroll or other reporting vendors to assist in this process.

What's New?

There are no significant changes to the 2025 forms, however, the instructions include further explanation of the relief available for furnishing these Forms to full-time employees and covered individuals in a self-funded health plan.

Employers are permitted to only furnish these Forms upon request when certain requirements are met, including providing advance notice. An employer that wants to take advantage of this relief, and only furnish the Form upon request, must:

- Provide a clear, conspicuous and accessible notice on its website so that an individual may request a copy of their statement.
- Post the notice by March 2, 2026, and have it remain accessible through October 15, 2026.
- Upon request, timely furnish a copy of the statement. A statement is timely furnished if provided no later than the later of January 31, 2026, or 30 days after the date of the request.

Notice requirement

The notice should:

- Be written in clear language with font size large enough (or provide other visual cues) to call to the reader's attention that the notice contains important tax information.
- Contain a statement that individuals have a right to receive a copy of the Forms upon request as well as contact information (e-mail, mailing address, and phone number) and instructions on how to request a copy of the Form(s).
- Be posted in a location on the employer's website that is reasonably accessible to all individuals. For example, a reporting entity's website provides a clear and conspicuous notice if it includes a statement on the main page – or a link on the main page, reading "Tax Information," to a secondary page that includes a statement in capital letters "IMPORTANT HEALTH COVERAGE TAX DOCUMENTS."

While the IRS did not furnish a sample notice in its guidance, it referred to a notice found in previously issued regulations. Note that employers that are required to furnish Forms 1095-C (or 1095-B) pursuant to a state individual coverage mandate may still need to furnish these Forms as they have in prior years to covered employees who reside in states with an individual mandate (e.g., California, Washington D.C., New Jersey, and Rhode Island).

Electronic Filing Required (10+ Forms)

Employers required to file 10 or more information returns (e.g., Forms W-2, 1094-C, 1095-C, 1094-B, 1095-B) during the year must file these forms electronically with the IRS on or after January 1, 2024. Previously, the IRS allowed employers filing fewer than 250 returns to file hard-copy (paper) forms.

The IRS also encourages employers filing fewer than 10 returns to consider electronic filing.

Penalties for Non-Compliance

The instructions reiterate that all ALEs and other employers that sponsor self-funded group health plans that fail to comply with the information reporting requirements may be subject to the general reporting penalty provisions for failure to file correct information returns and failure to furnish correct payee statements. *Good faith relief is no longer available.* However, penalties may be waived if the failure is due to reasonable cause and not willful neglect.

For 2025, the following penalties may apply:

- Failure to file a correct return is $340/statement (total calendar year penalty not to exceed $4,098,500).
- Failure to furnish a correct statement is $340/statement (total calendar year penalty not to exceed $4,098,500).

It should be noted that an employer that fails to both file and furnish a correct statement is subject to a combined penalty of $680/statement with a maximum penalty of $4,098,500.

Employer Action

It is important to identify vendors, like payroll or other reporting administrators, to assist in this process, especially as most employers will be required to file forms electronically with the IRS. A health plan carrier typically does not prepare this reporting.

ALEs should begin preparing and ensure that Form 1095-C is furnished to full-time employees and other individuals by March 2, 2026. Form 1094-C and all Forms 1095-C should be electronically filed with the IRS by March 31, 2026.

Employers that are not ALEs but offer self-funded group health plan coverage should ensure a process is in place for furnishing and filings Forms 1094-B and 1095-B. Form 1095-B must be furnished to covered individuals by March 2, 2026, and all forms 1095-B along with Form 1094-B must be electronically filed with the IRS by March 31, 2026.

Employers choosing to take advantage of the available relief, and only furnish the applicable Forms upon request, must review and implement the specific notice requirement and timely furnish Forms upon request. Don't forget that all Forms 1095-C along with Form 1094-C (or all Form 1095-B along with Form 1094-B) must still be filed with the IRS.

Employers should be certain the statements are complete and accurate since good faith relief is no longer available.

Employers may have additional reporting obligations for employees residing in states with an individual mandate (California, Massachusetts, New Jersey, Rhode Island, Vermont, Washington D.C.). Ensure vendors will assist with state reporting obligations. We will issue a compliance update when information on state reporting for 2025 becomes available.

Texas' Woman and Child Protection Act

Issued date: 11/17/25

Effective December 4, 2025, the Woman and Child Protection Act (the "Act," also known as House Bill 7) allows individuals to sue individuals who import abortion drugs into Texas, with potential damages of at least $100,000 per violation.

Background

Following the Supreme Court's decision in *Dobbs v. Jackson Women's Health Organization* (2022), which overturned *Roe v. Wade*, and Texas' subsequent criminal ban on all elective abortion under the Human Life Protection Act, abortion-inducing drugs are increasingly being purchased online from out-of-state entities. Texas is seeking to curtail this practice by creating civil remedies similar to those in the Texas Heartbeat Act which allows individuals to bring civil lawsuits against those who perform or are involved in the facilitation of a medical abortion.

The Act

The Act authorizes a private citizen to initiate a civil action against anyone who manufactures, distributes, mails, transports, delivers, prescribes, or provides abortion-inducing drugs in Texas. Remedies include injunctive relief, damages of at least $100,000 per violation, and attorneys' fees and costs. A private citizen unrelated to a pregnant woman seeking abortion pills would receive $10,000, with $90,000 going to the charity of their choice, if they prevail.

In defining who could be a defendant in a civil action under the Act, the list is extensive and includes out-of-state actors.

The bill includes several exemptions, including:

- Suits against pregnant women seeking or obtaining abortion-inducing drugs for their own abortions;
- Suits against hospitals, health care facilities, and physician groups;
- Abortion-inducing drugs used for medical emergencies, ectopic pregnancies, or removing a deceased unborn child;

- Conditional exemptions for internet service providers, search engines and cloud providers, transportation companies, delivery networks, and pharmaceutical manufacturers; and

- "Speech or conduct protected by the First Amendment."

Potential Effects on Health Plans

Importantly, in the context of employee benefits, there is no exemption for plan sponsors. Therefore, an employer whose drug program covers abortion-inducing drugs in violation of this law might be held liable.

The Act does not expressly define what "distribute" or "provide" means, or at what point First Amendment protected conduct crosses into "providing" abortion-inducing drugs.

Because lawsuits can be brought by private citizens, plan sponsors face the risk of litigation from ideologically or financially motivated individuals, even if the legal grounds are tenuous. Defending against these lawsuits could be costly, regardless of the outcome.

Under ERISA, state law is preempted to the extent that it relates to benefits. Although unclear, employers other than governmental and church employers may be protected under this doctrine.

Abortion shield laws (state-level protections designed to shield individuals seeking and providing reproductive care from legal action, particularly from out-of-state investigations and prosecutions) enacted in the provider's home state have made it challenging for these types of lawsuits to advance.

Employer Action

Employers with self-funded plans covering abortion-inducing drugs in Texas should decide whether they want to continue to do so.

Employers should watch for further developments, as this law is expected to face legal challenges.

California Redefines Approach to Preventive Care Standards

Issued date: 11/18/25

California has enacted legislation allowing the state to set its own standards for preventive care required to be provided at no cost by fully insured health plans. The new law adopts the federal recommendations for preventive care and immunization coverage as they existed on January 1, 2025, as a baseline, and authorizes the state to modify or supplement these guidelines in the future. The new state law does not apply to self-funded plans governed by ERISA.

Background

Under the Patient Protection and Affordable Care Act ("ACA"), non-grandfathered group health plans must provide coverage for in-network preventive items and services and may not impose any cost-sharing requirements (such as a copayment, coinsurance, or deductible) with respect to those items or services. Specifically, the following must be covered as preventive:

- Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force ("USPSTF");
- Immunizations for routine use in children, adolescents, and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices ("ACIP") of the Centers for Disease Control and Prevention ("CDC");
- With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration ("HRSA"); and
- With respect to women, preventive care and screening provided for in comprehensive guidelines supported by HRSA, to the extent not already included in certain recommendations of the USPSTF.

Previously, California's health insurance preventive care mandates were tied to these federal preventive care guidelines.

New State Legal Framework

California Governor Gavin Newsom signed Assembly Bill 144 ("AB 144") into law on September 17, 2025, effective immediately. The law was intended to preserve health care coverage of preventive services and vaccines for California residents, regardless of any rollback in federal policy.

To accomplish this, AB 144 codifies the federal recommendations for preventive care and immunization coverage in effect on January 1, 2025 (before the current administration took office), and allows the California Department of Public Health ("CDPH") to supplement those recommendations.

Specifically, AB 144:

- Establishes the list of preventive services, items, and immunizations recommended as of January 1, 2025, by USPSTF, ACIP, and HRSA as the baseline recommendations for California.
- Authorizes the CDPH to modify or supplement the baseline recommendations, taking into consideration guidance and recommendations from additional medical and scientific organizations, including, but not limited to, the American Academy of Pediatrics, the American College of Obstetricians and Gynecologists, and the American Academy of Family Physicians.
- Authorizes CDPH to incorporate subsequent evidence-based recommendations from USPSTF, ACIP, or HRSA, to the extent the department determines them to promote public health.
- Requires CDPH to publish the baseline recommendations, including any modification or supplement, and that any updates, modifications, or supplements are deemed effective on the date of publication.
- Replaces references to USPSTF, ACIP, or HRSA for coverage of preventive services and items, and for the administration of vaccines by various health professionals and other personnel and entities, with references to these federal recommendations as they existed on January 1, 2025, as modified or supplemented by CDPH pursuant to its authority under the baseline recommendations.

On September 18, 2025, the California Department of Managed Health Care ("DMHC") issued All Plan Letter 25-015 providing information and guidance to health care plans on the protections enacted under AB 144.

Application of California Insurance Law to Group Health Plans

The California insurance law requirements set forth above generally apply to:

- Group health insurance policies issued or delivered (i.e., situsted) in California.
- HMOs in California.
- Group health insurance policies issued or delivered (i.e., situsted) outside of California, to the extent that the policy covers California residents; but not if (a) the employer's principal place of business is located outside of California, and (b) a majority of employees are located outside of California.

In addition, the California law does not apply to self-funded group health plans governed by ERISA.

Employer Action

Carriers are generally responsible for complying with preventive service coverage requirements and making updates as needed. Plan sponsors should not need to take any action at this time. However, sponsors of plans with employees in multiple states should be aware that the preventive coverage requirements under a fully insured plan in California may differ from federal guidelines or the coverage requirements in other states.

Reminder: Illinois Fertility Benefits & Dependent Coverage for Parents Go Into Effect Jan 1, 2026

Issued date: 12/19/25

The Illinois legislature enacted two new laws impacting certain health benefits plans. These provisions take effect for policies issued, amended, delivered or renewed in Illinois on or after January 1, 2026.

Briefly, these Illinois benefit mandates:

- Broaden benefits related to infertility treatment, and
- Expand dependent coverage to include the tax dependent parent (or stepparent) of the insured.

These provisions apply to fully insured group health plans issued in Illinois. ERISA covered self-funded health plans are not required to comply.

Mandatory Fertility Benefits

The new law broadens mandatory coverage of infertility and provides that no group policy of accident and health insurance that provides pregnancy-related benefits may be issued, amended, delivered, or renewed in Illinois on or after January 1, 2026, unless the policy contains coverage for the diagnosis and treatment of infertility, including specified procedures. Covered plans must also include coverage for the procedures necessary to screen or diagnose a fertilized egg before implantation.

State insurance mandates are generally pre-empted by ERISA and apply to fully insured group health plans with Illinois as their situs state. However, since the law also amended the County, Municipal, and School Codes, the mandates also apply to non-ERISA self-funded group health plans sponsored by Illinois state or local governmental entities as well as public schools.

Additionally, any group policy that covers more than 25 employees that is amended, delivered, issued, or renewed on or after January 1, 2026, shall provide, for individuals 45 years of age and older, coverage for an annual menopause health visit without any cost-sharing applied to the insured member.

Dependent Parent and Stepparent Coverage

The Illinois Insurance Code was amended so that a group or individual policy of accident and health insurance issued, amended, delivered, or renewed after January 1, 2026, which provides dependent coverage, shall make that dependent coverage available to the parent or stepparent of the insured if the parent or stepparent:

- Meets the definition of a qualifying relative under 26 U.S.C. 152(d); and
- Lives or resides within the accident and health insurance policy's service area.

The expanded definition does not apply to specialized health care service plans, Medicare supplement insurance, hospital-only policies, accident-only policies, or specified disease insurance policies that reimburse for hospital, medical, or surgical expenses.

Generally, to satisfy the definition of a "qualifying relative" the parent or stepparent must have:

1. Gross income for the calendar year in which such taxable year begins that is less than $5,300 for 2026 (as indexed for inflation); and
2. The taxpayer (the primary insured) provide over one-half of the individual's support for the calendar year in which such taxable year begins.

This Illinois state insurance mandate is generally preempted by ERISA and would only apply to fully insured group health plans with Illinois as their situs state.

Employer Action

Carriers issuing and renewing group health plan policies in Illinois should be making the necessary changes to the plan designs to comply with the law.

Self-funded non-ERISA plans employers should work with their TPAs and stop loss carriers to comply with new fertility requirements.

If applicable, employers should amend plan documents to include dependent parent/stepparent eligibility language and communicate these changes with participants.

IRS Notice 2026-5: Key HSA Eligibility Updates Under OBBA

Issued date: 12/19/25

On December 9, 2025, the IRS issued Notice 2026-5 (Notice), providing guidance on Health Savings Account (HSA) changes introduced by the One Big Beautiful Bill Act (OBBA). The IRS is seeking comments on all aspects of this Notice with comments due by March 6, 2026.

HSA Eligibility Generally

Section 223 of the Internal Revenue Code allows eligible individuals to establish HSAs. To qualify, an individual must:

- Be covered under a high-deductible health plan (HDHP).
- Have no disqualifying coverage (coverage that provides cost-sharing before meeting HDHP minimums).

HDHPs must meet minimum deductible and maximum out-of-pocket limits set by the IRS, though preventive care and certain other coverage can be disregarded without affecting HSA eligibility. OBBA expanded these rules to increase access to HSAs, and the Notice addresses these changes, specifically on telehealth services, bronze and catastrophic plans, and direct primary care service arrangements (DPCSA).

Telehealth and Remote Services

Telehealth, or other remote care services, provided for free, or at a reduced cost, before satisfying the minimum deductible in an HDHP are generally disqualifying coverage. OBBA made a permanent safe harbor that permits first dollar coverage for telehealth and other remote care services. The guidance addresses telehealth services that can be reimbursed by an HDHP without affecting HSA eligibility. Services that are reimbursed by the plan are qualified if the services appear in the Health and Human Services annual Medicare telehealth payable list. The list is updated annually. It should be noted that this relief is optional for employers and are not required to offer free or reduced telehealth services.

The Notice also confirms that in-person services, medical equipment, and drugs furnished in connection with a telehealth or other remote care service may not be offered before the minimum deductible is met unless they would otherwise be treated as telehealth services in accordance with the Medicare payable list.

Individual Bronze and Catastrophic Plans

Effective January 1, 2026, bronze and catastrophic plans will be treated as HDHPs if available as individual coverage through an ACA Marketplace, whether they meet standard HDHP deductible minimums or out-of-pocket limits or not. This also applies to off-Marketplace plans that are identical to Marketplace versions. However, if an individual has no reason to believe that a plan is not offered on the Marketplace and is enrolling in off-Marketplace coverage, they can still enroll in the plan and be eligible for an HSA.

For employers:

- ICHRAs can be used to purchase coverage without affecting HDHP status. However, it is important to note that reimbursements should be limited to either premiums or post-deductible expenses in order for the individual to retain HSA eligibility.

- Bronze plans offered through SHOP do not qualify under this provision. Thus, employer sponsored plans must continue to comply with HDHP requirements.

Direct Primary Care Service Arrangements

DPCSAs charge a fixed fee and provide an array of primary care services and items, such as physical examinations, vaccinations, urgent care, laboratory testing and the diagnosis and treatment of some sicknesses and injuries. Before OBBA, this type of arrangement would be disqualifying coverage for purposes of contributing to an HSA because it provides coverage for non-preventive care services before the minimum HDHP deductible is satisfied.

The Notice confirms much of what was already in OBBA but provides some additional insights. It reiterates that DPCSAs will not be treated as health plans if they meet strict criteria: primary care services only provided by primary care practitioners, a fixed periodic fee not exceeding the statutory annual limit ($1,800 self-only / $3,600 family for 2026) and there is no separate billing for any items and services provided to the participant.

It also clarifies that for billing purposes, the arrangement can be made for periods more than a month, but the fee must be a fixed amount that does not exceed the annual limit. The following examples were provided for a single individual:

- Option 1: One $1,800 payment for the year

- Option 2: $900 for six months (two payments during the year)

- Option 3: $450 for three months (quarterly payments).

With respect to paying for the fee, the Notice permits reimbursement on the first day of each month of coverage on a pro rata basis, the first day of the period of coverage, or the date the fees are paid. The HDHP may not pay for the fee without a deductible or before the deductible has been satisfied and the fees paid by the individual for the DPCSA do not count toward the annual HDHP deductible or out-of-pocket maximum.

Finally, fees paid through a Section 125 plan or employer-paid fees cannot be reimbursed by the HSA. And, if fees are higher than the annual limit, the individual will be ineligible to contribute to the HSA, but the fee remains reimbursable.

Employer Action

Employers interested in implementing telehealth or DPCSA solutions with HDHP/HSA plans, or those that already have these in place, should review the guidance and discuss with applicable carriers, TPAs, and vendors to ensure compliance.

Consider the following action items in response to this Notice:

- Review telehealth services that may go beyond what is permitted, to not cause a loss of eligibility.
- Assess DPCAs offered to employees to ensure fees and services meet IRS criteria, including the periodic fee limits.
- Be aware that offering services more than primary care will create problems for HSA eligibility, even if the individual can waive the non-primary care services.
- Update plan communications to explain to employees how these arrangements might affect HSA eligibility.
- SHOP Employers: be prepared to answer questions from employees on whether their bronze plan can be paired with an HSA, if offering SHOP coverage.
- Stay tuned for additional guidance!

New Jersey Releases 2026 Disability and Family Leave Amounts

Issued date: 12/22/25

New Jersey has announced the 2026 contribution rates and benefit level parameters for the Temporary Disability Insurance ("TDI") and Family Leave Insurance ("FLI") programs. The 2026 rates and benefit parameters are as follows:

	2025	2026
Maximum TDI and FLI Weekly Benefit	**$1,081**	**$1,119**
Alternative Earnings Test Amount for TDI and FLI	**$15,200**	**$15,500**
Base Week Amount for TDI and FLI	**$303**	**$310**
Taxable Wage Base (employers) for TDI	**$43,300**	**$44,800**
Taxable Wage Base (employees) for TDI and FLI	**$165,400**	**$171,100**
Employee Contribution Rate for TDI	**0.23%**	**0.19%**
Employee Contribution Rate for FLI	**0.33%**	**0.23%**

Temporary Disability Insurance 2026

Temporary Disability Insurance provides benefits to eligible New Jersey workers for non-job-related illness, injury, or other disability that prevents them from working or due to certain public health emergency reasons.

To be eligible for TDI employees must have –

- Worked 20 weeks earning at least $310 per week ("Base Week Amount"), or
- Have earned a combined total of $15,500 ("Alternative Earnings Test") in the four quarters ("base year") prior to taking leave.

Following a 7-day waiting period (except for certain public health emergencies), the weekly TDI benefit is 85% of an employee's average weekly wage but no greater than $1,119. TDI may be payable for up to 26 weeks in a 52-week period.

The maximum contribution for 2026 is 0.19% up to the Taxable Wage Base (Employee) of $171,100 equal to $325.09.

Family Leave Insurance 2026

Family Leave Insurance provides benefits to eligible New Jersey workers for (i) the first 12 months following the birth, adoption or foster care placement of a child, or (ii) to care for a seriously ill family member.

To be eligible for FLI employees must have –

- Worked 20 weeks earning at least $310 per week ("Base Week Amount"), or
- Have earned a combined total of $15,500 ("Alternative Earnings Test") in the four quarters ("base year") prior to taking leave.

The weekly FLI benefit is 85% of an employee's average weekly wage but no greater than $1,119. FLI may be payable for 12 consecutive weeks in a 12-month period, or up to 8 weeks (56 individual days) in a 12-month period, if taking leave intermittently.

Employees contribute 0.23% of wages up to the 2026 Taxable Wage Base (Employee) of $171,100 equal to $393.53.

Employer Action

- Adjust payroll systems to reflect the new employee contribution rates.
- Notify employees about updated contribution rates, maximum weekly benefits and eligibility requirements for 2026.
- Ensure internal leave policies align with updated benefit parameters and eligibility rules.
- Confirm employer taxable wage base for TDI and adjust employer contributions.

Another Round of Changes to Delaware's Paid Family and Medical Leave Law

Issued date: 12/23/25

On December 1, 2025, Delaware published new regulations amending Delaware's paid family and medical leave ("PFML") law. These new regulations will impact the implementation of the PFML program which is set to begin paying benefits on January 1, 2026.

Background

Delaware's PFML law, the Healthy Delaware Families Act, requires certain employers to provide their covered employees with up to $900 per week (for 2026 and 2027, and will be adjusted for inflation thereafter) 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.

Employers must provide written notice to each employee of their rights at the time of the employee's hire, whenever an employee requests covered leave, or the employer has reason to believe an employee's leave is due to a qualifying event

The regulations address several provisions of the PFML law, specifically the following:

- The definition of "application year";
- The definition of "employee";
- Clarification of when employers can deduct employee contributions to the program from their pay; and
- Providing guidance for employers utilizing a self-funded private plan to meet the law's requirements regarding their claim reserve accounts

New Definition of "Application Year"

Previously, the Act defined "application year" consistent with the federal Family and Medical Leave Act ("FMLA"). The FMLA allows employers to choose amongst four different methods for determining the 12-month period during which covered employees are entitled to leave.

The regulations now specifically define the "application year" as the 12-month period beginning on the first day that an employee takes family and medical leave continuing forward for the next 12-months.

Modified Definition of "Employee"

The regulations modify the definition of "employee" so that instead of basing eligibility on where the individual physically works, it is now based on where the individual earns their wages. Under this new definition, an individual is considered an employee if they are earning at least 60% of their wages physically in Delaware each calendar quarter. Individuals primarily reporting for work, earning wages at a worksite, or telecommuting outside of Delaware are not considered "employees" under PFML unless the employer and employee agree in writing to reclassify them as such.

In addition, the regulations clarify that owners or officers of an employer that receive a Form W-2 are considered "employees" under PFML. They are eligible for benefits and subject to contribution withholding requirements.

Clarification on Deducting Employee Contributions from Wages

Employers with 10-24 employees are only required to provide paid parental leave. While not required to provide paid leave for medical, family caregiver, or military exigency leave, an employer can voluntarily opt into providing these lines of coverage. The regulations clarify that an employer that voluntarily opts into any additional line of coverage under PFML, the employer is responsible for the additional cost and cannot require employee contributions for these voluntary benefits.

Guidance Regarding the Claims Reserve Account for Self-funded Plans

Employers utilizing a self-funded private plan must prefund a claims reserve account with at least half of the required maximum benefits that a self-funded plan must be able to pay. The regulations state that this reserve account is a separate fiduciary non-interest-bearing account established for the sole purpose of paying benefits under the law. In addition, all employee and employer contributions to the private plan must be deposited into the reserves account.

Finally, the reserve account must be maintained according to sound actuarial principles and must not be over or underfunded. If employee contributions are held by the account, employers must file annual actuarial study reviews with the Division of Paid Leave. The manner of these studies will be provided by the Division of Paid Leave at a later date. Based on the results of these studies, employers may be required to make increased employer contributions or refund employee over-contributions.

Employer Next Steps

Many employers have already adopted their leave policies, so the timing of these regulations is less than ideal. Employers should promptly review their leave policies and determine whether they should adjust them according to these new regulations.

- Employers utilizing an "application year" other than measuring forward from the date PFML benefits are first received should amend their policy to ensure that they are utilizing the updated definition of "application year."

- Employee eligibility should be modified to reflect where wages are earned.
- Employers voluntarily opting into lines of coverage should ensure that employee contributions are required only for the parental leave line of coverage.
- If a self-funded private plan is being utilized, employers should make sure they are not commingling PFML contributions, that all PFML contributions are deposited into their reserve account, and that contributions are calculation using sound actuarial principles.
- Stayed tuned for additional updates as they are released.