# Compliance Monthly Update: June 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.*

**DOL/EBSA launch opinion letter program.** On June 2, the DOL announced the relaunch of its opinion letter program in an expansion of its compliance assistance tools. The program is designed to provide plan sponsors (and others) with clear, tailored guidance related to group benefit plans from the DOL's Employee Benefits Security Administration (EBSA). The EBSA is responsible for enforcing ERISA and will be able to issue opinion letters in the form of (1) advisory opinions that will apply the law to specific factual situations presented by requesters or (2) information letters that will provide general interpretation of the law without applying it to specific facts. Anyone can request an opinion letter, and to request one, the requesting party should submit a detailed inquiry to EBSA outlining the specific facts and questions for which guidance is sought. Submission guidelines are available on DOL's website. Note that opinion letters are somewhat limited in their application. For advisory opinions, the opinion assumes that all material facts and representations set forth in the request are accurate, and the opinion applies only to the situation described in the submission. Other particular circumstances may be different enough to warrant a different result. Additionally, only the parties described in the request for opinion may rely on the opinion, and they may rely on the opinion only to the extent that the request fully and accurately contains all the material facts and representations necessary to issuance of the opinion. Information letters are informational only and not binding on the DOL/EBSA.

**Reminder that PCORI fee and filing is due by July 31.** The annual ACA Patient-Centered Outcomes Research Institute (PCORI) filing and fee on insurers and sponsors of self-funded medical plans (including HRAs) is coming up. The filing and payment due July 31, 2025, is required for policy and plan years that ended during the 2024 calendar year. For plan years that ended January 1, 2024 – September 30, 2024, the fee is $3.22 per covered life. For plan years that ended October 1, 2024 – December 31, 2024 (including calendar year plans that ended December 31, 2024), the fee is $3.47 per covered life. The PCORI fee is reported and paid using IRS Form 720. See the Form 720 Instructions for more information and instructions on reporting and paying the fee. Please also refer to our branded resource on the topic. As a reminder:

- Insurers report and pay the fee for fully insured group medical plans.
- For self-funded plans, the plan sponsor (e.g., the employer) reports and pays the fee.
- An employer that sponsors an HRA along with a fully insured medical plan must pay the PCORI fee based on the number of employees (dependents are not included in this count) participating in the HRA, while the insurer pays the PCORI fee on the individuals (including dependents) covered under the insured plan.
- Where an employer maintains an HRA along with a self-funded medical plan and both have the same plan year, the employer pays a single PCORI fee. Each person covered by both plans is only counted once. If the HRA covers anyone who is not also covered under the self-funded medical plan, the sponsor counts those individuals using the one life per participant rule.

**Federal court blocks enforcement of ACA Section 1557 regulations against Catholic association**. On June 5, a federal court blocked enforcement of ACA Section 1557 regulations against members of a

Catholic employer association. The association challenged the 2024 Section 1557 regulations that prohibit discrimination on the basis of gender identity and provides a case-by-case procedure for religious exemptions. The association argued the rules violate the Religious Freedom Restoration Act (RFRA) by requiring Catholic organizations to cover or provide gender-transition procedures, which they consider immoral. The court sided with the association, ruling that the 2024 regulations' prohibition of discrimination on the basis of gender identity violates the members' sincerely held religious beliefs under the RFRA. Concluding that the 2024 regulations' new case-by-case procedure for exemptions substantially burdened the members' exercise of religion because it did not allow them to predict their legal exposure and was not the "least restrictive means available," the court issued a permanent injunction preventing HHS and the EEOC from enforcing regulations that require the members to perform or provide insurance coverage for gender-transition procedures. While this case was decided under the RFRA and applies only to the current members of this association, another court has issued a broader nationwide injunction and stay on the portions of the 2024 regulations that extend the protections of Section 1557 to gender identity.

**Supreme Court upholds state law banning transgender treatment for minors.** On June 18, the Supreme Court of the United States (SCOTUS) in *United States v. Skrmetti* upheld a Tennessee law banning certain medical treatments for transgender minors—ruling the law does not violate the equal protection clause of the 14th amendment.

- The Tennessee law (which is similar to laws in about half the states) prohibits all medical treatments intended to allow "a minor to identify with, or live as, a purported identity inconsistent with the minor's sex" or to treat "purported discomfort or distress from a discordance between the minor's sex and asserted identity." Such medical treatments may include surgery, puberty blockers, and hormone therapy. Those treatments are permitted for other medical purposes besides treating gender dysphoria, gender identity disorder, or gender incongruence.
- SCOTUS reasoned that the law classifies on the basis of age and medical use—both of which are subject to rational basis review—and not on the basis of sex which would trigger heightened scrutiny by the Court. Chief Justice Robert wrote that while the law's "prohibitions reference sex, the Court has never suggested that mere reference to sex is sufficient to trigger heightened scrutiny. And such an approach would be especially inappropriate in the medical context, where some treatments and procedures are uniquely bound up in sex." The Court distinguished this case from *Bostock* (the 2020 SCOTUS ruling finding that Title VII of the Civil Rights Act prohibits an employer from firing workers for being gay or transgender) because *Bostock* held that firing individuals for being gay/transgender is sex discrimination because the individual's sex is a "but-for" cause of differing outcomes. Here in *Skrmetti*, SCOTUS found that sex is not a "but-for" cause because neither a boy nor a girl would have access to the prohibited treatment for gender dysphoria or certain conditions under the law.
- The majority found the law was constitutional under the rational basis standard due to the legitimate interest of the Tennessee legislature in preventing harm associated with using puberty blockers to treat gender dysphoria in minors. The Court reached this holding while acknowledging that under Tennessee law puberty blockers remain a legal treatment of minors for conditions other than gender dysphoria. The Court found this distinction did not create an unlawful sex-based distinction.
- For group health plan sponsors, coverage of transgender care for minors should be viewed similarly to abortion—in that SCOTUS is essentially leaving the regulation of these items to the states. *Skrmetti* does nothing to limit access to transgender care for minors in states that do not currently ban or restrict such care, or where states have taken extra steps to protect these types

of transgender treatment. That is, employer group health plans can cover these services as long as it is legal where provided. For example, In the case of insured plans, currently about half the states prohibit plan exclusions of transgender care, and these states may soon follow Colorado's lead and affirmatively require coverage for medically necessary "gender-affirming" care.

**Federal court vacates 2024 HIPAA reproductive health care privacy rule**. On June 18, a federal district court issued an order vacating, on a national basis, a majority of the 2024 HIPAA Privacy Rule to Support Reproductive Health Care Privacy. As a reminder, HHS had issued the 2024 Privacy Rule in response to the Supreme Court's *Dobbs* decision holding that the Constitution does not prohibit states from regulating or banning abortion. The 2024 Privacy Rule amended the broader HIPAA Privacy Rules with new definitions, imposed a new attestation requirement for requests of Protected Health Information (PHI) potentially related to reproductive health care, and required covered entities to make changes to their Notice of Privacy Practices (NPP). Here, the court concluded that the 2024 Privacy Rule unlawfully limits disclosures to state authorities regarding abuse and public health and exceeds HHS's authority by unlawfully defining "person" to exclude unborn children and narrowing the definition of "public health." The court further held that HHS had acted outside its statutory authority by promulgating special protections for reproductive health care information, regulating a matter of great political significance that is traditionally left to the states, without clear Congressional authorization. While the court struck down the requirement to update the NPP related to reproductive health care, the court left in place the changes to the NPP regarding substance use disorder records. Plan sponsors should review their HIPAA policies and procedures, Business Association Agreements (BAAs), NPP, and any HIPAA training materials to ensure they are current and do not reflect the parts of the 2024 Privacy Rule that were vacated. But the NPP will still need to be revised to include language about confidentiality of substance use disorder records by February 16, 2026. We expect HHS to release an updated model NPP prior to this deadline.

**HHS finalizes ACA exchange coverage and affordability rule with revised 2026 cost-sharing limits.** On June 20, HHS and CMS released final regulations titled "Patient Protection and Affordable Care Act; Marketplace Integrity and Affordability" (and an associated press release and fact sheet). The final rule largely finalized with little or no changes to the proposed rule we discussed in March earlier this year. The final regulations address the integrity of the ACA Exchanges (aka Marketplaces), the affordability of health coverage, changes to annual cost-sharing limits, eligibility and enrollment procedures, and the definition of essential health benefits (EHBs). Below are the highlights.

- Revised 2026 annual cost-sharing limits. HHS has updated the methodology for calculating the "premium adjustment percentage" (which is used to set several ACA parameters) to align with premium trends, beginning in 2026. Based on this change, the maximum annual limitation on cost-sharing for 2026 has been revised to $10,600 for self-only coverage and $21,200 for other than self-only coverage. The revised limitation supersedes the previously announced 2026 limits of $10,150 and $20,300.
- Prohibition of coverage of transgender procedures as an EHB for individual and small group plans. Beginning in 2026, HHS will prohibit insurance plans subject to the ACA EHB coverage requirements from providing "specified sex-trait modification procedures" as an EHB. HHS provides a lengthy definition of specified sex-trait modification procedures which includes "any pharmaceutical or surgical intervention provided for the purpose of attempting to align physical appearance with an asserted identity that differs from biological sex" such as puberty blockers, sex hormones and surgical procedures. But the prohibition does not extend to mental health services, including for persons with gender dysphoria. This will impact all non-grandfathered plans in the individual and small group market (which are subject to the EHB requirements).

HHS explains that insurers may still voluntarily cover specified sex-trait modification procedures and states are generally not prohibited from mandating coverage of such services, but they are not considered EHB.

- Exchange eligibility and enrollment. The Exchange integrity changes (which do not have a direct impact on group health plans) are designed to tamp down on improper enrollments, to stop the excess flow of federal funds that resulted from the temporary expansion of ACA premium subsidies in response to COVID, to protect against adverse selection, and to lower individual coverage premiums. The final regulations include revised standards for Exchange income verification processes, new rules for pre-enrollment verification for special enrollment periods, and modified eligibility redetermination procedures. These provisions will apply for the 2026 plan year but are currently scheduled to sunset at the end of that year. The regulations also remove Deferred Action for Childhood Arrivals (DACA) recipients from the definition of "lawfully present" for eligibility and enrollment in Exchanges, effective August 24, 2025. Starting in 2027, the Exchange annual open enrollment period has been revised to begin no later than November 1 and end no later than December 31 of the calendar year preceding the benefit year, with the period not to exceed 9 weeks. The federal Exchange open enrollment period will run from November 1 through December 15. Coverage for enrollments during the open enrollment period must begin on January 1.

**Supreme Court upholds constitutionality of ACA preventive services mandate**. On June 27, the Supreme of the United States (SCOTUS) in *Kennedy v. Braidwood Management, Inc.* upheld as constitutional the appointment of members of the U.S. Preventive Services Task Force (PSTF)—one body whose recommendations help determine which items and services are "preventive care" for purposes of required coverage under the ACA.

- As a reminder, the ACA requires health plans to cover preventive services with no cost-sharing for participants, and the ACA empowers three agencies—the U.S Preventive Services Task Force (PSTF), the Health Resources and Services Administration (HRSA), and the Advisory Committee on Immunization Practices (ACIP)—to determine what kinds of preventive care fall within each category of mandatory coverage by issuing guidelines or recommendations.
- In March of 2023, a district court ruled in the *Braidwood* case that the ACA requirement to provide preventive services as recommended by the PSTF is unconstitutional and issued a nationwide injunction that prohibited the federal government from enforcing the ACA preventive services mandate. However, that district court ruling was stayed pending the outcome of the appeal.
- In June of 2024, the Fifth Circuit affirmed that the PSTF's members had not been validly appointed under the Constitution because they were not nominated by the President and confirmed by the Senate. The court explained that this appointment process is necessary due to the level of power exercised by the PSTF in making recommendations on preventive services required to be covered under the ACA. Under this ruling, HHS was enjoined from enforcing PSTF recommendations, but only as to the *Braidwood* plaintiffs. The court reversed the trial court's decision to vacate all agency actions taken to enforce the preventive services mandates and to universally block the agencies from enforcing the mandates with a nationwide injunction. The court withheld judgment and remanded the case back to the trial court to determine if the members of HRSA and ACIP were also unconstitutionally appointed. So, although the Fifth Circuit ruled that some aspects of the ACA preventive service requirements are unconstitutional, those requirements still applied to group health plans nationwide (except for the plaintiffs who brought this lawsuit). Therefore, the preventive services requirement remained intact for the time being.

- Then the DOJ, under the Biden administration, asked SCOTUS to review the Fifth Circuit holding that the appointment of the PSTF is unconstitutional. On January 10, 2025, SCOTUS agreed to hear the case, and on April 21, 2025, oral arguments were held.
- Now, on June 27, 2025, SCOTUS held that the PSTF members were validly appointed by the Secretary of HHS. The Court explained that whether the appointment was constitutional turns on whether the members are "principal officers" or "inferior officers." Principal officers must be nominated by the President and confirmed by the Senate, whereas inferior officers may be appointed by department heads, such as the Secretary of HHS. SCOTUS held that PSTF members are inferior officers because they are supervised and directed by the Secretary, removable at will by the Secretary, and their recommendations are reviewable and may be revoked by the Secretary. The Court concluded that, because Congress has the authority to vest the power to appoint inferior officers in the Secretary (and has done so), the Secretary's appointment of members pursuant to that grant of authority is valid under the Constitution. SCOTUS's decision affirms the constitutional authority of the PSTF to shape the ACA preventive services mandate. Group health plans generally should not require any immediate action since the Fifth Circuit decision was put on hold pending appeal and the coverage requirements remained in effect during the litigation.