***Employee Benefits and Executive Compensation Preparing for 2026* – Top Five Health and Welfare Updates**
Hosts: Lydia Parker and Laura Ferguson
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Lydia Parker (00:05):

Hi everyone, I'm Lydia Parker, and joining me is my co-host Laura Ferguson. We're partners in Troutman Pepper Locke's Employee Benefits and Executive Compensation Practice. And today we're going to discuss the top five health and welfare updates for 2025

Laura Ferguson (00:20):

From legislative changes to emerging litigation trends. We'll unpack what these updates mean for plan sponsors and how to navigate the evolving legal landscape. Alright, Lydia, what did you choose as your first topic?

Lydia Parker (00:33):

I'm going to go with the One Big Beautiful Bill Act, which was passed in 2025 and has a few implications for health and welfare plans, at least one of which will likely require an amendment to existing cafeteria plans.

Laura Ferguson (00:47):

The amendment item should likely be on top of plan sponsor's mind as the end of the year approaches. Is that the dependent care FSA contribution increase?

Lydia Parker (00:55):

Yes, exactly. The OBBB increases the annual dependent care FSA limit from $5,000 to $7,500 or if for married individuals filing separately $2,500 to $3,750. And there's no adjustment for inflation. So similar to the current limit and the change is effective for plan years beginning after 12/31/25. So, for calendar years, that's going to be January 1st, 2026. And what we'll need to look out for is that cafeteria plans may bake in the $5,000 limit. So, if plan sponsors want to take advantage of the increased limit, that's going to require a plan amendment. And then on the other hand, a plan may refer to the statutory limit by reference. And so, if the plan sponsor doesn't want to increase the limit to $7,500, that will require a plan amendment. So, either way, you need to look at your plan document and see how it references the limit and whether an amendment would be required.

Laura Ferguson (01:58):

I know there were several other changes which may not as directly impact year end amendments, but what are some of the other provisions plan sponsors may want to be aware of when planning their health and welfare plan design for 2026?

Lydia Parker (02:11):

I think the changes to HSA eligibility provisions is an interesting one that could impact design for 2026 and one change relates to telehealth. So, the agencies previously granted temporary relief to the HDHP HSA rules that allowed employers to offer telehealth coverage pre deductible under an HDHP without jeopardizing individual's HSA eligibility. And that relief also provided that the telehealth coverage is not disqualifying coverage and the OBBB makes that permanent. And then in addition, direct primary care arrangements with monthly premiums of $150 or less are no longer disqualified coverage.

Laura Ferguson (02:55):

So, the changes to the treatment of telehealth and direct primary care arrangement for HSA eligibility is different?

Lydia Parker (03:02):

Yes, it's slightly different, which is not kind of what you're seeing sometimes they're kind of lumped together. But as background, there are two requirements for someone to be HSA eligible, they have to be covered by an HDHP and they can't have disqualifying coverage. So, the telehealth rules solve for both of those issues. So, an HDHP can offer it and it's not disqualifying coverage, but the direct primary care arrangement language only solves for the latter. So, it seems like based on the drafting that an employer's HDHP couldn't offer a direct primary care arrangement without jeopardizing its status as an HDHP.

Laura Ferguson (03:46):

Interesting. Anything else from the OBBB?

Lydia Parker (03:47):

There are a couple things that may impact fringe benefits. So, for one example, it does index the limit for educational programs exclusion under code section 127. So that has historically been $5,250 and that's now adjusted for inflation. It also eliminates the exclusion for qualified bicycle commuting reimbursement and it modifies the inflation adjustment calculation that's used to calculate the limitation on the exclusion for all qualified transportation fringe benefits, some small changes there. And then the moving expenses exclusion, which had been temporarily suspended for all employees except certain members of the armed forces, has been permanently terminated. Although that exception for armed forces members has been expanded to include certain members of the intelligence community. And I think the last thing

worth mentioning are the new Trump accounts, which are new tax preferred accounts for children that are generally treated, at least from a tax perspective, like traditional IRAs.

And the media has focused on the seed money that the government will contribute to these accounts for certain children. But the OBBB contemplates employer contributions of up to $2,500 adjusted for inflation on a tax-free deferred basis to these accounts, subject to a lot of rules. But that new ability of employers to contribute to accounts for employee dependent may create a new opportunity to attract and entertain employees, which is what our clients are always looking to do. But I will say word of warning of these accounts are going to be subject to non-discrimination testing rules similar to dependent care FSAs. So, this won't be a mechanism to just add additional compensation for your highly comped employees. So definitely a few interesting developments from the OBBB.

Laura Ferguson (05:46):

Now on to one of the more interesting topics in the welfare space. In my opinion, the Mental Health Parity and Addictions Equity Act sometimes referred to as MHPAEA. Broadly speaking, MHPAEA is a law that prohibits discrimination based on an individual's mental health condition or substance use disorder. Plan sponsors must prepare the non-qualitative treatment limitations analysis required by ERISA section seven 12 A eight, which we usually refer to as a comparative analysis. Conducting this analysis is challenging for self-funded health plan sponsors, given they're not the parties administering the health plan, and they're usually not an expert in the claims administrator's processes.

Lydia Parker (06:25):

I feel like a lot of plan sponsors thought they didn't need to do the comparative analysis now that the 2024 final rules aren't being enforced because of that lawsuit brought in January 2025 by the ERISA industry committee against the government agencies that issued the final rules.

Laura Ferguson (06:43):

Exactly. There's confusion around this. That case resulted in non-enforcement of those final rules, which contained agency guidance on implementing the law. However, the underlying law in ERISA is still in effect and enforceable. And the requirement to prepare that NQTL analysis is alive and well. As a refresh, ERISA 712(a)(8) requires the group health plan that provides both medical and surgical benefits and mental health or substance use disorder benefits to perform and document a comparative analysis of the design and application of non-qualitative treatment limitations, which I refer to as NQTLs.

Lydia Parker (07:21):

And just for the listeners, what exactly is an NQTL?

Laura Ferguson (07:25):

An NQTL is generally a limitation on the scope or duration of benefits for treatment, things that are more subjective and by its definition non-quantitative. So things like prior authorization requirements, medical necessity criteria, step therapy, fail first therapy criteria for pharmacy or formulary development requirements. To comply with MHPAEA plan's use of these NQTLs cannot be more stringent for mental health and substance use disorders versus medical and surgical issues both in writing and in operation. So, the comparative analysis should demonstrate the plan's compliance and being made available upon request to participants and the Department of Labor along with all supporting information.

Lydia Parker (08:07):

What are the most challenging aspects of putting together the comparative analysis? And do you have any tips for plan sponsors on how they can tackle it?

Laura Ferguson (08:15):

The first step is requesting the claims administrator's comparative analysis that they use for their insured book of business and requesting confirmation of whether the plan sponsors self-funded plan is administered consistently with that insured book of business. And if not, what are the differences in administration that need to be addressed in the plan sponsors analysis.

Lydia Parker (08:35):

And is it safe to assume that most plan sponsors just follow the insurer's process? Is that typically what you found?

Laura Ferguson (08:42):

Yes, that's right. Our clients have always been advised they're following the insurer's standard processes across its books of business. With that knowledge in hand, the plan sponsor needs to review the insurer's analysis and develop anything that's missing, which will require asking various questions of the claims administrator and building out the documentation needed to support the processes. A few issues I've seen during the DOL audit process is that sometimes the claims administrator updates their comparative analysis for the insured book of business, but they don't provide the self-funded plan sponsor with an updated analysis. Usually the claims administrator updates this analysis as a result of DOL audits of their client plans. So those updates should be appropriate for the self-funded plan sponsor as well, and that the analysis should be updated. So I always recommend to clients, it's important to periodically ask your account representative whether updates have been made so you have the latest version and can review and update your own analysis and be ready for requests if access is requested by a participant or a DOL audit arises.

Similarly, sometimes the claims administrator has stopped a certain administrative practice that violated MHPAEA. For example, if they used to impose a restriction on the availability of private rooms such that only medical or surgical issues would result in coverage for a private room and

treatment for mental health or substance use disorder would not permit a private room that had to change. So, the ways we find out about this usually is if the plan sponsor requests new benefit booklets every year, they're going to notice those changes. If the plan sponsor hadn't changed, their benefits in any way, this could be something that they would miss. So, I always recommend our clients reach out every year, get new benefit booklets from the claims administrator, ask for those updates for the analysis as well, and that'll help inform the annual updates they need to make their own analysis.

Lydia Parker (10:33):

Yeah, that makes good sense. So, let's say we have our comparative analysis ready. Can we put it on a shelf and we just going to wait for a participant request or a DOL audit?

Laura Ferguson (10:43):

That would be amazing, wouldn't it? The analysis actually needs to be reviewed at least annually to ensure that it reflects the current terms of the plan and the administration by the claims administrator. And I say that because most plans aren't changing things mid-year. Generally, we're usually operating on a plan year basis. Of course, if the plan sponsor is aware of a material change to the plan or is informed of a claims administrator updating their processes, then they should do that update sooner. One of the important issues that is always on my mind is that if a participant is appealing the denial of a claim and they're requesting the portion of the analysis relevant to that claim. It's critical that portion reflects accurately the administration for that type of claim and shows that everything is at parity. That should hit the high notes on MHPAEA.

Lydia Parker (11:29):

Perfect. So, I think that comes to me for topic three. And for that one, I picked tobacco surcharge litigation. And this is the litigation that's being brought against plan sponsors alleging that they improperly charge participants a surcharge for using tobacco. So, for example, you have a plan sponsor that generally charges a hundred dollars per paycheck for self only medical coverage, but for tobacco users that amount is $150 per paycheck. These surcharges have been the topic of many class action lawsuits over the last couple of years with over 20 pending in 2024 alone.

Laura Ferguson (12:06):

I do feel like I've been seeing a lot of these cases since this is legal podcast. What are the legal requirements that underlie these lawsuits?

Lydia Parker (12:14):

They mainly relate to the HIPAA non-discrimination provisions, which are applicable to wellness programs, and the rules are really complex. But just to give an overview, wellness programs that provide medical care, so think biometric screenings, physical exams, they need to be designed to comply with HIPAA's non-discrimination rules. The compliance requirements vary based on

the wellness program type. So, you can think participation only versus activity only health contingent or outcome-based health contingent. And for an outcome-based health contingent program like a tobacco surcharge program, an employer can only reward an individual if the reward is available to all similarly situated individuals. And the reward is only available to all similarly situated individuals if it provides a reasonable alternative standard. So that's going to be the key to most of this litigation is that reasonable alternative standard as another means to earn the same reward. And that's regardless of whether it's unreasonably difficult due to a medical condition or medically and advisable to attempt to satisfy the standard. And then of course, wellness programs are also subject to ERISA.

Laura Ferguson (13:32):

And how does that tie to the recent wave of tobacco surcharge litigation?

Lydia Parker (13:36):

The allegations in the majority of these cases again relate to the reasonable alternative standard, but there are a few different variations. So, some argue that the wellness program failed to offer a reasonable alternative standard at all. And usually for a tobacco surcharge, we see the reasonable alternative standard being a tobacco cessation program. So maybe this just wasn't offered and some of the allegations relate to the failure to notify participants of the reasonable alternative standard and the notice requirements. And the HIPAA non-discrimination rules are pretty specific, and you're supposed to include notices in any communication describing the wellness program. So honestly, it's kind of easy to mess them up or to not completely fit within the requirements. And then there are cases alleging the failure to refund premiums after completion of the small alternative standard. And this is another one that can be tricky because some programs are designed to only remove the surcharge on a prospective basis after the tobacco cessation program is complete. And plaintiffs are arguing that adjustments to the premium should be removed for the entire plan year, so they should be retroactively removed once the program is complete. So, a couple different flavors of that kind of reasonable alternative standard issue. And then of course, because we're in the benefit space, we have to kind throw in the breach of a recess fiduciary duty claims.

Laura Ferguson (15:03):

That's always there, isn't it? So, what are the takeaways for plan sponsors?

Lydia Parker (15:07):

I would say if you have a tobacco surcharge review the design of your program and your notice is describing the program to make sure they comply with the HIPAA non-discrimination rules. And then I've also really had clients assess, do a more broad assessment of whether the tobacco surcharge is accomplishing what they're intended to accomplish and whether it still makes sense from a business perspective and based on this new litigation to still have the tobacco surcharge at all.

Laura Ferguson (15:39):

And now for a more boring topic that I will refer to as please don't forget, your welfare plan documents are important too.

Lydia Parker (15:46):

So, are we going to lecture plan sponsors about this today?

Laura Ferguson (15:50):

I mean, lecture, reminder, it's a fine line, but I think it's important. Many times, welfare plan documents are seen as less important than retirement plan documents, and it makes sense when you look at historical enforcement activity by the IRS and DOL, which most of the time focused on retirement plans. But nowadays, a DOL Group Health Plan audit really is not as rare.

Lydia Parker (16:11):

And an audit will always get our attention. So, what does the DOL typically ask for?

Laura Ferguson (16:17):

The DOL notes in the audit letter the purpose of the audit is to determine whether any person is violated or is about to violate any provision of this title or any regulation or order they're under and require the submission of reports, books and records, and the filing of data in support of any information required to be filed with the DOL. So very broad. They also state that they're going to review compliance with HIPAA, the Newborns and Mother's Health Protection Act, Women's Health and Cancer Rights Act, Mental Health Parity and Addiction Equity Act, Genetic Information Non-Discrimination Act, and the Patient Protection Affordable Care Act, of course, and the Healthcare and Education Reconciliation Act as we all refer to those as the Affordable Care Act. Long list of documents and questions there. The DOL of course wants the governing plan document, any amendments, summary plan description, material modifications, and if you're unlucky, the audit might get expanded and they're going to ask for that MIA comparative analysis I mentioned earlier and dive into your compliance with MHPAEA.

Lydia Parker (17:16):

So, lots of documents related to the health plan. Any worries about other welfare benefit plan documentation?

Laura Ferguson (17:23):

Yes. Most plan sponsors with a hundred or more employees in its welfare plans will adopt a single welfare wrap plan document in order to be able to file a single Form 5500 instead of filing separate Forms 5500 for each welfare benefit that has a hundred more employees participating.

So, for employers that have done that, the welfare plan document is going to be really important in the audit context.

Lydia Parker (17:46):

And aside from the audit context, what else might come up that would require the plan documents to be in order?

Laura Ferguson (17:53):

It's common now for plan sponsors to receive voluminous requests for governing plan documents from out-of-network medical providers that have a purported assignment from a participant in the medical plan. And this provider's exercise in the participant's ERISA rights to request planned documents. The strategy they're using is to try to create a risk of the employer failing to respond within the statutory 30-day period with the necessary documents and threatening the employer will be subject to X amount of penalties per day if they don't produce the documents. In reality, those penalties are not guaranteed. They actually have to be judicially established and the judge might not actually award any, but usually this language in these letters scares employers into settling with the providers and there's a risk that a court could actually impose them if the participant was harmed by the inability to access plan documents and they were prevented from being able to effectively appeal their claim denial. As a result of that practice, I always recommend plan sponsors have an executed copy of the welfare wrap plan ready and an up-to-date SPD in the event a request comes in and there's a limited time to respond.

Lydia Parker (18:59):

Yeah, that's a very good point. And since we mentioned it earlier any ERISA fiduciary considerations?

Laura Ferguson (19:05):

Of course, yes, there's risk there. I'd say there tends to be a lack of enforcement though in that area. Aside from the audit aspect where the fiduciary issue could be raised by the DOL, the plan sponsor is the fiduciary of the ERISA welfare plans and is charged with acting in accordance with the terms of the plan documents. So if the plan documents are not up to date, the plan sponsor may be considered to have breached their fiduciary duty by failing to follow the terms of the plan, which is a concern more so if the operation of the plan is less favorable to the participants than the terms provide. I think the fiduciary issues ultimately translate to risk of participant litigation. If the plan said X, but the employer did Y and the participant sues for X, the participant is likely going to win that argument either as a claim for benefits or showing of a breach of fiduciary duty claim and request for surcharge. So, as you can see, there's many reasons the plan sponsor should periodically review their welfare plan documentation

Lydia Parker (19:59):

And how should they undertake that type of review?

Laura Ferguson (20:02):

They call us, of course, Lydia.

Lydia Parker (20:04):

Of course.

Laura Ferguson (20:05):

If they're going to do it in-house, they should review the wrap plan to determine whether any changes to the plan's operations have occurred that should be reflected, any changes in the law, or any future changes are desired, such as beefing up their anti-assignment provision to prevent those out of network providers from suing the plan. We usually recommend considering restating the welfare wrap plan if they've got multiple amendments out there so they can simplify the plan document. We also recommend plan sponsors review the eligibility as stated in the wrap plan aligns with the underlying benefit booklets for the welfare benefits offered. Many times, we find there's a disconnect in describing dependent eligibility from how the benefit booklets describe eligibility, what the wrap plan says, and further how eligibility is actually being handled in operation. So, remember to check your open enrollment materials to ensure eligibility is described accurately there too. Once the welfare wrap plans updated, corresponding changes to the SPD should then be prepared and distributed. In addition, the plan sponsor should review required notices are up to date and being distributed either with open enrollment materials or with the SPD as applicable.

Lydia Parker (21:12):

And there you have it, folks. Put the review of the welfare plan documents on your end of year compliance list. I love it. That brings us to topic five and we're running pretty low on time, so I'm going to cheat a little bit on this one and refer to a different podcast we did on GLP1's prescribed for weight loss. And just as a primer, GLP1's includes drugs like Ozempic, Zepbound, and Wegovy, that help to reduce hunger and cause individuals to feel full for a longer period of time. And they've proven to be very effective for weight loss and also proven to be very expensive for plan sponsors. So, for our clients with self-insured plans, we've had so many grappling with how to provide effective coverage while controlling the extremely high cost that these drugs. But this is really a topic in and of itself. So, if that's of interest, you could check out our podcast Navigating Legal Strategies for Living GLP One Access and Self-Insured Health Plans.

Laura Ferguson (22:09):

Well, that wraps up our discussion on the top five health and welfare updates and the employee benefits law space for 2025. We've covered significant legislative changes, compliance challenges, and emerging trends that plan sponsors need to be aware of.

Lydia Parker (22:24):

But as always, staying informed and proactive is key to navigating these complexities. If you have any questions, or you need any further guidance, please feel free to reach out to us at Troutman Pepper Locke. Thanks for listening.

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