12/10/25 Alert 2025-04

Employee Benefits Compliance

What a Year! 2025 Group Health Plan Compliance Review and Checklist

Introduction

This year brought a different type of change for employer-sponsored group health plans, driven less by new federal requirements than it was by state developments, federal regulation roll backs, litigation, and an aggressive vendor marketplace responding to significant cost increases. Certain developments ease plan compliance obligations, including under the Health Insurance Portability and Accountability Act (HIPAA) and the Mental Health Parity and Addiction Equity Act (MHPAEA), while the cost of weight loss drugs and the ongoing state regulation of pharmacy benefits created new and significant compliance issues. Moreover, the debate over ACA subsidies and the overall cost of healthcare, have created both uncertainty among employers and employees, and have also facilitated an environment where employers are considering less traditional and more innovative plan solutions, including ICHRAs, which we expect to be on the legislative agenda in 2026. We address the following 2025 developments and will continue to monitor these and other developments:

- One Big Beautiful Bill Act
- Mental Health Parity and Addition Equity Act Enforcement Pause
- HIPAA Privacy Reproductive Rights Rules Vacated
- Preventive Services and Fertility Coverage
- Health Plan Litigation Update
- State Pharmacy Benefit Manager (PBM) Laws

The One Big Beautiful Bill Act (OBBBA)

On July 4, 2025, President Trump signed into law the One Big Beautiful Bill Act (OBBBA or the Act), which contained several group health plan provisions that expand access to certain types of care. For plan years beginning in 2025, OBBBA permanently allows first dollar coverage for telehealth and other remote care services to be offered alongside a high-deductible health plan (HDHP) without impacting HSA eligibility. Beginning January 1, 2026, the OBBBA also expands flexibility for Direct Primary Care (DPC) by excluding DPC arrangements from HSA-disqualifying coverage, subject to certain key parameters. In addition, the Act specifies that a DPC arrangement is a qualified medical expense reimbursable by an HSA. The law also increases the dependent care assistance program

(DCAP) limit to $7,500 beginning in 2026. Notably, and despite significant interest, the Act did not contain provisions intended to expand the use of Individual Coverage Health Reimbursement Arrangements (ICHRAs). For additional details on key OBBBA provisions, Alert 2025-02 Group Health Plan Impacts of the One Big Beautiful Bill Act, and our Webinar on OBBBA and Other Compliance Developments.

Action Items:

☐ Work with section 125 vendors and third-party administrators (TPAs) to ensure plan documents are updated for the DCAP increase.

Enforcement Pause for Complex Mental Health Parity 2024 Final Rules

By way of reminder, the Mental Health Parity and Addiction Equity Act (MHPAEA) 2024 Final Rules, enhanced the already complex nonquantitative treatment limitation (NQTL) comparative analysis requirements mandated by the Consolidated Appropriations Act of 2021 (CAA). After an industry group filed litigation against the Final Rules, the current Administration moved to suspend the litigation, citing plans to reconsider the 2024 final rules, with the possibility of rescinding or modifying the rules. The court granted the motion. The Departments also issued a non-enforcement policy applicable only to the 2024 final rules while the litigation is pending, plus an additional 18 months. While enforcement of the NQTL testing portion of the 2024 Final Rules is paused, existing obligations under the MHPAEA remain in place, including the requirement to maintain written NQTL comparative analyses. For additional information, see our (See Alert 2024-03). Compliance Insight, Mental Health Parity, It's Time for a Checkup.

Action Items:

☐ Review plan design to ensure no obvious MHPAEA red flag plan design provisions.

☐ Coordinate with carriers, TPAs, and vendors to ensure general MHPAEA compliance, including the maintenance of a written NQTL comparative analysis**.**

HIPAA Reproductive Health Privacy Rule Vacated

In June 2025, a federal district court vacated the 2024 HIPAA Privacy Rule to Support Reproductive Healthcare Privacy (the Final Rule), which aimed to strengthen privacy protections for reproductive health information. (See Alert 2024-02). The current Administration did not appeal the decision, so the

reproductive health privacy protections no longer apply. Notably, separate requirements regarding the confidentiality of substance use disorder (SUD) treatment information remain in effect, with NPPs updates for these rules required by February 16, 2026. HHS has indicated they will release an updated model NPP, but one has not been issued to date. Employers should also monitor for state reproductive-privacy laws and other regulatory developments applicable to their plan. For additional information, see our Compliance Insight, A HIPAA Foundation for Employer Plan Sponsors.

Action Items:

☐Plan sponsors that updated their HIPAA policies and procedures to incorporate the Final Rule should work with their counsel or advisors to revert those updates.

☐Ensure NPP is updated to include SUD treatment information by February 16, 2026.

Preventive Services and Fertility Benefits

The Supreme Court Upholds Current Preventive Care Mandate

In *Braidwood Management Inc. v. Becerra*, the U.S. Supreme Court effectively preserved the Affordable Care Act (ACA) preventive care mandate, which requires coverage of preventive services assigned an "A" or "B" rating by the U.S. Preventive Services Task Force (USPSTF) without cost sharing. The case questioned whether members of the USPSTF were properly appointed under the Constitution's Appointments Clause. The Court found the USPSTF's structure to be Constitutional, thereby keeping its recommendations and related coverage obligations in place. While the mandate remains unchanged, Administration changes could affect future preventive-service requirements. We will continue to monitor for developments and in the meantime, plan sponsors should continue to comply with existing ACA preventive care obligations.

ACA Preventive Services Update for Breast and Cervical Cancer Screenings

The Health Resources and Services Administration (HRSA) has issued updated women's preventive services guidelines, which group health plans and insurers must cover without cost-sharing (in network services only) for plan years beginning on or after January 1, 2026. The updates expand breast cancer screening requirements for women at average risk to include follow-up imaging (MRIs, ultrasounds, or additional mammography) and pathology evaluations, in addition to the initial mammogram. The HRSA also introduced a new guideline requiring coverage of patient navigation services for breast and cervical cancer screenings.

Fertility Care and Excepted Benefits Arrangements

In October 2025, the Departments issued guidance on employer-provided fertility benefits, including the provision of IVF treatment, intended generally to increase access and reduce costs. (See Alert 2025-03). This guidance does not create new fertility care structures but clarifies how employers can use existing excepted benefits arrangements to provide fertility care. As outlined in the guidance, fertility benefits may be offered through independent, non-coordinated excepted benefits, such as fully-insured specified-disease or fixed-indemnity policies, if provided under a separate contract and independent of the group health plan. The guidance also confirms that excepted-benefit HRAs may reimburse out-of-pocket fertility expenses when paired with major medical coverage and compliant with annual employer contribution limits. For additional information on the provision of fertility care, please listen to our Compliant with Alliant Podcast: Designing a Compliant Fertility HRA and see our Compliance Insight, Health Reimbursement Arrangement Rules and Issues.

Action Items:

☐Stay updated on new preventive care services and vaccine recommendations, and engage with carriers and/or TPAs if updates require plan design decisions.

☐Contact their carriers and TPAs to ensure timely, compliant implementation of these breast and cervical cancer requirements.

☐Plans interested in providing fertility care should review the latest fertility care guidance to determine which options are most viable.

Litigation Update

Legal Developments Shaping Gender-Affirming Care

In 2025, two major decisions reshaped the legal environment for gender-affirming care and associated group health plan design risk. In *United States v. Skrmetti*, the U.S. Supreme Court upheld Tennessee's ban on puberty blockers and hormones for minors, reinforcing similar laws in more than 20 states. Although self-funded plans are generally exempt from state insurance mandates, the ruling creates greater uncertainty for plans covering gender-affirming care in jurisdictions with these rules. In a related development, a Mississippi federal court vacated the gender-identify provisions of the 2024 Section 1557 final rule, narrowing federal nondiscrimination protections applicable to covered entities such as providers, carriers, and TPAs that receive federal funding. While Section 1557 rarely applies directly to employer plan sponsors, group health plans may be indirectly affected if carriers and/or TPAs choose to apply these requirements broadly to the plan designs they

administer. For additional details, see our Compliance Insight, Section 1557 Final Rule and the Impact on Self-Funded Plans.

Tobacco Surcharge Litigation

Tobacco-surcharge litigation persists, with multiple lawsuits challenging employer wellness programs that imposed tobacco surcharges without offering a compliant reasonable alternative standard (RAS) or the required "full reward" under HIPAA's nondiscrimination rules for wellness programs. Courts remain divided on these issues, and several cases involving large employers are ongoing. These cases highlight the growing litigation risk for programs that impose surcharges without properly communicating and administering a compliant RAS, or providing the full reward, potentially exposing employers to multi-year refunds, legal fees, and plan design changes. For a more detailed discussion see our Compliance Insight, 101 Wellness Plan Compliance Obligations.

ERISA Fiduciary Duty Litigation

ERISA fiduciary-duty litigation continues to expand, with plaintiffs alleging new theories of liability based on participant plan selection that results in alleged "financial domination" of one plan design over another. In addition, while fiduciary breach claims alleging plan fiduciaries failed to prudently monitor PBM pricing, rebate structures, and vendor compensation persist, a federal district court judge recently dismissed the complaint in the *Johnson & Johnson* case for a second time, finding the plaintiffs failed to demonstrate a financial harm as a result of the PBM fees. The plaintiffs have 30 days to file yet another amended complaint, meaning the case could proceed if new facts are added. Similar actions against Wells Fargo and JP Morgan remain pending. See our Webinar on ERISA Fiduciary Duties in the New ERA of Class Action Litigation and listen to the Compliant with Alliant podcast episode, Phonetical Fun: Pharmacy and Fiduciary (Duties) available on SoundCloud, Apple Podcasts and Spreaker.

Action Items:

☐For multi-state plans covering gender-affirming care, remain updated on states with limitations on the provision of such care and work with your advisors and counsel to evaluate risk.

☐Evaluate wellness programs to confirm any tobacco surcharges comply with HIPAA's RAS and full reward requirements in both written policies and day-to-day administration.

☐Understand ERISA fiduciary duties, ensure service provider fee disclosures, protect the plan with written process, regularly review PBM and other service provider contracts, assess pricing terms, and document fiduciary-related decisions.

State PBM Laws

With federal efforts to regulate PBMs stalled, states continue to advance their own pharmacy-related reforms, producing a patchwork of reimbursement, reporting, and network-related requirements. Many recent measures, like California's recent sweeping PBM law, follow a familiar pattern, targeting spread-pricing arrangements, rebate pass-through obligations, anti-steering restrictions, and expanded transparency and reporting rules. The true impact of these state PBM laws on employer plans remains an open question. While ERISA generally preempts state laws that relate to self-funded employer plans, there is currently a significant amount of litigation addressing the issue of how ERISA preemption applies to these laws, with differing results so far. For example, the Supreme Court in the *Pharmaceutical Care Management Association (PCMA) v. Mulready*, determined that an Oklahoma state statute's pharmacy network requirements were preempted as they relate to a self-insured ERISA plan, while other courts have decided that state reporting requirements are not. This may indicate a trend that state law provisions attempting to regulate network design and core plan administration are more likely to enjoy ERISA preemption, while PBM reimbursement and reporting mandates may not. As more states test the limits of permissible regulation, legal challenges will persist continue as the applicability of ERISA preemption remains uncertain. We will continue to monitor developments in this space, while employers should remain vigilant of applicable state PBM laws and work with counsel and PBM vendors to evaluate compliance exposure, operational impact, and strategy as ongoing challenges arise.

Action Items:

☐For multi-state plans, direct your PBM vendor to provide periodic updates identifying state-level pricing, rebate, anti-steering, and reporting mandates that affect your plan's covered populations, along with any required operational changes.

☐Review PBM contracts with advisors to confirm they clearly assign responsibility for complying with applicable state requirements and provide appropriate protections to the plan if vendor practices or state enforcement actions create financial or operational risk.

☐Work with counsel to evaluate potential preemption issues, understand operational and cost impacts on the plan, and maintain documentation of oversight and compliance-related decisions.

Looking Ahead to 2026

As employers look ahead to 2026, health and welfare benefits compliance will continue to influence plan design and strategy. Oversight of prescription drug coverage is expected to intensity with growing momentum for PBM transparency and reform, underscoring the need to review pricing

arrangements, rebate practices, and vendor compensation. Coverage of GLP-1s will continue to spark discussion as plans balance participant demand with rising costs. Employers should also anticipate continued legislative regulatory efforts to expand fertility benefits, as well as increased flexibility for employers to offer ICHRAs. Mental health parity will remain a key compliance priority, with the Departments reassessing portions of the MHPAEA 2024 Final Rules. Finally, as always, plan sponsors should remain vigilant about their fiduciary duties as they explore the marketplace for new options to manage increasing costs, now and into 2026.