Compliance Monthly Update: July 2025

A brief update on what happened the prior month in group health plan compliance at the federal level–organized chronologically. If you would like additional information, please reach out to the GBS Compliance Team.

Supreme Court declines to review Oklahoma PBM case, upholding 10th Circuit ruling that ERISA preempts the Oklahoma PBM law. On June 30, the Supreme Court of the United States (SCOTUS) announced that it will not review the 10th Circuit Court of Appeal's decision in the *PCMA v. Mulready* case. The 10th Circuit had held that ERISA preempts an Oklahoma law regulating PBMs because the provisions of the law regulated central matters of plan administration and interfered with nationally uniform plan administration. The provisions held preempted under ERISA included: (a) network restrictions that mandated access to brick-and-mortar pharmacies based on where individuals reside (which could be different than the pharmacy networks applicable for a group health plan's participants), (b) prohibitions on restricting an individual's choice of in-network provider (e.g., retail or mail order) and promotion of network pharmacies by using cost-sharing and copayment reductions—prohibitions that were generally interpreted to prohibit mail-order pharmacy benefit incentives, (c) any-willing-provider provisions that require plans to accept any provider into a pharmacy network who meets network standards, and (d) prohibitions on basing a pharmacy license on the probation status of a licensed pharmacist. Oklahoma requested that SCOTUS review the case, but with the decision to not hear the case, the 10th Circuit ruling that ERISA preempts the Oklahoma law will stand. This decision is an important ruling that strengthens ERISA preemption and will likely be a significant factor in whether future state PBM laws will apply to ERISA-governed plans.

Supreme Court vacates lower court ruling requiring plan coverage for "gender-affirming" care under ACA Section 1557 nondiscrimination rules. On June 30, the Supreme Court of the United States (SCOTUS) weighed in on health plan exclusions of "gender-affirming" care when they vacated a Fourth Circuit Court of Appeal's decision that the exclusion of coverage for "gender-affirming" care by state health plans and Medicaid programs violated the nondiscrimination protections of ACA Section 1557. Plaintiffs alleged that the exclusion of coverage for certain procedures for the treatment of gender dysphoria—but not other medical conditions—discriminated on the basis of sex in violation of Section 1557 and other nondiscrimination laws. The trial court agreed with the plaintiffs, and the Fourth Circuit affirmed. SCOTUS has now vacated the decision, sending it back to the Fourth Circuit for reconsideration in light of the recent SCOTUS decision in *United States v. Skrmetti*. In *Skrmetti* (as we discussed in last month's update), SCOTUS upheld a Tennessee law's ban on puberty blockers and hormone therapy for transgender teenagers, concluding that the law did not violate the U.S. Constitution's Equal Protection Clause. SCOTUS subjected the law to only the lowest level of scrutiny because it determined that the ban does not draw classifications based on sex—rather, it prohibits such treatments for certain medical uses with respect to all minors, regardless of sex or gender.

Group health plan provisions in the budget reconciliation bill. On July 4, President Trump signed into law the sweeping tax and spending budget reconciliation bill titled the "One Big Beautiful Bill Act" (OBBB) that includes several provisions applicable to group health plans. The original version of the bill passed by the House on May 22 contained various changes applicable to HSAs and ICHRAs, but most of those items (except for the items listed below) were removed by the Senate during the reconciliation

process. The final version of the bill does include some helpful changes related to HSA eligibility and dependent care assistance programs (DCAPs). Here are the highlights:

- Telehealth and HSA eligibility. The OBBB revives the previously expired rule permitting individuals to contribute to an HSA when eligible to receive free or reduced cost telehealth services (even if the telehealth visit is not for preventive care) before satisfying the statutory minimum deductible for HDHPs. This change is permanent and retroactive to plan years beginning on or after January 1, 2025. Now that this allowance is permanent, plan sponsors no longer need to charge HDHP participants the fair market value for non-preventive telehealth services and participants can receive first-dollar telehealth coverage without jeopardizing HSA eligibility.
- Direct primary care and HSA eligibility. Direct primary care (DPC)—a model where patients pay providers a retainer-like fee to obtain certain primary care services—will no longer be considered a disqualifying health plan for HSA purposes effective January 1, 2026. The DPC arrangement may only provide for primary services, not including any procedure requiring general anesthesia, prescription drugs (other than vaccines), or laboratory services not typically administered in an ambulatory primary care setting. The monthly DPC fee cannot exceed $150 for an individual or $300 for family coverage (indexed for inflation). In addition, DPC membership fees will now qualify as an HSA-eligible expense that can be reimbursed from an HSA starting January 1, 2026.
- DCAP limits increased. For the first time since 1986, Congress has increased the amount parents can contribute to a DCAP (also known as a dependent care FSA). The limits of $5,000 ($2,500 for married but filing separately) will increase to $7,500 and $3,750 respectively, effective beginning January 1, 2026. As with the prior limits, this new limit is not indexed for inflation and will remain at $7,500/$3,750 unless Congress again changes it.
- Other changes. The OBBB provides that Marketplace bronze and catastrophic individual coverage plans are to be treated as qualifying HDHPs for HSA purposes beginning in 2026. Also, employers sponsoring a Section 127 Educational Assistance Program will be able to continue to provide tax-free student loan repayments (previous rule was set to expire December 31, 2025) up to the indexed statutory maximum (currently $5,250). Finally, the bicycle commuting reimbursement has been removed from under the Section 132(f) Transportation Fringe Benefit allowances effective January 1, 2026.

2026 ACA affordability percentage increases to 9.96%. On July 18, the IRS announced in Rev. Proc. 2025-25 that the ACA affordability percentage for plan years beginning in 2026 will be increasing to 9.96% (from 9.02% for 2025). As a reminder, under the ACA employer mandate, applicable large employers (ALEs) must offer affordable health coverage to full-time employees or face potential penalties. The annually adjusted affordability percentage is used to determine the threshold, at or below which the cost of coverage will be considered affordable. Generally, coverage offered to a full-time employee will be considered affordable if the employee's contribution for self-only coverage does not exceed the applicable percentage of the employee's household income for the taxable year. Because employers typically are unaware of what an employee's actual household income is, the rules provide three affordability safe harbors: (1) employee's Form W-2 wages; (2) employee's rate of pay; and (3) the federal poverty line. Employers should review the required employee contribution for 2026 coverage if they plan to meet the ACA's affordability limit under the applicable safe harbor.

2026 ACA employer mandate penalty amounts released. On July 22, the IRS issued Rev. Proc. 2025-26 with 2026 indexed amounts used to calculate the ACA employer shared responsibility payments (ESRP) that applicable large employers (ALEs) may be liable for if they (1) fail to offer minimum essential

coverage to 95% of full-time employees and their dependent children (i.e., the subsection (a) penalty), or if they (2) fail to offer coverage to full-time employees that is affordable and minimum value (i.e., the subsection (b) penalty). The adjusted penalty amount for failures occurring in the 2026 calendar year under subsection (a) will be $3,340 per full-time employee (less the 30-employee reduction)—a $440 increase from 2025. The 2026 calendar year penalty under subsection (b) will be $5,010 per full-time employee that receives subsidized coverage through an Exchange—a $660 decrease from 2025. Current and previous penalty amounts are available on the IRS Question and Answers on Employer Shared Responsibility under the ACA webpage. Note that the IRS uses Letter 226-J to inform ALEs of potential ESRP amounts, and a response is generally due within 90 days for the ALE to inform the IRS if they agree or disagree with the proposed penalty. ALEs should be prepared to promptly respond to any Letter 226-J received.

Updated model CHIP Notice released. The DOL has released a new model employer CHIP Notice (available HERE) with information current as of July 31, 2025. As a reminder, group health plans that maintain a plan with participants who reside in a state that provides premium assistance under Medicaid or CHIP have an annual notice requirement to notify employees of the potential opportunities for premium assistance. The model CHIP notice is updated periodically to reflect changes in the states that offer premium assistance and changes to the relevant state contact information.