



THE 2025 HEALTH BENEFITS LEGISLATIVE/ REGULATORY ROUNDUP

Written By Alston & Bird Health Benefits Practice

This past year that just ended kicked off with a new administration heralding big policy changes in areas that affect employee health & welfare benefits. This roundup is packed with the latest legislative and regulatory developments that matter most to health benefit plan sponsors and service providers. From significant consumer-directed health legislative changes in telehealth and health savings accounts to pivotal court decisions impacting mental health parity, reproductive health privacy, and wellness program benefits, we break down what's new, what's paused, and what's next for employer health plans.

LEGISLATIVE SPOTLIGHT

Big bill, big changes: The OBBBA's impact on your benefit plans

The One Big Beautiful Bill Act (OBBBA) made headlines with its ambitious consumer-directed health proposals, but only a few provisions made it into law. Agencies are feverishly working on additional guidance for those provisions.

- **HDHP/HSA Exception for Telehealth and "Remote Care."** The Senate's version made permanent the exception for pre-deductible telehealth coverage and extended the exception to "other remote care," which means telehealth or "other remote care" coverage before satisfaction of the high-deductible health plan's (HDHP) deductible will not disqualify participants from health savings account (HSA) eligibility for plan years beginning after December 31, 2024. This retroactive effective date bridges the gap that would have otherwise followed the sunset date of the last telehealth extension at the end of 2024.

Consider: *When is care telehealth or remote care? For example, there are some who hope that the exception may apply beyond services to durable medical equipment or prescription drugs obtained through telehealth providers. Agency guidance may address this issue.*

- Bronze and Catastrophic Exchange Plans / HSA Compatibility. Beginning in 2026, bronze and catastrophic Exchange plans will qualify as HSA-compatible HDHPs.

Consider: *Exchange plans cannot be pre-tax funded under a cafeteria plan, but the premiums can be reimbursed through an individual coverage health reimbursement arrangement (ICHRA).*

- Direct Primary Care Arrangements. Direct primary care (DPC) arrangements that meet certain requirements will also be HSA compatible. The fee for a compatible DPC will also qualify as an eligible expenditure for HSA purposes (up to \$150/month for individuals, \$300/month for families).

Consider: *The OBBBA failed to answer a few critical questions. Can annual payments be prorated? Can the DPC be funded on a pre-tax basis by the employer or employee (through a cafeteria plan)? What is the scope of allowable DPC “primary care” services? Can a DPC be integrated with an employer’s HDHP coverage? Agency guidance is welcomed on these points.*

Many House-proposed health benefit reforms, such as expanded HSA eligibility and ICHRA codification, were not included in the final law. But perhaps we may see further activity on some of these provisions in the future.

The OBBBA also included changes for other types of employee benefits:

- Dependent Care Assistance Program. Dependent care assistant program (DCAP) limits have increased to \$7,500 – or \$3,750 for married individuals filing separately in 2026. Be aware that increasing pre-tax salary reduction limits can adversely impact the DCAP 55% average benefits nondiscrimination test.
- Student Loan Benefits. The student loan repayment assistance benefit is now permanent, with annual limits adjusted for inflation after 2026.
- Commuter Benefits. The bicycle commuter benefit, which was frozen January 1, 2017, through December 31, 2025, is now permanently eliminated after December 31, 2025.
- Trump Accounts. This investment vehicle is similar to an individual retirement account for parents to set up for their minor children. Beginning in 2026, parents can contribute up to \$5,000 per child, and employers can contribute up to \$2,500 annually, indexed and tax-free. Employer contributions must be made under the terms of a written plan document that complies with rules similar to those for DCAPs.

REGULATORY UPDATE

2024 MHPAEA Rule: Agency enforcement paused, comparative analysis still required

Federal agencies have paused enforcement of the 2024 final rule under the Mental Health Parity and Addiction Equity Act (MHPAEA) due to ongoing litigation (ERISA Industry Committee (ERIC) v. HHS) and a presidential Executive Order directing regulatory review.

What's Next. The departments will not enforce the 2024 final rule or otherwise pursue enforcement actions if a plan fails to comply before a final decision in the litigation, plus an additional 18 months. The departments are considering whether to issue a notice of proposed rulemaking rescinding or modifying the regulation through notice and comment rulemaking.

What Plan Sponsors Need to Know. Plan sponsors must still comply with the 2013 final rule and the Consolidated Appropriations Act of 2021, including maintaining written comparative analyses for nonquantitative treatment limitations. Private litigation under the MHPAEA from plan participants remains a risk for all MHPAEA requirements.

Federal court vacates HIPAA reproductive health privacy protections

A federal district court in Texas in *Purl v. HHS* vacated most provisions of the HIPAA Reproductive Health Privacy Rule. Covered entities are no longer required to comply with the new federal privacy requirements for reproductive health information, such as the prohibition on certain uses and disclosures and the attestation requirement for law enforcement requests.

What's Next. The Department of Health and Human Services (HHS) has not appealed the decision and attempts by other states to intervene and appeal the decision were unsuccessful.

WHAT PLAN SPONSORS NEED TO KNOW.

- Plans that took compliance action before the rule was vacated should consult with legal counsel on next steps.
- The court's decision does not affect new HIPAA Notice of Privacy Practices (NPP) requirements for substance use disorder records under 42 C.F.R. Part 2. Plan sponsors must still update NPPs to address these changes by February 16, 2026. NPPs must still be updated for HIPAA Part 2. Model language had been promised, but none has been issued.
- Monitor state activity for any applicable non-preempted state laws that may provide additional privacy protections for reproductive health information.

Court vacates interpretation of "sex" as "gender identity" under Section 1557

In October, a federal court in Mississippi vacated the expanded definition of sex discrimination to include gender identity under the 2024 final rule for the Affordable Care Act (ACA) Section 1557, holding that HHS exceeded its statutory authority. The opinion listed the specific provisions that were vacated. (*State of Tennessee v. HHS*)

What's Next. The outcome of the Mississippi order aligns with the first Trump Administration's version of gender identity under the final rule under Section 1557, making an appeal less likely. Section 1557 litigation is still pending in other jurisdictions.

What Plan Sponsors Need to Know. This outcome could have broad implications for other Section 1557 cases. See the Litigation Update section for more information on gender identity litigation and benefits.

ACA CONTRACEPTIVE RELIGIOUS AND MORAL EXEMPTION VACATED

A Pennsylvania district court in *Pennsylvania v. Trump* vacated two federal regulations—the Religious Exemption Rule and the Moral Exemption Rule—that had allowed a broad range of employers, including for-profit entities, to opt out of providing contraceptive coverage under the ACA based on religious or

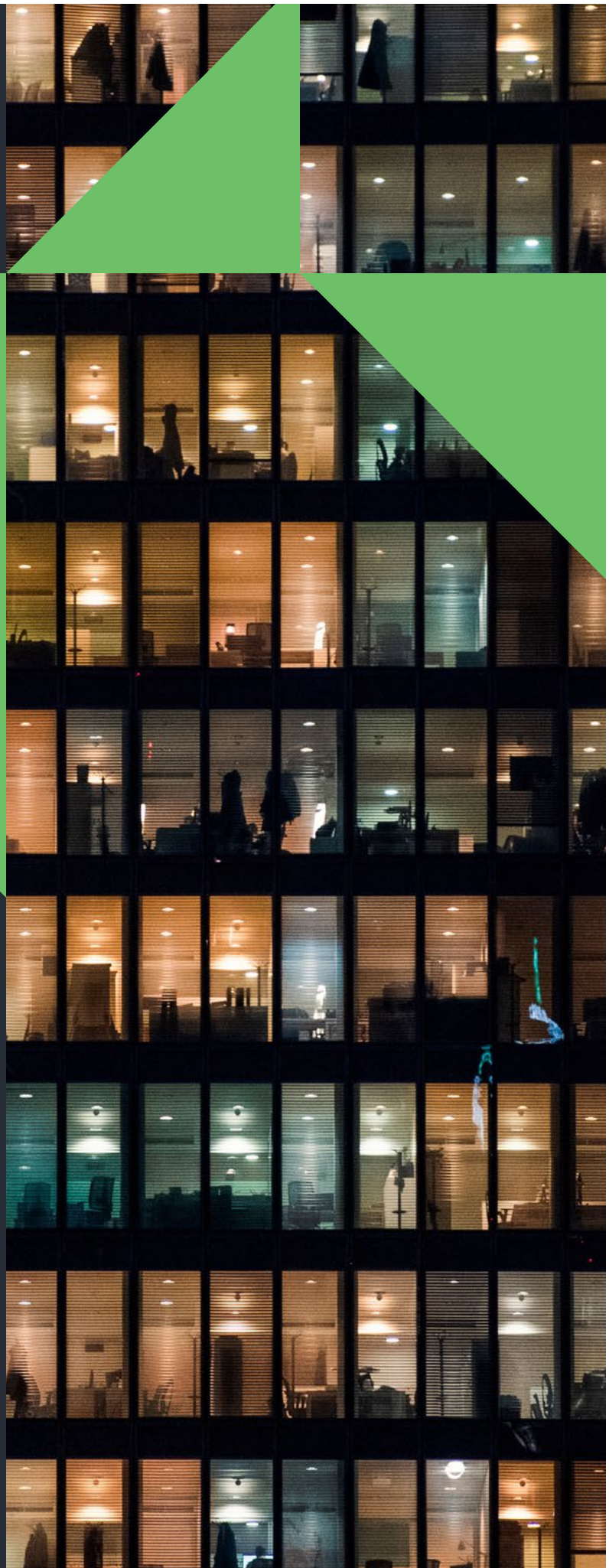


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moral objections. The court found these rules to be “arbitrary and capricious” under the Administrative Procedure Act.

What’s Next. The Trump Administration appealed, though the briefing has been delayed due to the government shutdown. Unless stayed on appeal, the Religious and Moral Exemption Rules are vacated, reverting the contraceptive coverage framework to the pre-2017 accommodation regime.

What Plan Sponsors Need to Know. Plan sponsors already covering all ACA-mandated preventive services are not affected by this ruling. However, employer health plans that were relying on either exemption to not

offer the full range of contraceptive coverage required under the ACA should consult legal counsel.

PREVENTIVE SERVICES AND FERTILITY BENEFITS

Supreme Court upholds ACA preventive services mandate

In June 2025, the U.S. Supreme Court issued its decision in *Kennedy v. Braidwood Management Inc.*, affirming the constitutionality of the U.S. Preventive Services Task Force (USPSTF) appointment process and upholding the ACA’s requirement that employer-sponsored group health plans cover preventive services receiving an A or B recommendation from the USPSTF without cost-sharing. These services include screenings for breast, cervical, and colorectal cancers, as well as screenings for sexually transmitted diseases and PrEP for HIV prevention.

What’s Next. The case now returns to the lower courts to consider challenges to the authority of two other advisory bodies, the Health Resources and Services Administration (HRSA) and the Advisory Committee on Immunization Practices (ACIP). The HRSA makes recommendations on contraceptive coverage for women and other types of preventive services for women and children. The ACIP is the advisory committee that recommends vaccines, including the schedule for childhood vaccines.

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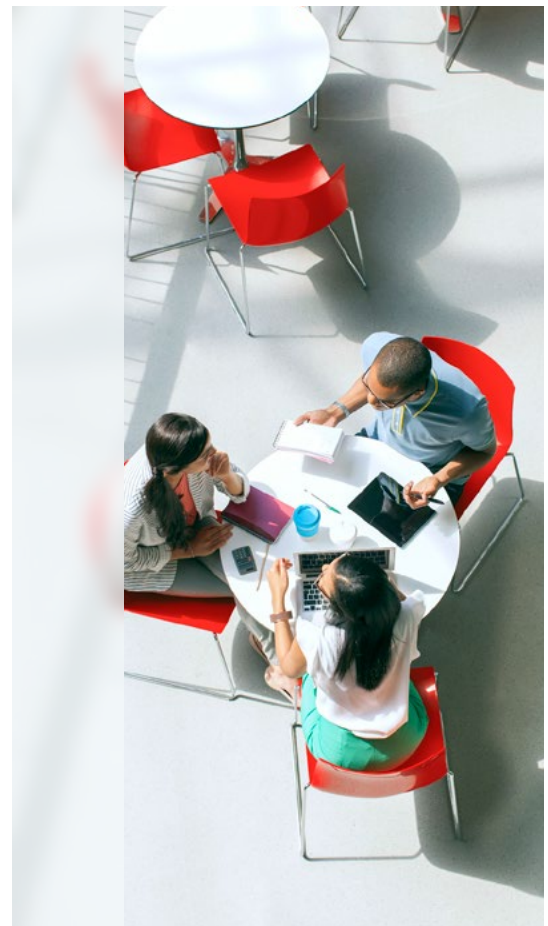
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HRSA EXPANDS WOMEN'S PREVENTIVE SERVICES

Finalized Updates for 2026. In December 2024, the HRSA approved recommendations to add additional imaging (such as MRI, ultrasound, and mammography) and pathology after initial screening to the HRSA-supported Women's Preventive Services Guidelines. Plans are required to cover these updates for plan years beginning in 2026.

Proposed Updates. In late September 2025, the HRSA proposed additional updates to screening for cervical cancer. These proposed changes include updates to screening recommendations for women ages 30 to 65, the option of patient-collected hrHPV testing for the same age group, and coverage of additional testing (such as cytology, biopsy colposcopy, extended genotyping, and dual stain) and pathologic evaluation, if indicated, for women of all screening ages. Plan coverage for these proposed updates for cervical cancer screening, if finalized, would become effective for plan years beginning on or after one year after the recommendation or guideline is officially issued.

INFERTILITY COVERAGE GETS FEDERAL SPOTLIGHT—TAX RULES STILL TRICKY

The new administration is committed to increasing access and reducing costs for infertility treatment (see Executive Order 14216 and Fact Sheet). In October, the Departments of Labor, Health and Human Services, and the Treasury published guidance for stand-alone benefit packages to employees interested in coverage for treatment of infertility, including IVF (see ACA FAQs Part 72). Although this guidance did not alter current rules, it explained that employer plan sponsors have two main pathways to offer fertility benefits as “excepted benefits” under federal law:

- **Noncoordinated excepted benefit.** First, fertility coverage can be provided as an independent, non-coordinated excepted benefit—for example, through a specified disease or illness policy (such as infertility-only insurance) or hospital indemnity coverage. To qualify, these benefits must be offered under a separate insurance policy, certificate, or contract, with no coordination between the excepted benefit and any group health plan maintained by the same sponsor. Importantly, these policies cannot be self-funded; they must be fully insured. Employees do not need to enroll in the employer's traditional group health plan to access these benefits, and enrollment in such coverage does not disqualify participants from contributing to an HSA if they otherwise meet HSA eligibility requirements.
- **EBHRAs and EAPs.** Second, employers may offer fertility benefits as a limited excepted benefit—most commonly through an excepted benefit health reimbursement arrangement (EBHRA) or certain employee assistance programs (EAPs). EBHRAs must be offered alongside a traditional group health plan, must have annual limits (\$2,150 for 2025), and cannot reimburse premiums for major medical coverage. EAPs may provide coaching or navigator services related to fertility but cannot offer significant medical care or be coordinated with other group health plans.

What's Next. The departments are considering future rulemaking to expand options for fertility benefits and may adjust the value limits for supplemental coverage.

What Plan Sponsors Need to Know. Although not discussed in the FAQs, certain fertility treatments or services may not meet the current definition of “medical care” under U.S.C. § 213(d) for purposes of tax-favored treatment. Employers need to remain mindful of the IRS guidance limit on infertility treatments. The table below summarizes some of the treatments and services that have been addressed in sources other than formal rulemaking:

Expense Type	Deductible?	IRS Guidance/Letter Rulings
<i>IVF for taxpayer/ spouse</i>	<i>Yes</i>	<i>Must be necessary to overcome inability to have children</i>
<i>Egg/sperm donor fees</i>	<i>Sometimes</i>	<i>If preparatory to procedure for employee/spouse/ dependent</i>
<i>Surrogacy expenses</i>	<i>No</i>	<i>Surrogate is not a dependent; reimbursement and benefits are only permitted for employees and their tax dependents</i>
<i>Storage of eggs/ sperm</i>	<i>Yes (temporary)</i>	<i>Must be for imminent use and necessary due to a medical condition</i>
<i>Legal fees</i>	<i>Sometimes</i>	<i>If directly related to the provision of medical care</i>

LITIGATION UPDATES

Legal landscape shifts for gender-affirming coverage

Recent federal court decisions have reshaped the legal landscape for gender-affirming care, with significant implications for employer health plan sponsors. In *United States v. Skrmetti*, the Supreme Court upheld Tennessee’s ban on gender-affirming medical care for minors, holding that such laws do not trigger heightened scrutiny under the Equal Protection Clause because they classify based on age and medical use, not sex or transgender status. The court declined to extend the Title VII reasoning of *Bostock v. Clayton County* to constitutional claims, emphasizing that state bans on gender-affirming care for minors are subject only to rational basis review. This decision is now binding nationwide and signals a restrictive approach to constitutional challenges against similar state laws.

A mix of circuit courts and district courts has also addressed federal nondiscrimination protections this year. In *Lange v. Houston County*, the Eleventh Circuit, sitting en banc, reversed a district court and held that employer health plan exclusions for “sex change” services are not facially discriminatory under Title VII, echoing the Supreme Court’s logic in *Skrmetti*. Meanwhile, in September, a federal district court in Washington in *L.B. v. Premera Blue Cross* found that a categorical exclusion of gender-affirming chest surgery for minors violated Section 1557 of the ACA but acknowledged that the Supreme Court’s recent decisions could affect the outcome if appealed.

However, in October, the regulatory efforts to expand gender-identity protections under Section 1557 faced setbacks when the Southern District of Mississippi in *State of Tennessee v. HHS* vacated specific regulatory provisions that expand the definition of sex discrimination to include gender identity, holding that HHS exceeded its statutory authority. Then, in mid-November, the Ninth Circuit in *C.P. v. BCBSIL* vacated a lower court’s ruling for summary judgment that favored the transgender plaintiffs who sued a third-party administrator (TPA) of a self-insured plan for denying coverage for gender dysphoria, remanding the case back to the lower court to reconsider the analysis of sex discrimination under Section 1557 in light of *Skrmetti*. In its analysis, the Ninth Circuit invoked *Loper Bright* to set aside a set of 2020 regulations that would have excluded the TPA from Section 1557.

What’s Next.

- On September 15, 2025, Premera filed an appeal to the Ninth Circuit. It is unclear if the ruling in the Mississippi district court will have any impact in the Ninth Circuit.

- The Western District of Washington will revisit its Section 1557 sex discrimination analysis under Skrametti to determine whether a TPA impermissibly applied an exclusion for gender-affirming care.
- The Eleventh Circuit remanded *Lange v. Houston County* back to the district court for claims turning on the intent of the exclusion for sex-change procedures.

TOBACCO SURCHARGE LITIGATION HEATS UP

A new wave of litigation is targeting tobacco wellness programs, but they are not one-size-fits-all. For example, some offer only prospective removal of the surcharge upon completion of a tobacco cessation program, while others impose time restrictions on when a participant can qualify for retroactive reimbursement while offering prospective removal. In short, the crux of the plaintiffs' claims is that employer health plans must offer full retroactive reimbursement of all tobacco surcharge payments any time a participant completes a tobacco cessation program and that certain plan disclosures do not contain specific information they allege is required.

Courts are divided on whether plaintiffs state a plausible violation of the law by alleging an employer health plan fails to retroactively reimburse tobacco surcharges. For example, in *Williams v. Bally's Management Group LLC*, the plaintiff alleged that Bally's violated the law by offering only prospective removal of the tobacco surcharge upon completion of a tobacco cessation program. The Rhode Island federal court declined to read a retroactive reimbursement requirement into the law and found that Bally's was not required to provide retroactive reimbursement of the tobacco surcharge. Other courts, however, have found the opposite.



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What Plan Sponsors Need to Know.

The case law for tobacco wellness programs is evolving rapidly. There are numerous unresolved legal issues in these cases, and with over 40 cases filed in the last couple of years, we are sure to see further development. Programs that offer retroactive reimbursement after completion of a tobacco cessation program have fared better on motions to dismiss. We recommend consulting with counsel experienced in the nuances of this litigation and the law and monitoring the law in your jurisdiction.

PBM LITIGATION

In 2025, two pivotal lawsuits targeted the use of pharmacy benefit managers (PBMs) under ERISA. The plaintiffs alleged that employers failed to properly select and monitor PBMs, resulting in excessive drug costs and higher participant expenses, but federal courts dismissed these claims due to lack of standing, finding the alleged injuries too speculative or not directly linked to employer actions. In one of the cases, the court noted that the employer retained sole discretion in the plan document to set participants' contributions, which also factored into the court's view that the connection between PBM fees and drug pricing and participant cost was speculative.

What's Next. The courts permitted the plaintiffs to file amended complaints that are subject to renewed motions to dismiss.

TCPA LAWSUITS SPIKE—HIPAA COMPLIANCE ISN'T ENOUGH

HIPAA compliance does not shield plans from Telephone Consumer Protection Act (TCPA) liability, which carries steep statutory damages for each violation—up to \$500–\$1,500 per violation—making it a source of litigation risk for health plans. Litigation under the TCPA surged in 2025, especially after the Supreme Court clarified that courts are not bound by the Federal Communications Commission's interpretations in *McLaughlin Chiropractic Associates Inc. v. McKesson Corp.* Health plans and TPAs face risk for automated calls/texts without proper consent and for failing to honor opt-outs.

Plan sponsors will want to be mindful of the following:

- Have outbound communications (calls, texts, faxes) been evaluated for TCPA compliance, not just HIPAA?
- Have proper consents been obtained for all automated or prerecorded messages? Which party is responsible for obtaining them?
- Are opt-out mechanisms clear, easy to use, and honored promptly?
- What does the TPA or vendor agreement say about TCPA compliance? Which party obtains any required consent and indemnification for TCPA failures?

NO SURPRISES ACT: ONGOING LEGAL BATTLES AND NEW FAQs

Litigation over the federal independent dispute resolution (IDR) process under the No Surprises Act remains unsettled, with key cases shaping the landscape for employer plan sponsors and TPAs. In *Guardian Flight v. Health Care Service Corp.*, the Fifth Circuit held that providers cannot enforce IDR awards in federal court but must rely on administrative enforcement through HHS. This aligns with district court decisions in New York and Florida, while a District of Connecticut decision reached a different conclusion, creating a divide that may require Supreme Court review.



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Ongoing litigation in the Fifth Circuit led by the Texas Medical Association (TMA) also challenges the use of the qualifying payment amount (QPA) in arbitration. The departments issued two FAQs this year to address some of these issues:

- FAQ Part 69 (Jan 2025) introduced a new extension policy for providers that miss IDR deadlines due to delayed or missing QPA disclosures. Providers can now request deadline relief from the Centers for Medicare & Medicaid Services (CMS) with supporting documentation.
- FAQ Part 71 (July 2025) extended enforcement discretion for QPA calculations through February 1, 2026, and clarified that plans must still certify that QPAs were calculated in compliance with applicable rules.

What's Next.

- A petition for certiorari was filed in October for the Guardian Flight case.
- The full Fifth Circuit heard arguments in the TMA case in September, but no opinion has been issued.
- CMS and the Employee Benefits Security Administration both listed federal IDR operations on their semi-annual regulatory agendas published in September, and a new final rule is anticipated.

ACA 4980H penalties: Court says IRS can't act without HHS certification

In *Faulk Company Inc. v. HHS*, the Northern District of Texas addressed whether the IRS properly assessed the employer shared responsibility payment (ESRP) penalty under IRC § 4980H for failing to offer minimum essential coverage required by the ACA. The court found that under the statutory framework, only HHS—not the IRS—has authority to provide the required certification to employers before the IRS can assess the ESRP. The IRS's practice of sending Letter 226-J as certification was deemed improper because it did not originate from HHS and did not provide adequate notice of liability or appeal rights as required by ACA Section 1411. The court ordered the IRS to refund the over \$200,000 penalty paid by Faulk and set aside the regulation (45 C.F.R. § 155.310(i)) that allowed the IRS to issue certifications.

What's Next. HHS has not appealed.

What Plan Sponsors Need to Know.

- ESRP penalty assessment must be preceded by proper certification and notice from HHS.
- An IRS Letter 226-J alone does not meet the HHS certification requirement.
- Employers that have been assessed a Section 4980H penalty under the ACA or have already paid a penalty should consult with legal counsel. Refund requests are typically required within two years of paying the penalty. Those assessed a penalty in the future may have a defense if HHS certification hasn't been received for employees identified as triggering a penalty.

YEAR-END REMINDERS

Cost of living updates

Provisions	2025	2026
HSA contribution max for self/family	\$4,300/\$8,550	\$4,400/\$8,750
HSA additional catch-up contributions	\$1,000	\$1,000
HDHP annual deductible minimum self/family	\$1,650/\$3,300	\$1,700/\$3,400
Limit on HDHP OOP max self/family	\$8,300/\$16,600	\$8,500/\$17,000
ACA limit on OOP expenses self/family	\$9,200/\$18,400	\$10,600/\$21,200
Health FSA salary reduction max	\$3,300	\$3,400
Health FSA carryover max	\$660 (carried into 2026)	\$680 (carried into 2027)
Dependent care salary reduction max	\$5,000 (\$2,500 married filing separately)	\$7,500 (\$3,750 married filing separately)
Excepted benefit HRAs	\$2,150	\$2,200
Qualified small employer HRAs (QSEHRAs) self/family	\$6,350/\$12,800	\$6,450/\$13,100
Adoption assistance		
• Max tax credit	\$17,280	\$17,670
• Phase-out begins	\$259,190	\$265,080
• Phase-out ends	\$299,190	\$305,080
Transit and parking benefits	\$325/mo.	\$340/mo.

1095-C reporting to individuals

- Automatic distribution of ACA statements (Forms 1095-B and 1095-C) is no longer required under the Paperwork Burden Reduction Act. Plan sponsors must instead provide a clear and accessible notice informing individuals they can request a copy of their statement. If requested, the statement must be furnished by January 31 of the following year or within 30 days of the request, whichever is later.
- Filing requirements with the IRS remain unchanged—plan sponsors must still submit all required ACA returns.
- Employers that have been assessed a Section 4980H penalty under the ACA should consult with legal counsel to determine if proper HHS certification was provided. Employers that have already paid this penalty should consult with legal counsel to determine if they may be entitled to a refund.

Gag clause attestation

- Due December 31, 2025
- Submit via CMS HIOS portal
- Review contracts for prohibited data restrictions
- Self-insured plans: sponsor is responsible for reporting (but can delegate to a TPA)

HRSA preventive services update

- New guidelines for breast/cervical cancer screening and patient navigation
- Effective for new plan years beginning in 2026

HIPAA Part 2 notice of privacy practices

- Update required by February 16, 2026
- Must include new protections for substance use disorder records ■

Attorneys John Hickman, Ashley Gillihan, Amy Heppner, and Laurie Kirkwood provide the answers in this column. John is partner in charge of the Health Benefits Practice with Alston & Bird, LLP, an Atlanta, New York, Los Angeles, Charlotte, Dallas and Washington, D.C. law firm. Ashley is a partner in the practice, and Amy and Laurie are senior members in the Health Benefits Practice. Answers are provided as general guidance on the subjects covered in the question and are not provided as legal advice to the questioner's situation. Any legal issues should be reviewed by your legal counsel to apply the law to the particular facts of your situation. Readers are encouraged to send questions by E-MAIL to John at john.hickman@alston.com.