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Cooking Up a Compliant Benefits Strategy

September 9, 2025

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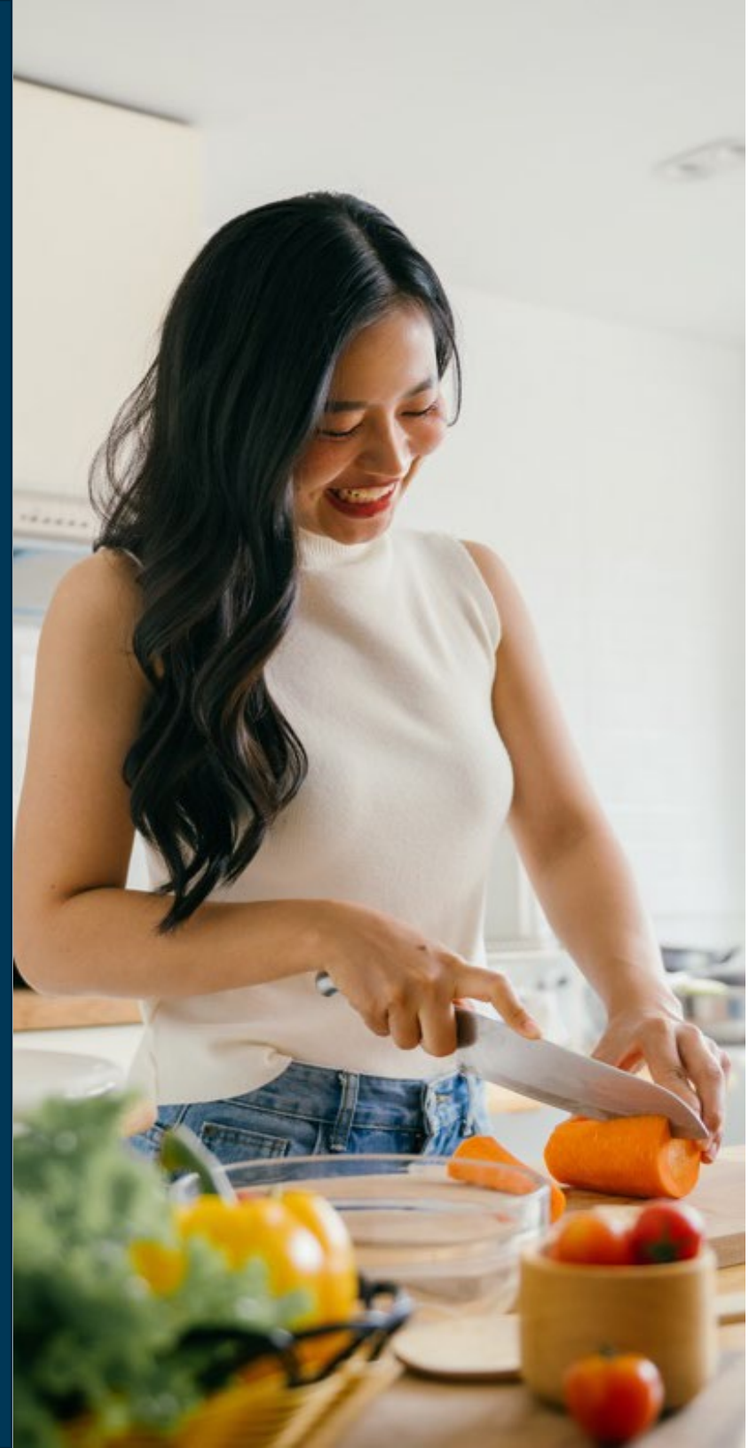
MENU

- ***New Recipes:*** *Effects of the One Big Beautiful Bill Act (OBBBA) on Employee Benefits*
- ***Adjusting the Temperature:*** *Effects of Recent U.S. Supreme Court Rulings on Employee Benefits*
- ***Measuring Correctly:*** *2026 Plan Limits and Employee Contributions*
- ***It's Getting Spicy:*** *Wellness Program Compliance*
- ***Mixing It Together:*** *Plan Eligibility Considerations*
- ***Finishing Touches:*** *Compliance for the Plan Year*

New Recipes:
Effects of the One Big Beautiful Bill Act (OBBBA) on Employee Benefits



HSA/HDHP Expansion: Permanent First-Dollar Telehealth Coverage Relief

- To be eligible to contribute to a health saving account (HSA), or receive HSA contributions from an employer plan sponsor, individuals must be covered by a high-deductible health plan (HDHP), not be covered by other disqualifying coverage, not be enrolled in Medicare, and not be eligible to be claimed on another person's tax return
- Except for preventive care, an HDHP cannot pay for benefits with no cost sharing until the minimum annual deductible has been satisfied
  - Historically, having access to first-dollar telehealth or other remote care services before the HDHP deductible was satisfied made individuals ineligible to contribute to an HSA
  - Legislative relief enacted during COVID-19 provided temporary relief allowing HDHPs to provide benefits for telehealth or other remote care services before plan deductibles were met; this relief expired and did not extend to plan years beginning on or after 1/1/2025
- **OBBBA permanently extends this relief; plan sponsors now have the option to allow HDHPs to provide pre-deductible telehealth or other remote care services coverage without negatively impacting HSA eligibility**
- Relief is retroactive to 1/1/2025

HSA/HDHP Expansion:
Permanent First-Dollar Telehealth Coverage Relief *(cont.)*

- OBBBA HSA telehealth/other remote care expansion is *optional,* but wide-spread adoption is expected
- Plan amendments via updated Summary Plan Description (SPD) or Summary of Material Modifications (SMM) may be required. Any changes should be communicated to plan participants
- Retroactive relief is allowed to 1/1/2025 but is likely not practical
- If employer has maintained no cost coverage since 1/1/2025, no changes necessary for retroactive effect
- Mid-plan year prospective changes could create qualifying life event for carved-in telehealth and possibly require opportunity for participants to make plan changes
- New plan year implementation is simplest administrative choice

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HSA/HDHP Expansion: Permanent First-Dollar Telehealth Coverage Relief Stand-Alone Telehealth Still Not Recommended

- OBBBA did not lessen compliance risks of stand-alone telehealth (i.e., an employer offering telehealth to employees outside of those enrolled in an underlying health plan)
  - In most cases, a stand-alone telehealth benefit that has not been integrated into the employer's group medical plan coverage is unable to comply with the ACA's preventive care mandate, as many preventive care services require in-person visits with healthcare providers (e.g., vaccinations)
  - A stand-alone telehealth program must also comply with requirements under ERISA, including a plan document, SPD, 5500 filings, claims and appeals process, etc. (unless an ERISA exemption applies)
  - Because telehealth programs provide medical care, they are also subject to COBRA
  - There is no EAP exception for general telehealth

HSA/HDHP Expansion: Direct Primary Care (DPC)

- Direct Primary Care (DPC) is an arrangement where physicians, pediatricians and internists charge a monthly membership fee instead of charging for or accepting insurance for routine, primary care visits
- Historically, unless the DPC was limited to preventive care, DPC members were ineligible to participate in an HSA as they had access to disqualifying primary care coverage prior to satisfying their HDHP deductible
- **Effective 1/1/2026, OBBBA changes the law to specifically exclude DPC arrangements from being HSA-disqualifying coverage and specifies that HSA funds can be used tax-free to pay membership fees for DPC arrangements**

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HSA/HDHP Expansion: Direct Primary Care (DPC) *(cont.)*

- OBBBA HSA expansion only applies to certain DPC arrangements that:
  - Charge a monthly fee of $150 or less, or $300 if the arrangement covers more than one individual (indexed annually) (no other fees allowed);
  - Provide medical care consisting of only “primary care services” provided by “primary care physicians”; and
  - Do not offer certain prohibited services, including procedures requiring general anesthesia, prescription drugs (not including vaccines), and lab services not typically administered in an ambulatory primary care facility
- HHS has been directed to provide future guidance regarding DPC reimbursements
- Employers can enable employees to pay DPC membership/subscription fees on a pre-tax basis through the employer’s cafeteria plan; however, employees cannot both pay for the fees on a pre-tax basis and seek reimbursement from their HSA

HSA/HDHP Expansion: Missing Ingredients

- The following provisions were considered, but ultimately not included in OBBBA:
  - Allowing individuals who enroll in Medicare Part A to be HSA-eligible
  - Permitting individuals with access to an on-site medical clinic providing certain limited services to be HSA-eligible
  - Allowing individuals to be HSA-eligible where their spouse is enrolled in a general-purpose health FSA
  - Adding the ability to use an HSA for gym memberships and other similar physical exercise/activity costs of up to $500 per year
  - Permitting both spouses to make the $1,000 catch-up contribution (available at age 55+) to the same HSA
  - Allowing amounts to be distributed into an HSA from a health FSA or HRA for employees newly enrolled in an HDHP, capped at twice the current-year health FSA salary reduction contribution limit
  - Increasing the HSA contribution limit by an additional $4,300 for individual coverage and $8,550 for family coverage with phaseouts for incomes above $75,000 ($150,000 married), applicable only to employee contributions

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Dependent Care Flexible Spending Account (DCFSA): Annual Limit Increase

- **OBBBA increased the annual limit on Dependent Care Flexible Spending Account (DCFSA) from $5,000 to $7,500** (and from $2,500 to $3,750 for married individuals filing separately) for the 2026 tax year
  - This is a one-time only increase (not indexed for inflation)
  - The annual limit applies on a calendar-year basis, regardless of the plan year (although some vendors are encouraging non-calendar year plans to wait until the start of the 2026 plan year to implement any increase)
  - This increase is optional, but wide-spread adoption is expected
    - Employers may take into account past employee usage, gain/loss experience as well as Section 129 nondiscrimination (NDT) testing results
    - DCFSAs often fail NDT as highly compensated employees (HCE) tend to take advantage of the tax vehicle, and the increased limit may further increase failures; accordingly, some employers may consider increasing the limits only for non-HCE
  - Plan amendments via updated Summary Plan Description or SMM may be required. Any changes should be communicated to plan participants

Adjust for Taste: Child and Dependent Care Tax Credit Expansion (DCTC) vs. DCFSA Increase

- The DCTC allows a taxpayer to pay for child or other eligible dependent care expenses and claim a percentage of the amounts as a credit against taxes owed on their federal personal income tax return:
  - Up to $3,000/year in qualifying expenses for a single eligible individual, or
  - Up to $6,000/year in qualifying expenses for two+ eligible individuals
- **Effective for tax year 2026, OBBBA increases the DCTC calculation from 35% to 50% of qualifying dependent care expenses and introduces a new phase-out structure based on AGI**
- The DCTC and DCFSA are not mutually exclusive, but the rules prohibit double-dipping on tax breaks for the same expense
- Choosing between the DCTC and a DCFSA depends on an employee's specific childcare needs, filing status and income level; employers should encourage employees to seek financial guidance

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Other OBBBA Employer Benefits-Related Provisions

- Bronze/Catastrophic Marketplace Plans Now Automatically HSA Eligible (effective 1/1/2026)
- Trump Accounts (effective 1/1/2026)
- Student Loan Repayment through Employer-Provided Educational Assistance Programs (made permanent)
- Bicycle Commuter Benefits Eliminated (made permanent)
- Paid Family Medical Leave Credit Improvements (2026 tax year)
- Qualified Tip Deduction (effective 1/1/2025)
- Qualified Overtime Compensation Deduction (effective 1/1/2025)

Adjusting the Temperature:
Effects of Recent U.S. Supreme Court Rulings on Employee Benefits

Kennedy v. Braidwood Management: ACA Preventive Services Mandate

- **Court Ruling:** Upheld ACA rule that non-grandfathered plans must continue to cover the full range of recommended preventive care services at no cost
- An employer with religious objections may still be able to claim an exemption from certain requirements

Compliance Notes

- Recommendations for certain preventive care services, such as vaccines, may change depending on the administration. If a particular preventive service is eliminated from the recommended list, employers will need to consider whether they want to continue no-cost coverage

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U. S. v. Skrmetti: Gender-Affirming Care

- **Court Ruling:** Upheld Tennessee state law banning gender-affirming medical care for minors (e.g., puberty blockers, hormone therapy, surgical procedures)
- While *Skrmetti* is narrowly tailored to treatment of minors in Tennessee, at least ½ of states have laws banning similar care for minors (while other states protect access). This decision will be persuasive in similar lawsuits

Compliance Notes

- If plans want to cover gender-affirming care for minors, consider medical travel benefits for participants who need to travel to other states
- If plans want to exclude, consult with counsel as laws are constantly evolving under Section 1557, Title VII, and state insurance laws
- Flexibility will vary based on plan funding mechanism

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PCMA v. Mulready: State Pharmacy Benefit Manager (PBM) Regulation

- **Court Ruling**: SCOTUS *declined* to hear the case, upholding the appellate court decision that state law setting pharmacy benefit manager (PBM) network standards is preempted by ERISA
- Protects self-funded plan sponsors' ability to structure network and benefit design, but other case law indicates that states may retain authority to regulate PBM pricing and pharmacy reimbursement rates
- 10th Circuit case only binding in those states (CO, KS, NM, OK, UT, WY and parts of MT, ID)
- All states have at least one PBM related law; laws similar to the Oklahoma law may see similar results in litigation, but state laws vary significantly

Compliance Notes

- Several states have introduced annual reporting and attestation rules (e.g., AR, FL); ERISA preemption may or may not be applicable for self-funded plans depending on the specifics of the laws

Measuring Correctly:

2026 Plan Limits and Employee Contributions

HSA/HDHP and ACA Out-of-Pocket Limits Increase for 2026

Level of Coverage	2025 Limit	2026 Limit
HSA Contribution Limit Self-Only	$4,300	$4,400
HSA Contribution Limit Family	$8,550	$8,750
HSA Catch-Up	$1,000	$1,000
HDHP Minimum Deductible Self-Only	$1,650	$1,700
HDHP Minimum Deductible Family	$3,300	$3,400
HDHP Out-of-Pocket Maximum Self-Only	$8,300	$8,500
HDHP Out-of-Pocket Maximum Family	$16,600	$17,000
ACA Out-of-Pocket Maximum Self-Only	$9,200	$10,600
ACA Out-of-Pocket Maximum Family	$18,400	$21,200
EBHRA	$2,150	$2,200

- ACA Out-of-Pocket maximum limits apply to *non-grandfathered plans* placing annual limit on cost-sharing for coverage of essential health benefits (EHB)
- Check the Out-of-Pocket maximum to confirm it complies with the limits
- Remember HDHP Out-of-Pocket maximum is lower than allowed ACA limit
- Watch out for embedded individual deductibles

2026 Employee Contributions: ACA Affordability

If an employer is an Applicable Large Employer, it must offer affordable, minimum value coverage to full-time employees or risk tax penalties. Coverage is considered affordable if the employee's required contribution for self-only coverage on the employer's lowest-cost minimum value plan is <= **9.96%** of the employee's household income for the year (2026)

Federal Poverty Level (FPL) Safe Harbor

Annual FPL * 9.96% / 12 months

January 2026 Renewals

$15,650 * 9.96% / 12 <= $129.89

February – December 2026 Renewals

$TBD * 9.96% / 12 <= $TBD

- Most predictable safe harbor
- Most costly safe harbor

Rate of Pay Safe Harbor

Hourly Rate * 130 hours * 9.96%

Ex: $12.00 * 130 * 9.96% <= $155.37

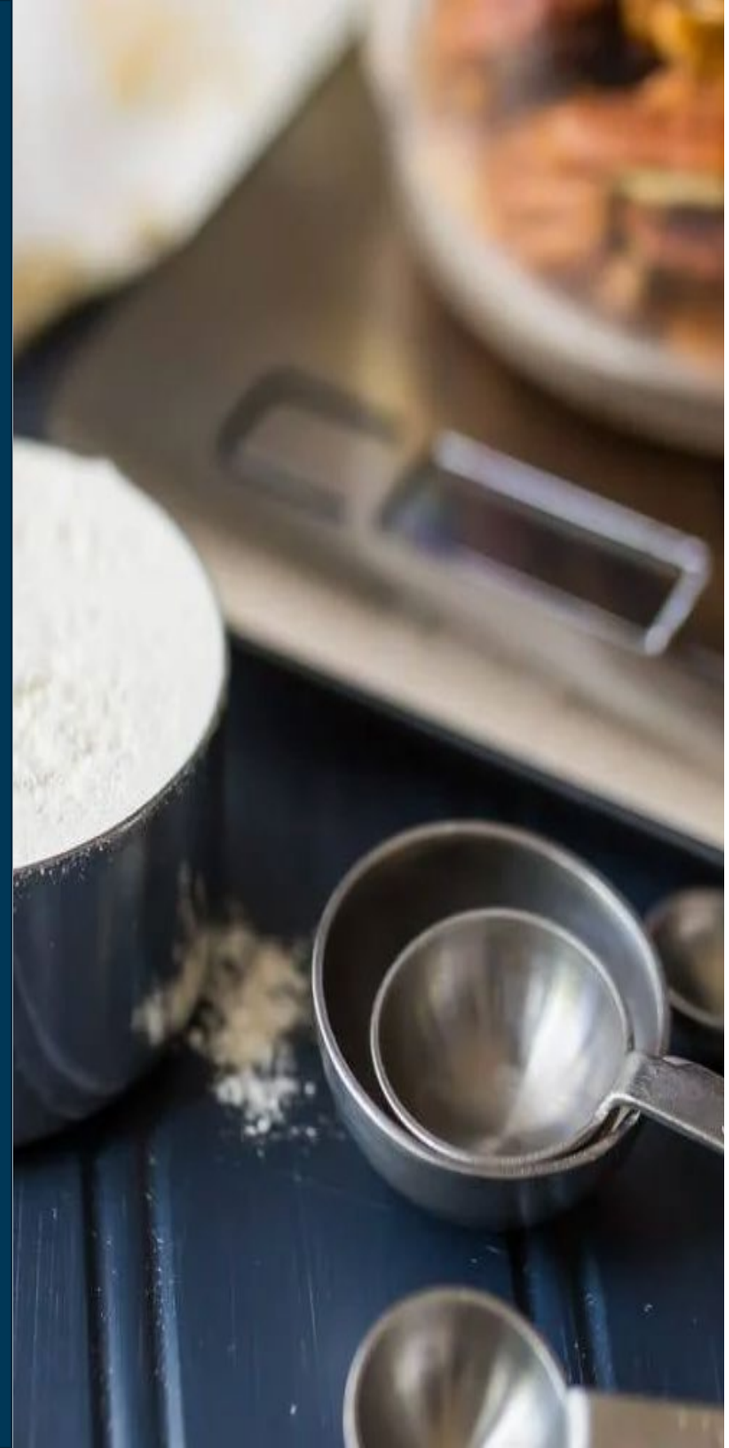
- Predictable safe harbor
- Based on EE's hourly rate first day of plan year or lowest rate during month
- Does not generally work for salaried, commissioned or tipped employees

W-2 Safe Harbor

Box 1 of 2026 W-2 * 9.96% / 12 months

Ex*:* $20,000 * 9.96% / 12 <= $166.00

- Least predictable safe harbor
- Can estimate expected Box 1 earnings to set rates, but affordability is based on *actual* 2026 Box 1 earnings
- EE contribution must remain consistent amount or % of all W-2 wages



Employee Contributions: ACA Affordability Special Factors

- Opt-Out Payments: *Conditional* opt-outs (i.e., the employee attests they have other minimum essential coverage) do not affect affordability calculations; however, if the opt-out is *unconditional* (no proof of coverage required), the affordability calculation includes both the employee's premium contribution *plus* the amount of the opt-out payment forgone as a result of electing coverage
  - Ex: EE contribution = $200. Opt-out incentive = $100. For purposes of ACA affordability, if opt-out is conditional, cost of coverage = $200; if opt-out is unconditional, cost of coverage = $300
- Wellness Program Incentives: For incentives related to tobacco cessation, assume all employees *meet* program requirements (i.e., use lower premium for affordability calculations); however, for all other incentives, assume all employees *fail to meet* the terms of the program (i.e., use higher premium for affordability calculations)
  - Ex: EE contribution = $200. Non-tobacco incentive = $50. Incentive for biometric testing = $25. Cost of coverage = $150 ($200 - $50 non-tobacco incentive)

It's Getting Spicy!
Wellness Program Compliance

Some Spicy Notes about Tobacco Surcharge Litigation

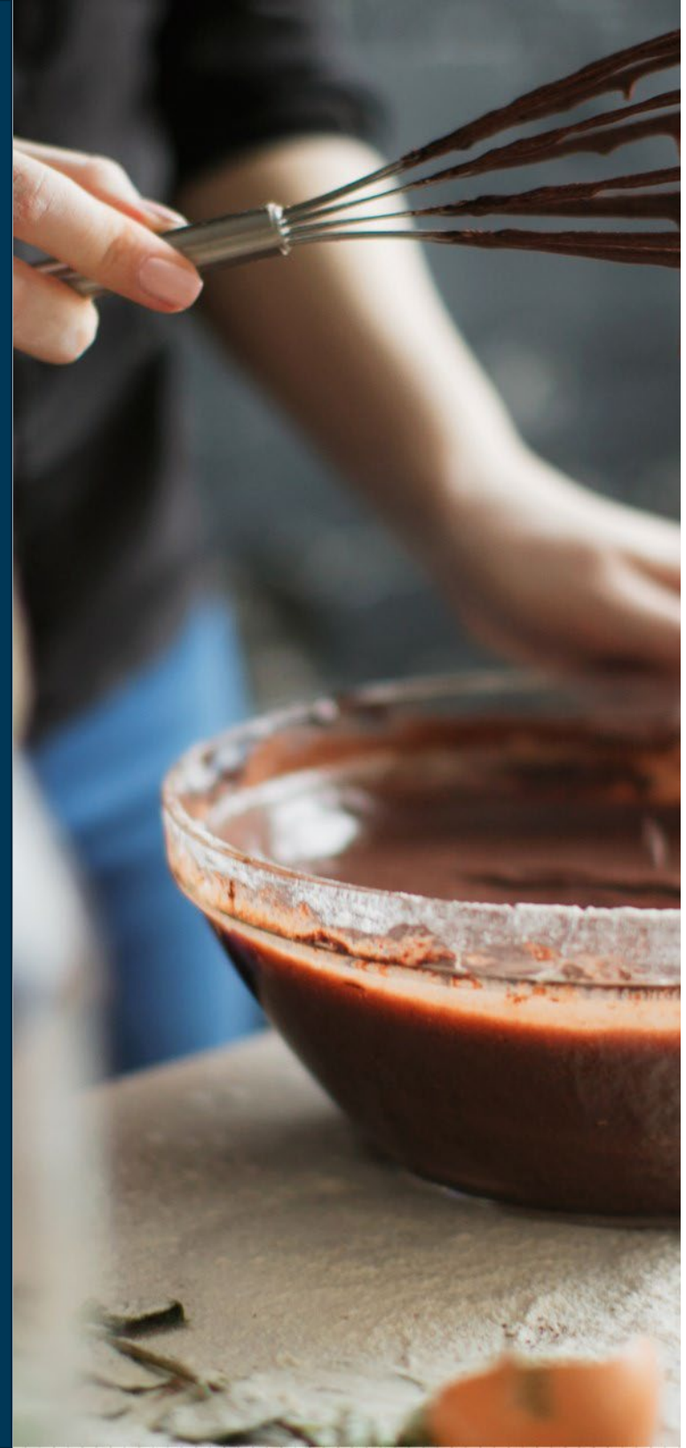
- Recent wave of class action lawsuits challenging wellness programs that impose a health coverage premium surcharge on participants if they do use tobacco or do not complete a tobacco cessation course
- Lawsuits allege:
  - Violations of HIPAA nondiscrimination rules because the defendants only offered the tobacco-free premium rate to participants who completed a tobacco cessation course on a *prospective* basis and not for the full plan year, failing to satisfy rules surrounding the reasonable alternative standard (RAS)
  - Notices regarding the availability of the tobacco cessation course as a way to earn the tobacco-free rate failed to comply with the wellness program rules
  - Breach of fiduciary duty
- No dispositive court ruling yet, but have had a case settle where employer agreed to pay back 62% of surcharges – another case allowed case to proceed past pleading stage

It's Getting Spicy! Wellness Program Litigation

Practical tips for employers:

- Employer must offer and pay for a RAS (e.g., tobacco cessation program)
- If employees are permitted to complete a RAS at any point during the plan year, the *full* reward must be made available (i.e., the incentive must be applied retroactively to the beginning of the plan year and not merely prospectively)
  - To avoid the issue of retroactive incentives, consider communicating early and setting a deadline for completing RAS prior to start of the plan year (e.g., for a Jan. 1 renewal, communicate wellness program far enough in advance to require employees to complete tobacco cessation program by Nov. 30)
- Remember that employees qualify for an incentive if they simply complete the RAS (e.g. a tobacco cessation program); they do *not* have to quit using tobacco
- Confirm RAS is properly disclosed in ALL plan materials and specifically states that participants unable to meet the standard for the reward might qualify for an opportunity to earn the same reward by different means and that the plan will work with participants (and, if they wish, with their doctor) to find a wellness program with the same reward that is right for them in light of their health status; the DOL provides a model notice for this communication
- Train staff and/or ensure vendor staff trained on RAS availability

Mixing It All Together
Plan Eligibility Considerations



Mixing It All Together: Plan Eligibility Considerations

Plan sponsors must determine how they want to define eligibility for each plan and clearly describe the criteria in plan documents

- **Who is considered a "full-time" employee?**
  - Applicable Large Employers: Which measurement method is being used to measure full-time status for ACA (i.e., monthly or look-back)? Is there is a written ACA Eligibility Policy and has it been approved by the carrier/stop-loss?
  - Is full-time measured the same for each benefit plan (e.g., medical vs disability)?
- **Who is considered an eligible spouse?**
  - Spousal Carve-Outs: What constitutes "other coverage?" It is advisable to limit to coverage offered through the spouse's employer (i.e., do not include Medicare, Tricare, Medicaid or Marketplace coverage). Employers should also consider administrative practicalities (i.e., affidavit requirements and timing)
  - Domestic Partnerships: Is coverage required? This may depend on employee/employer location and whether plan is fully-insured or self-funded. How are terms defined? What proof is required?
- **Are any "other participants" eligible for the plans?**
  - Covering non-employees raises MEWA concerns (e.g., independent contractors, Board of Directors, employees of unrelated entities outside of controlled group)

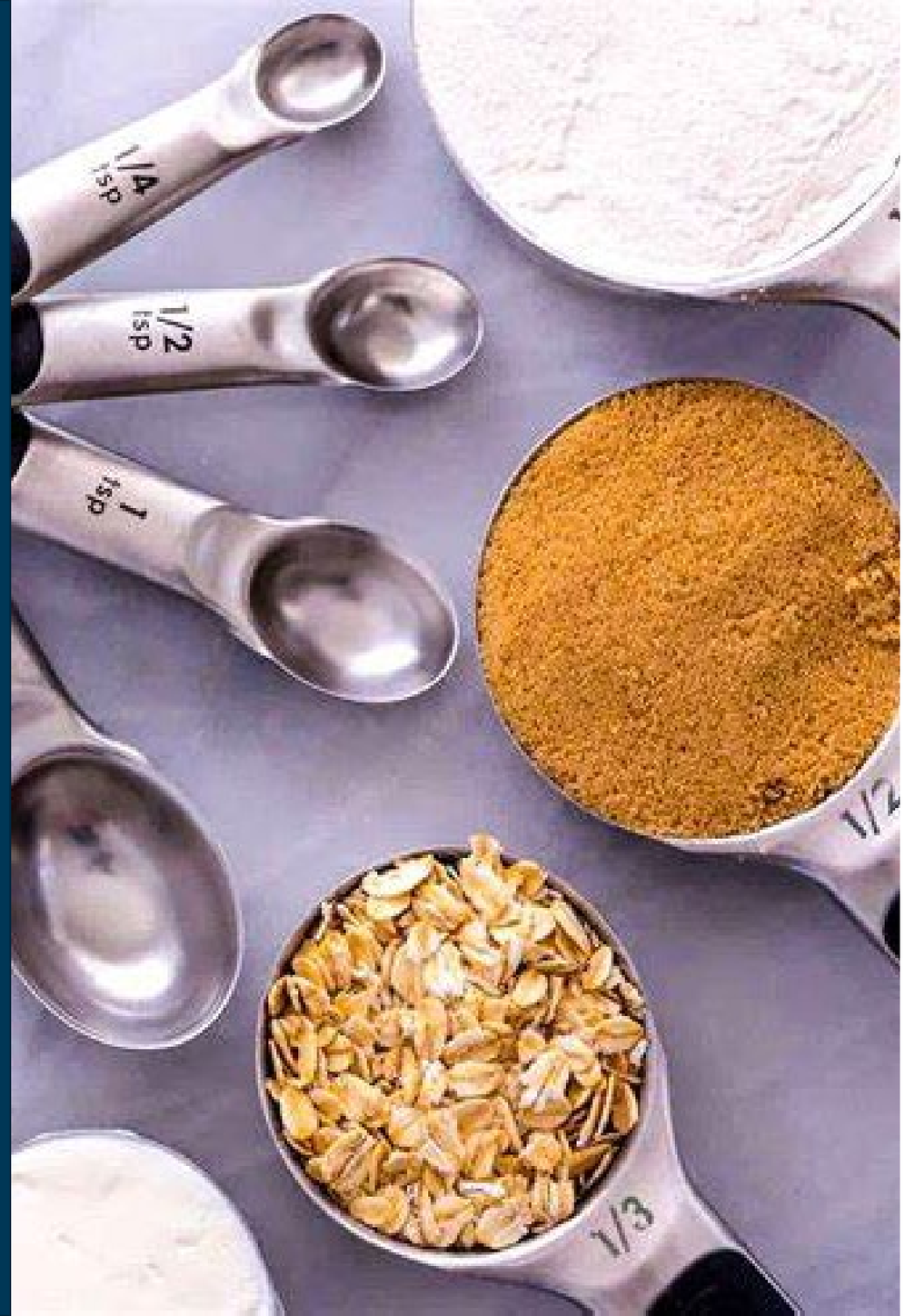
Mixing It All Together: Plan Eligibility and Impermissible Exclusions

- Medicare Secondary Payer rules apply to employers with 20 or more employees and prohibit forcing or encouraging Medicare-eligible employees (or spouses) to move off the health plan
- HIPAA prohibits group health plans from discriminating against individuals with regard to eligibility (premiums or coverage) based upon a health status-related factor (e.g., medical condition, claims experience, medical history, genetic information)
- The ACA prohibits plan sponsors from imposing a waiting period that exceeds 90 days

Mixing It All Together: Plan Eligibility and Continuation of Benefits During Periods of Inactive Status

How long do benefits continue when an employee is inactive for an extended period (leave of absence, furlough, etc.)?

- Ideally, plan documents for each benefit offered should clearly define how eligibility is impacted when an employee is inactive for an extended period, accurately reflecting how eligibility is handled in actual practice
- If leave is protected by FMLA or other state leave regulation, employer plan sponsors may be required to continue benefits for a certain duration
- If the employer is using the look-back measurement method to determine full-time status and the employee is currently in a stability period, this directly impacts whether the employee is considered eligible through the end of the stability period
- It's a best practice to have a policy addressing how long benefits may be continued when an employee is not actively working, to have that policy approved by the carrier or stop-loss vendor, and to follow that policy consistently to avoid any perception of discrimination



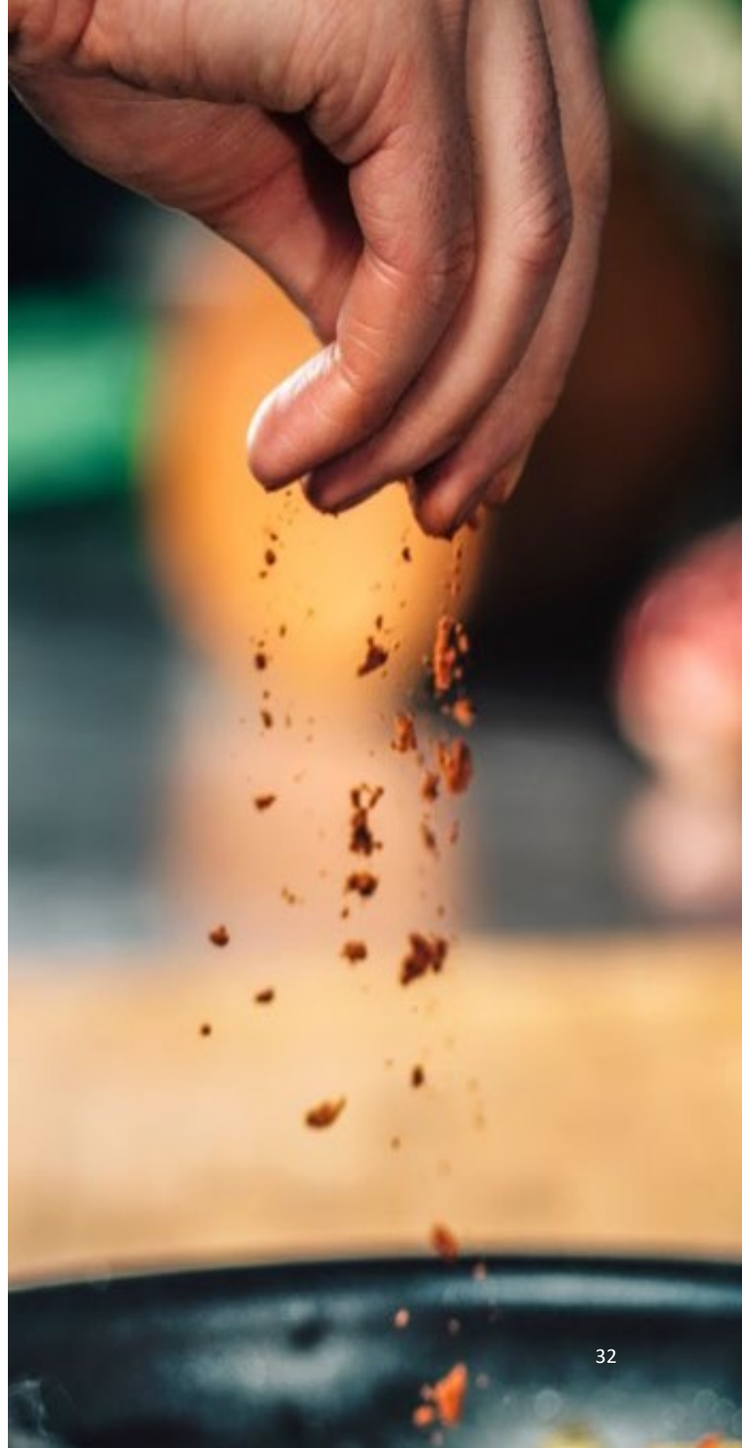
Mixing It All Together: Plan Eligibility, Plan Documents & Making Exceptions

- Plan sponsors of ERISA plans are required to have a written plan document and summary plan description (SPD) and have a fiduciary duty to establish, maintain and administer their plan in accordance with these written terms
- Eligibility should be clearly defined
- Employers should ensure that all employee communications are consistent (e.g., benefits guide, ben admin enrollment, etc.)
- Granting exceptions violates this ERISA fiduciary duty, creates potential financial risks, and may act in the same manner as a plan amendment, creating a precedent requiring the plan to offer the same benefit coverage to all similarly situated participants
- Exceptions may also create a risk of carriers/stop-loss denying claims for ineligible participants, leaving employers financially responsible for violations

Finishing Touches:
Compliance for the Plan Year

Finishing Touches: Compliance for the Plan Year

- McGriff One Big Beautiful Act - Employee Benefit Effects
- Compliance Concerns for Stand-Alone Supplemental Health Programs
- Compliance Q&A: 2026 ACA Affordability Safe Harbors
- Tobacco Surcharges – Legal Rules
- McGriff Fiduciary Responsibilities Placemat
- Compliance Q&A: Continuation of Benefits During a Leave of Absence
- McGriff ACA Eligibility Policy Toolkit (ask your McGriff Benefits Consultant for more information)
- McGriff Compliance Calendar (ask your McGriff Benefits Consultant for more information)
- McGriff 2026 Reporting and Disclosures Guide and accompanying Brainshark Recording



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