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Employee Benefits and Executive Compensation: Preparing for 2027 — Health and Welfare Plan Developments

SPEAKERS

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In this episode of *Employee Benefits and Executive Compensation: Preparing for 2027*, Troutman Pepper Locke attorneys [Lynne Wakefield](#) and [Heather Heath Ryan](#) explore the rapidly evolving health and welfare plan landscape and what plan sponsors and fiduciaries need to consider heading into 2027. The discussion opens with a foundational overview of health and welfare plan governance and fiduciary best practices, including the critical distinction between settlor and fiduciary functions, and explains why robust governance structures are increasingly essential in today's legal and regulatory environment.

From there, Heather and Lynne turn to the key developments driving risk and change for plan sponsors, including the surge in breach of fiduciary duty litigation involving prescription benefit managers (PBMs), voluntary benefits, and tobacco surcharges; new CAA 2026 disclosure and reporting requirements for group health plan service providers; proposed DOL regulations expanding PBM fee transparency; recent guidance on fertility benefits; anticipated guidance on mental health parity (MHPAEA) and overfunded VEBAs; and considerations related to GLP-1 coverage. Whether you are evaluating your PBM contracts, reviewing your voluntary benefits offerings, or building out your health and welfare plan committee structure, this episode offers practical insights to help your organization manage risk and prepare for the year ahead.

Listeners can find updates on Trump accounts, executive compensation, and retirement plans in other episodes in the series.

Transcript

Episode: *Employee Benefits and Executive Compensation: Preparing for 2027 – Health and Welfare Plan Developments*

Hosts: Heather Ryan and Lynne Wakefield

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Heather Ryan (00:05):

Hi everyone. Welcome to our podcast series, *Employee Benefits and Executive Compensation: Preparing for*

2027. I'm Heather Ryan, and I'm joined today by my colleague, Lynne Wakefield.

Lynne Wakefield (00:17):

Thanks, Heather. I'm excited to chat with you today about recent health and welfare plan developments and considerations for plan sponsors and fiduciaries as we head into 2027 and beyond.

Heather Ryan (00:27):

Given the changing landscape for health and welfare plan governance and administration, it really is an interesting time to be advising on these issues. Typically, in this podcast series, we review key year-end actions and amendments for health and welfare plans based on legislation, regulatory, and other agency guidance issued throughout the year. However, unlike the retirement and 401(k) plan space with the SECURE and SECURE 2.0 amendments, this is a relatively light year from a health and welfare plan amendment perspective.

Lynne Wakefield (01:01):

Agreed, but that doesn't mean that the health and welfare plan space has been quiet. Quite the opposite. We've recently seen an uptick in health and welfare plan breach of fiduciary duty litigation related to the selection and monitoring of prescription benefit managers, or PBMs, voluntary benefits like critical illness and hospital indemnity plans, and tobacco surcharges.

Heather Ryan (01:23):

We also have the recent legislation and proposed regulations regarding prescription drug transparency and enhanced reporting and disclosure for group health plan vendors. And the PBM space really seems to be evolving with new players entering the market and movement away from traditional PBMs, creating interesting fiduciary and contracting issues.

Lynne Wakefield (01:45):

Right. And there's also been new guidance issued on a variety of health and welfare plan issues, including fertility benefits, and it seems like everyone is anxiously awaiting the issuance of the new proposed mental health parity regulations and hoping for some VEBA guidance as well.

Heather Ryan (02:01):

My clients are definitely focused on these topics in the health and welfare plan space. We will dig into these developments during today's podcast, but before we do that, it may be helpful to take a step back and talk about health and welfare plan governance and fiduciary duties just generally. A bit of level setting, so to speak. So, given the important role these concepts play in all the developments we'll be talking about, Lynne, why don't you take us away?

Lynne Wakefield (02:24):

That's a great idea, Heather. There's definitely a lot to cover here, so let's jump right into the substance. Why don't we start with how you've typically seen health and welfare plan fiduciaries address health and welfare plan governance?

Heather Ryan (02:38):

You know, it seems like health and welfare plan governance is inconsistent at best, similar to how 401(k) plan

governance was maybe a decade or two ago. At this point, most plan committees have a solid grasp on 401(k) and pension plan governance and fiduciary best practices. Things like making sure there is a clear delegation from the board or the compensation committee to the fiduciary committee, a current charter, a regular cadence of conducting RFPs for 401(k) plan recordkeepers and investment consultants, and a process for monitoring recordkeeping and investment fees and expenses and reviewing recordkeeper and investment option performance. These are common, basic table stakes. It's been a journey for most of my clients to get to this point, and the emphasis on 401(k) procedural prudence has been in large part due to the significant 401(k) plan fee litigation we've seen over the last couple of decades. In contrast, health and welfare plan governance still seems to be in its infancy, with practices a little more all over the map.

Lynne Wakefield (03:41):

I agree. It seems like a lot of companies continue to have individuals within the HR function selecting TPAs and insurers. There may be regular monitoring of performance and a regular cadence of RFPs, but there may not be. And there's also a lack of documentation evidencing the factors that were considered in the selection process, the rationale for selecting particular vendors, and how the performance of those vendors is evaluated, if at all. And all of this is before we even talk about the fee structures, which can be murky with a lack of transparency, complex commission structures, and in the PBM space, the role of rebates. I think even for those companies that have a committee structure in place with respect to their health and welfare plans, there seems to be some confusion about the scope of the committee's authority. The committee may be looking at health and welfare plan design and cost issues, which are historically settlor functions, rather than focusing on their fiduciary obligations.

Heather Ryan (04:39):

This is so true, and a helpful prompt for a quick reminder on the distinction between settlor and fiduciary functions. A settlor function is essentially a plan design function that is not subject to ERISA's fiduciary duty obligations. Examples of settlor functions include things like deciding to add or remove a medical plan option, changing the funding mechanism for a medical plan from an insured to a self-insured arrangement, changing coinsurance, deductibles, and out-of-pocket maximums, setting premiums, and even deciding to add or terminate a plan. It's important that these types of activities be exempt from ERISA's fiduciary duties because, in reality, there are certain changes that would likely never be able to be made if they weren't. For example, given the fiduciary obligation to act solely in the interest of participants and beneficiaries, it would be impossible to ever remove a medical plan option, increase premiums or cost-sharing, or even terminate a plan if these types of settlor functions were subject to ERISA fiduciary duties.

Lynne Wakefield (05:41):

Right. While the fiduciary functions are focused more on plan operation and administration, things like making sure that the plans are being administered in accordance with their terms, reporting and disclosure requirements are being satisfied, and vendors are being selected in the best interest of participants and beneficiaries, both with respect to the services that are provided and the related fees. ERISA also requires plan fiduciaries to act prudently under the circumstances and to avoid conflicts of interest. Recognizing that the ERISA fiduciary duties are essentially the same in the 401(k) plan space as they are in the health and welfare plan space, what are your thoughts about how governance should be structured for health and welfare plans?

Heather Ryan (06:22):

From my perspective, the gold standard and what we're seeking to achieve here is something similar to what

exists for 401(k) plan governance today: a clear, documented process of evaluation and decision-making that includes clear delegations of fiduciary authority and the scope of such authority, regular RFP processes for health and welfare plan third-party administrators and insurers, a clear understanding, evaluation, and approval of fees and expenses, consistent monitoring of performance and fees, and of course, strong documentation to evidence adherence to the ERISA fiduciary duties.

Lynne Wakefield (07:00):

Do you think that there necessarily needs to be a dedicated health and welfare plan committee, or is it possible for other structures to work?

Heather Ryan (07:06):

I don't think there's necessarily any magic to the governance structure as long as the fiduciary obligations are being satisfied. You could have a dedicated health and welfare plan committee, a benefits committee with authority over both health and welfare plan and 401(k) administration with a separate 401(k) plan committee for investments, or one benefits committee that does it all. The problem is that, given the scope of responsibility, having one committee with authority over all of these things can be very time-consuming for the committee members, and it does get harder to make sure the committee is devoting the requisite amount of attention to the areas within the scope of their fiduciary responsibility.

Lynne Wakefield (07:46):

Right. I've also seen a general benefits committee with various subcommittees or a committee with a delegation to HR to select and monitor TPAs and insurers. I think the subcommittee structure can work, but in my experience, the delegation to HR is a little bit more challenging just because it gets harder to demonstrate that the various fiduciary obligations are being satisfied if you don't have a regular cadence of committee meetings with materials and minutes. If I had to pick a favorite structure, I'd probably go with a benefits committee that has fiduciary responsibility for the administration of all plans, including 401(k) and health and welfare, and a separate committee with authority over 401(k) plan investments. What about you, Heather? What is your ideal structure?

Heather Ryan (08:32):

You know, Lynne, my preference has changed over the years, and assuming that committee members have a firm grasp on the distinctions between settlor and fiduciary decisions and related duties, I've recently liked one retirement committee with purview over design, administration, and investment, and a separate health and welfare plan committee that covers both design, settlor, and fiduciary functions. The members of those committees could have some overlap if desired, but I find more finance and treasury representation on the retirement plan committees than on the health and welfare plan committees. There really is a lot to think about in terms of how you set up health and welfare plan governance, and it is an additional time commitment for individuals within the organization who are already busy in their everyday jobs. In addition to being the right thing to do for participants and beneficiaries, it's also a critical risk mitigation strategy. Given this, putting in this type of structure may seem like an uphill battle, but there are things folks can do efficiently to set up a workable structure pretty quickly. Frankly, I don't believe a more laid-back or amorphous governance approach can really withstand all of the new considerations, legal claims, and risks that we are now seeing in the health and welfare space. Which brings us to the recent health and welfare plan developments. Lynne, why don't you start us off with highlighting the key claims being raised in PBM litigation, the current status of those cases, and related fiduciary implications?

Lynne Wakefield (10:01):

Will do. I think it's fair that there has been a lot of press on 401(k) plan litigation, but in recent years, there have also been several class action lawsuits brought against medical plan fiduciaries with respect to their PBMs. These cases have included a variety of different allegations. So just to highlight a few, plaintiffs in these cases have claimed that the process by which the fiduciary chose and/or retained their PBM was not an open RFP process, was not diligent or consistent with applicable fiduciary standards, and did not consider the full range of options available for PBM services. They've claimed that the fiduciary allowed its selection of the PBM to be guided by a broker with a conflict of interest and that the broker receives indirect compensation from the PBM in connection with its clients' use of the PBM. They've claimed that the fiduciary failed to adequately negotiate the plan's contract with the PBM and failed to prudently exercise its rights under the contract. They've claimed that the fiduciary failed to adequately consider contracting with a pass-through PBM instead of a traditional PBM for all of the plan's prescription drug needs, and these claims go on and on.

So, they've also claimed that the fiduciary failed to adequately consider carving out their specialty drug program from their broader contract with the PBM. They've claimed that the fiduciary mismanages its medical plan by paying its PBM inflated prices for generic specialty drugs that are widely available at a much lower cost. They've claimed that the fiduciary required participants to obtain all prescriptions for specialty drugs from the PBM's mail-order pharmacy, even though prices were routinely higher than the prices retail pharmacies charge for the same drugs. And they've claimed that the fiduciary breached its fiduciary duties by using pricing methods that are deceptive, misleading, arbitrary, illusory, unpredictable, and allow for inconsistent reimbursements. I think the nature of the plaintiffs' claims really highlight the importance of the various steps that need to be taken in the PBM selection and negotiation process, from considering a variety of different types of PBMs and selecting an independent broker to negotiating contract terms and pricing structures and having a clear understanding of the fees being charged.

Heather Ryan (12:24):

I got to say, sounds pretty overwhelming to be in the PBM space, but how have these cases played out in the courts to date?

Lynne Wakefield (12:31):

Yeah. So although these cases highlight the types of conduct that can be scrutinized in connection with the selection of a PBM, to date the cases have largely failed for lack of standing due to the plaintiffs' inability to demonstrate actual harm. So the courts have held that medical plans are more analogous to defined benefit pension plans than 401(k) plans, where the benefits to be provided are contractually defined by the plan terms and the plaintiffs aren't able to show that they were actually harmed by the fiduciary's conduct. The plaintiffs have tried to address this issue by adding additional members to the class such as COBRA continuants, but this has largely proven unsuccessful as well. One thing that I do think is worth mentioning, however, is that at least one court recently allowed some of the plaintiffs' claims to proceed beyond the pleading stage, holding that the plaintiffs adequately alleged standing with respect to their prescription drug overpayment and prohibited transaction claims. The court's decision was based on the recent Supreme Court decision in *Cunningham v. Cornell*, where the court determined that a plaintiff only had to allege the elements of a prohibited transaction to survive a motion to dismiss, and that it was up to the defendant fiduciaries to show that all requirements for the prohibited transaction exemption were satisfied.

Heather Ryan (13:55):

So it sounds like even though plaintiffs were allowed to proceed in this case, the cases so far are playing out more favorably for defendants. Is that correct?

Lynne Wakefield (14:03):

I think that's right, although I'm sure plaintiffs' attorneys are going to continue to look for creative ways to pursue these types of claims. And the Cunningham case I just mentioned, which I know we'll talk about in a little bit more detail later on in the podcast, may make it more difficult for defendants to survive a motion to dismiss and puts pressure on plan fiduciaries to be able to demonstrate and substantiate that a prohibited transaction exemption, like the exemption for reasonable compensation paid to parties in interest for necessary services, is satisfied. So I think that as these cases continue to play out, it will be really important for health and welfare plan fiduciaries to take stock of how they are handling PBM selection and monitoring and documenting their PBM selection process and considerations. The PBM compensation issues are tricky though, given that they are so difficult to understand. The CAA provisions on broker and consultant disclosures were the first legislative effort to address some of these concerns. And now with CAA 2026, most group health plan service providers are subject to these enhanced disclosure rules. Heather, can you give us some background on those rules, how they impact the plan fiduciaries, and actions plan fiduciaries should be taking to ensure compliance?

Heather Ryan (15:20):

Sure thing. For background and as you were just alluding to, when a group health plan engages a service provider for plan services, the arrangement is generally a prohibited transaction under ERISA Section 406 unless it qualifies for an exemption under ERISA Section 408. Importantly, ERISA Section 408(b)(2) exempts arrangements entered into for necessary services so long as the compensation is reasonable. CAA 2021 amended ERISA Section 408(b)(2) to require brokers and consultants providing services to a group health plan to provide written disclosure of both expected direct fees and expected indirect third-party fees in order to qualify for this exemption. CAA 2026 went further and expands the disclosure requirement established by CAA 2021 to basically all group health plan service providers, not just brokers and consultants. This includes PBMs as well as third-party administrators, stop-loss carriers, and vendors providing medical management, disease management, and employee assistance program services. To avoid these service provider arrangements being classified as prohibited transactions, plan fiduciaries must now ensure they receive 408(b)(2) disclosures from such service providers and should carefully evaluate and document evaluation of the total compensation disclosed for reasonableness.

Lynne Wakefield (16:51):

Yeah. I think this is helpful clarification given that there was previously some question regarding who was included in the legislative reference to brokers and consultants. When are the new CAA 2026 requirements effective?

Heather Ryan (17:04):

This expansion is effective now, and fiduciaries should be asking any new or renewing providers for this information as part of the evaluation and contracting process, incorporating the requirements into vendor contracts and assessing these fees for reasonableness. No doubt with these expanded disclosure requirements, the plaintiffs' bar will start focusing in on excessive fee claims in the group health plan context. My experience so far is that service providers aren't ready to provide this type of disclosure, but that doesn't mean that plan fiduciaries shouldn't be asking about it. This is just the first step. Given the current market environment with continued

increases in the cost of prescription drugs and obscure and opaque pricing structures persisting, CAA 2026 also added additional legislation addressing PBMs, and the Department of Labor issued proposed regulations that are consistent with CAA 2026 requirements earlier this year. Lynne, can you give our audience a high-level overview of the basic provisions in the legislation and the proposed regulations and how they may impact plan fiduciaries?

Lynne Wakefield (18:13):

Yeah, this area is really evolving so quickly at this point, and to a large extent, the content of the legislation and the proposed regulations overlaps. The provisions of the CAA 2026, which are effective for plan years beginning after August 3rd, 2028, require significant changes to PBM contracts, new reporting from PBMs to plan sponsors, and new reporting from plan sponsors to participants. The proposed DOL regulations address PBM compensation and if finalized, will be effective for plan years beginning on and after July 1, 2026. So soon. The goal of the legislation is to encourage more transparent PBM pricing models, which should allow for better fiduciary oversight. So a key component of the legislation is a requirement that PBMs remit 100% of rebates, fees, and other compensation received in connection with drug utilization and spending to the medical plan.

From a reporting perspective, the legislation requires PBMs to provide certain medical plans lists of drugs for which a claim was filed, including participant cost-sharing and the amount of rebates and discounts, as well as a list of all drugs for which the plan incurred \$10,000 or more in gross spending, or the top 50 drugs in gross spending if fewer than 50 drugs resulted in \$10,000 or more in gross spending. The reporting will have to be provided on at least a semi-annual basis, or the fiduciary can request it on a quarterly basis. The legislation also requires medical plans to provide participants and beneficiaries with an annual notice regarding the requirement for PBMs to provide reporting upon request, the summary PBM reporting data if requested, and detailed information with respect to any specific claim incurred by the participant. Failure to satisfy the requirements can give rise to civil monetary penalties of up to \$10,000 per day.

Heather Ryan (20:10):

Those are steep fines. So from a fiduciary perspective, it will be critical for plan fiduciaries to ensure that all of the compensation is being passed through to the plan, to review and monitor reporting provided by the PBM, and to ensure that required reporting is being provided to the participants. What about the proposed regulations?

Lynne Wakefield (20:29):

Yeah, so just before the legislation was passed in January of this year, the DOL issued proposed regulations that would, if finalized, significantly expand the fee and compensation disclosure requirements for PBMs and brokers and consultants serving self-insured group health plans in connection with PBM services. The proposed regulations establish a requirement for PBMs to provide disclosures regarding compensation before plan fiduciaries enter into, extend, or renew a PBM contract, and require PBMs to disclose any conflicts of interest and clarify their fiduciary status to plan sponsors. Required disclosures would include direct and indirect compensation, including estimated rebates, spread pricing and copay clawbacks, and compensation for termination of contracts. In addition, the proposed regulations would impose semi-annual reporting requirements for actual compensation, require an explanation if actual compensation materially exceeds the estimate in the initial disclosure, and grant plan fiduciaries an annual audit right that does not restrict the terms and conditions of the fiduciary's audit or selection of auditor. From a fiduciary perspective, there's going to be more for fiduciaries to monitor, evaluate, and document, which is just another reason why it's important to ensure that a solid governance structure is in place, like we talked about earlier in the podcast. So that's a lot of talk about PBMs and prescription drugs, but there

have also been breach of fiduciary duty lawsuits filed with respect to voluntary benefits and tobacco surcharges. Can you give us a summary of the voluntary benefits litigation and related fiduciary implications?

Heather Ryan (22:13):

Sure. Voluntary benefits are generally supplemental benefits such as accident, critical illness, cancer, and hospital indemnity insurance offered by employers on a strictly voluntary basis and fully paid by employees, typically via payroll deductions. Historically, these benefits have been viewed as outside of ERISA's scope pursuant to a DOL safe harbor and therefore considered low to no risk to employers. That's changing. Most programs clearly satisfy two of the four safe harbor requirements: voluntary employee participation and employers not subsidizing premiums. But employers may most often lose voluntary benefits exemption where they take an action or actions to endorse the voluntary benefits or receive consideration as a result of providing the voluntary benefits. Four recently filed class actions brought by a prominent plaintiffs' law firm against large employers and national consulting groups allege that certain voluntary benefit plans offered by the employers do not comply with the DOL safe harbor and are therefore subject to ERISA. As such, the lawsuits allege that employers are plan fiduciaries and breached their duties by failing to engage in a prudent process to monitor, evaluate, and select carriers, negotiate lower broker commissions, and identify better loss ratio options.

Further, the plaintiffs allege that employers have engaged in self-dealing in that the employers receive consideration for the voluntary benefits if the employer receives a discount on other benefits or receives rebates or uses commissions related to that voluntary coverage. Perhaps encouraged by the lower pleading standard set in the *Cunningham v. Cornell* Supreme Court decision you talked about earlier, Lynne, the lawsuits also allege that the plan fiduciaries engaged in prohibited transactions with consultants for these supplemental benefits. While we don't have a sense yet of how successful these claims will be, it is time for companies to more closely examine their voluntary benefits in light of these developments and for fiduciaries to engage in a more rigorous review and evaluation of the nature of the products and fees associated with them. But let's not stop there, Lynne. Tell us about the increase in tobacco surcharge litigation.

Lynne Wakefield (24:33):

So I'll do that, but one thing I want to just mention and hone in on briefly is the safe harbor for the voluntary plans and the endorsement requirement that you mentioned. It is really easy for actions with respect to a voluntary benefit to constitute endorsement. So even mentioning the benefit in an enrollment guide, in a communication that's affiliated with the company, can constitute endorsement. So I do think it's very difficult to satisfy the safe harbor, again kind of emphasizing why it's so important for health and welfare plan fiduciaries to be examining the issues that you spoke about, Heather. So then moving on to the tobacco surcharge litigation, over the last couple of years, there have been at least 50 different cases filed alleging that medical plan tobacco surcharges or discounts violate the HIPAA and ACA wellness program requirements as well as ERISA's fiduciary standards. So the primary claims being made in these cases are that the tobacco surcharge or discount program does not provide a reasonable alternative standard, that employees who are subject to the surcharge or who are not given the discount do not have access to the full reward upon completion of the reasonable alternative standard at least once per year, and that the program does not provide adequate notification of the availability of the reasonable alternative standards. Some of the complaints also allege that imposition of the tobacco surcharge is a breach of an employer's fiduciary duty under ERISA.

Heather Ryan (26:05):

Okay. So a large uptick of these cases, but have they been successful?

Lynne Wakefield (26:09):

At this point, there does not yet appear to be a clear consensus among the courts regarding how the HIPAA and ACA wellness program requirements should be applied. Some of the cases have survived a motion to dismiss, some have been dismissed, and others have settled out of court. So while these cases are continuing to work their way through the courts, it's important that medical plans with tobacco surcharges or tobacco user discounts be carefully reviewed to ensure compliance with the HIPAA and ACA requirements. So even if there aren't necessarily critical year-end amendments that need to be implemented for health and welfare plans this year, there's definitely a lot for plan sponsors and fiduciaries to be thinking about in the health and welfare plan space, and having a strong fiduciary governance structure is the best place to start in an effort to address these issues. Before we wrap up, let's switch gears and cover some other recent and anticipated guidance in the health and welfare plan space.

Heather Ryan (27:30):

I think most plan sponsors are anxiously awaiting the issuance of the new proposed mental health parity regulations, which are still expected by the end of the year. The new regulations are a function of recent litigation challenging the final mental health parity regulations issued back in 2024. And this spring, the agencies indicated that rather than continuing to defend the regulations in litigation, they would rather issue new regulations. The fact that the regulations are in a state of flux creates interesting challenges for plan sponsors, given that the statutory requirement to conduct and document a non-quantitative treatment limitations analysis is still in effect. So what does a plan sponsor do while they're waiting for these regs?

Lynne Wakefield (28:14):

This is a tough one. I think even while the guidance is in flux, I am continuing to see plan sponsors retain third-party service providers to prepare the NQTL analysis, but the service providers still seem to be struggling to obtain all of the information they believe is required for the analysis from the TPAs. And there are different views between the TPAs and the service providers on exactly what is required. It will be nice to see those new proposed regulations and hopefully get some clarity, but in the meantime, I think that it is prudent to go ahead and be conducting these NQTL analyses so that they can be available to provide to the DOL or a participant in response to a request.

Heather Ryan (28:59):

The DOL has provided some additional direction on its enforcement priorities in this space, with a new field assistance bulletin released the day after Labor Day, so plan sponsors can also take a look at that guidance as well. All right. Lynne, anything else that health and welfare plan sponsors need to be aware of and keep in mind? There's certainly a lot so far.

Lynne Wakefield (29:05):

Yeah. So I think for those plan sponsors who offer or are thinking about offering fertility benefits, it's important to note that the agencies issued proposed regs describing the required structure for these benefits to be considered HIPAA excepted benefits. So that's worth a read. Also, just a quick mention that the agencies have indicated that guidance on overfunded VEBAs is forthcoming, so plan sponsors with overfunded VEBAs should be on the lookout for that guidance. And I guess the last thing I would mention is that plan sponsors still seem to be

grappling with the high cost of GLP-1s prescribed for weight loss purposes, potential plan designs to reduce costs while remaining compliant, and the medical plan implications of participants purchasing these drugs direct-to-consumer.

Heather Ryan (29:52):

I agree this is a significant issue, particularly in light of some of these direct-to-consumer models that are becoming more widely available. Many of my clients are having these discussions right now, and they are considering including required management programs as a way to increase or enhance other lifestyle changes that could lead to more sustainable results over time when they allow for these drugs to be used for weight loss purposes. For additional information about legal considerations related to medical coverage for GLP-1s, refer to the resources section of this podcast webpage for additional content. This is surely a changing health and welfare landscape right now, and plan sponsors and fiduciaries have a lot to consider as they head into open enrollment for 2027. I think what we've also said is as these issues arise, do not forget the needed plan governance and structure around these decisions, as it is essential to minimize risk and position your organization for success in the years ahead. That wraps up our episode for today. If you have any questions or need further assistance, please don't hesitate to reach out to our team at Troutman Pepper Locke.

Lynne Wakefield (31:02):

And be sure to check out the additional episodes in our series, *Employee Benefits and Executive Compensation: Preparing for 2027*. We'll be covering other key developments in the employee benefits and executive compensation space. Thanks for listening.

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