

Key Employee Benefits Updates

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The rules governing employer-sponsored group health plans are moving on five key fronts:

1. Prescription drug costs and Pharmacy Benefit Manager (PBM) oversight.
2. Gender-affirming care coverage.
3. Reproductive health coverage.
4. Preventive care and services.
5. Wellness program design and tax arrangements.

These issues require active oversight throughout the year and should not be addressed only at renewal.

1. PRESCRIPTION DRUG COSTS AND PBM REFORM

Reporting & Review Requirements

Federal drug pricing initiatives have generated headlines; executive orders, direct-to-consumer programs, most-favored-nation pricing agreements. However, these efforts are largely aimed at improving costs for individual consumers, not group health plans in particular.

Employer pharmacy costs instead remain primarily controlled through Pharmacy Benefit Manager (PBM) relationships, which are subject to growing regulatory oversight. Provisions of the Consolidated Appropriations Act of 2026 are aimed at PBM reform, including requirements that:

- PBMs must provide plan sponsors with detailed, plan-specific reporting[1]; and
- PBMs must pass through 100% of manufacturer rebates and discounts to plan sponsors.

Notably, the full rebate pass-through requirement also indirectly addresses spread pricing. By requiring that all rebates, fees, and alternative discounts flow through to the plan, it significantly constrains the mechanism by which PBMs could charge a plan more for a drug than they reimburse the dispensing pharmacy and retain the difference. The law also requires PBMs to include spread pricing data in their mandatory reporting. While the statute does not ban spread pricing by name, the practical effect of the pass-through and reporting requirements significantly limits PBM ability to profit from it without plan sponsor visibility.

The Department of Labor (DOL) has also released a proposed rule confirming that PBMs are subject to the same ERISA service provider compensation disclosure requirements as other covered vendors, with additional mandatory data reporting for group health plans[2].

EMPLOYER ACTION ITEMS — PBM Transparency

- Review all data and reports received by PBM, and engage with consultants or advisors if needed to better understand the information.
- Perform a regular evaluation of the ongoing PBM relationship, including service agreements, and document that review process. Increased transparency over PBM practices also means increased scrutiny of your selection and oversight process.
- For plans covering participants in multiple states, confirm with your PBM which state PBM laws apply and clarify in your service agreement which party bears responsibility for state law compliance and reporting obligations.

2. GENDER-AFFIRMING AND REPRODUCTIVE HEALTH COVERAGE

Gender-Affirming Care

While insured health plans are subject to state coverage mandates, self-insured plans generally have discretion over whether, and the extent to which, to include coverage for gender-affirming care, including care for minors. When evaluating coverage options, sponsors should take into consideration current federal and state policies as one of many factors.

Following the U.S. Supreme Court's 2025 decision in *United States v. Skrmetti*, states are largely permitted to enact laws that restrict or prohibit access to gender-affirming care for minors (presently, 26 states impose such laws)[3]. Further, the Trump Administration has taken several steps to limit the provision of gender-affirming care for minors, as well as roll back prior guidance on sex-based discrimination within the context of health plans. Another factor for consideration is the risk of private causes of action and claims of discrimination. The case of *Langley v. Houston County*, Georgia involves a plan with a blanket exclusion for gender-affirming surgery and care[4]. Courts ruled in favor of the employee in 2022 and again on appeal in 2024, ending the exclusion constituted sex-based discrimination under Title VII of the federal Civil Rights Act.

However, in September 2025, the full appellate court reversed that decision, finding the exclusion does not violate Title VII. That reversal narrows, but does not eliminate, risk for health plans. Blanket exclusions for gender-affirming care remain potential targets for discrimination claims. A medical necessity or prior authorization standard may pose a lower risk than a blanket exclusion.

EMPLOYER ACTION ITEMS — Gender-Affirming Care Coverage

- Identify any blanket exclusions in your plan for gender-affirming care and assess whether a medical necessity or prior authorization standard would be a lower-risk alternative.
- Any limitation on mental health-related care must be evaluated for compliance with the Mental Health Parity and Addiction Equity Act.
- Balance the current federal policy position against the ongoing risk of discrimination claims. These considerations may point in different directions for different employers.
- Engage your TPA and legal counsel for qualified guidance when making coverage decisions in this area.

Reproductive Health Coverage

The state-by-state variation on legislation of reproductive health care that followed the Supreme Court's 2022 decision in *Dobbs v. Jackson Women's Health Organization* continues to create complexity for plan sponsors with multi-state workforces[5].

At present, thirteen states impose a total abortion ban, and seven impose restrictions on abortion that are more restrictive than those imposed pre-Dobbs. Conversely, thirty states permit abortion; six of which mandate some level of insurance coverage for abortion services[6].

With respect to fertility care, nineteen states mandate some level of insurance coverage for infertility services, and the Trump administration has demonstrated support for increasing access to these services[7]. In May 2026, the U.S. Department of Labor, at President Trump's direction, released proposed rules that would recognize fertility benefits as "excepted benefits" that could be offered by employers on a standalone basis, bypassing existing integration rules and expanding access to all employees. If finalized, employers will have more flexibility and options when selecting and offering fertility benefits to employees.

For fully-insured plans, state insurance mandates largely dictate minimum coverage requirements. Self-insured plans are generally exempt from state insurance mandates and have greater flexibility in designing coverage for reproductive health care, but should regularly monitor state law changes that may affect their plans and participants.

For employers seeking to address coverage gaps in reproductive services, Health Reimbursement Arrangements (HRAs) and Health Flexible Spending Accounts (FSAs) can be structured to cover specific reproductive care, providing a targeted supplement to medical coverage.

EMPLOYER ACTION ITEMS — Reproductive Health Coverage

- Multi-state employers should review how state law affects coverage of reproductive services for plan participants in each state where employees reside.
- Self-insured plans: monitor state law changes that may apply despite ERISA preemption arguments. The landscape is still rapidly moving.
- Consider whether an HRA or FSA program could address coverage gaps, particularly for employers with insured plans where state mandates limit flexibility.
- Given ongoing federal support for fertility coverage, employers may see an increase in employee expectations regarding access to this benefit.

3. THE PREVENTIVE SERVICES

Braidwood

The Affordable Care Act (ACA) requires group health plans to provide no-cost coverage for preventive services as identified by the U.S. Preventive Services Task Force (USPSTF), the Advisory Committee on Immunization Practices (ACIP), and the Health Resources and Services Administration (HRSA)[8]. The Supreme Court's 2025 decision in *Kennedy v. Braidwood*, resolved a direct constitutional challenge to this requirement as the court upheld the mandate in its current form[9].

Importantly, though, the USPSTF operates under the supervision of the Secretary of Health and Human Services (HHS). This creates a mechanism through which an administration can influence which services are designated as preventive, and therefore required to be covered by health plans at no cost. This dynamic has already been observed with vaccine recommendations: HHS Secretary Kennedy replaced ACIP members in June 2025, and the CDC subsequently released a revised childhood vaccination schedule that reduces the number of vaccines recommended for most children[10]. While the mandate is intact, its content is subject to administrative influence in a way plan sponsors should closely monitor.

EMPLOYER ACTION ITEMS — Preventive Services

- No immediate plan changes to preventive services are required following Braidwood.
- Monitor for changes to the categories of services designated as preventive. Changes to USPSTF or ACIP guidance may affect what your plan is required to cover at no cost.
- Where federal action reduces preventive coverage requirements, states may impose independent mandates on insured plans. Both federal and state developments must be tracked.
- Consult counsel before modifying preventive services coverage, including vaccinations.

4. WELLNESS PROGRAMS

Tobacco Surcharge Programs: Lawful, But Under Legal Scrutiny

A wave of class action lawsuits filed in 2024 continue to work through the courts, targeting employers that impose a premium surcharge on plan participants who use tobacco. The suits allege violations of the HIPAA wellness program rules, specifically the requirements that the program must offer a reasonable alternative standard and that the full reward (i.e., avoidance or removal of the surcharge) must be made available to participants who satisfy that alternative standard.

Tobacco surcharge programs generally remain lawful and permissible under current law and plan sponsors should not necessarily feel compelled to eliminate them. However, programs that remove the surcharge on a prospective basis only, rather than retroactively, are vulnerable to claims of HIPAA violations, which is the central (and presently unresolved) question in the pending cases.

EMPLOYER ACTION ITEMS — Tobacco Surcharge Programs

- Confirm that a reasonable alternative standard, such as a tobacco cessation program, is clearly offered and communicated to all participants in your tobacco surcharge program.
- Evaluate how the reward is provided when a participant satisfies the alternative standard. Retroactive correction to the start of the plan year likely carries lower litigation risk than prospective-only removal of the surcharge.

Wellness Program Tax Considerations

Promoters continue marketing to employers purported tax-savings programs that leverage cafeteria plans, wellness programs, and indemnity benefits, promising to deliver reduced taxable income for employees and payroll tax savings for employers. However, the IRS has repeatedly identified these arrangements as non-compliant over the past decade, targeting the way these programs exploit different tax code sections to achieve an impermissible double tax benefit[11]. Potential liability exists for both the employer and any employees who participate.

Before engaging with any such arrangement, ask hard questions of the promoter and consult qualified benefits counsel. It is also worth noting that many employers already capture the legitimate tax savings available under the Internal Revenue Code, by offering programs such as cafeteria plans, Health FSAs, and HRAs.

CONCLUSION

Group health plan compliance is not a single-focus strategy.

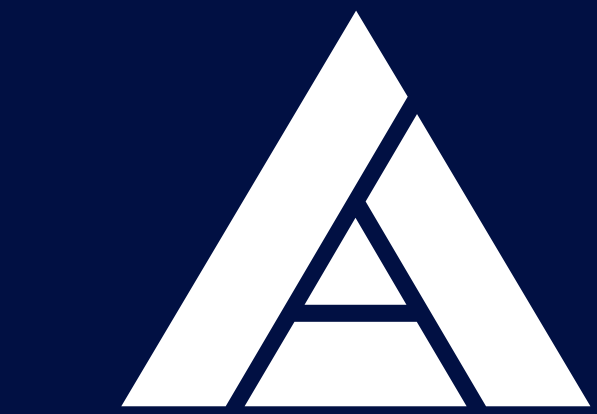
It is defined by cumulative accountability:

- PBM transparency increases fiduciary responsibility.
- Coverage decisions carry discrimination and parity risk.
- State legislative divergence demands active monitoring.
- Preventive service definitions may shift administratively.
- Wellness program structure is under scrutiny.
- Tax-advantaged arrangements invite enforcement attention.

Employers may be better positioned to manage long-term benefits strategy when they:

- Review the information they receive. from plan service providers.
- Engage qualified counsel when making material coverage decisions.
- Document their oversight process.
- Treat plan compliance as an ongoing management function.





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