Monthly Compliance Update

April 2026

*A brief update on what happened the prior month in group health benefits compliance at the **federal level** and organized chronologically.*

Regulatory agencies signal upcoming new MHPAEA regulations. In a March 30 joint status report—filed in litigation challenging 2024 final regulations under the Mental Health Parity and Addiction Equity Act (MHPAEA)—the DOL, IRS, and HHS indicated they do not intend to defend the 2024 final rule. Instead, the agencies stated that they will issue a new proposed rule, including significant revisions to the provisions challenged in the case. The agencies announced this new proposed rule is targeted for release no later than December 31, 2026. (Note that the dates indicated are not binding and frequently slip.) The regulatory agencies had previously announced that they would not enforce the 2024 final regulations with respect to alleged noncompliance occurring prior to a final decision in the litigation, plus an additional 18 months. But this enforcement relief applies only to provisions that are new relative to the 2013 final rule, so earlier statutory and regulatory obligations, including the non-quantitative treatment limitation (NQTL) comparative analysis requirement, remain in effect.

Appeals court dismisses two separate ACA Section 1557 challenges to plans' exclusion of weight-loss drugs. The First Circuit has affirmed two lower court dismissals of lawsuits challenging health plans' exclusion of weight-loss drugs. As a reminder, under ACA Section 1557, covered entities are prohibited from discriminating on the basis of protected characteristics—including race, color, national origin, sex, age, or disability. Only group health plans receiving federal assistance from HHS are considered covered entities under Section 1557, but in practice most plans do not receive federal assistance directly from HHS, therefore most plans are not directly subject to Section 1557. However, most carriers (including related TPAs) are subject to Section 1557 through receipt of Marketplace subsidies. The risk of a Section 1557 lawsuit for employers then, is that a carrier or TPA subject to litigation changes its clients' plans or requires client indemnification for the carrier's continued exclusion to avoid further litigation.

- In *Whittemore v. Cigna Health*, the First Circuit held that a participant did not plausibly allege she had a disability simply by stating she had been diagnosed with obesity and prescribed medication to treat it. The plaintiff filed the lawsuit alleging disability discrimination under ACA Section 1557. The court explained that to state a disability discrimination claim, the participant had to show she was disabled as defined by the ADA—that defines disability as a physical or mental impairment that "substantially limits one or more major life activities." The participant's complaint alleged that her obesity substantially limited her in major life activities such as walking, standing, and sleeping. The court, however, concluded that these allegations were conclusory "threadbare recitals of the elements of a cause of action." The court also rejected the participant's argument that any individual diagnosed with obesity and prescribed medication for it is, by definition, substantially limited in the operation of major bodily functions—reasoning that such general statements about obesity's potential health impacts do not plausibly support an inference that every person in that category is disabled under the ADA. So, this case is an example that a medical diagnosis by itself will not automatically rise to disability discrimination under ACA Section 1557.

- Then in *Holland v. Elevance Health*, the First Circuit affirmed the dismissal of another proposed class action disability discrimination claim for failure to cover weight-loss drugs. In this case, an employee who was diagnosed with obesity and prescribed FDA-approved weight-loss medications sued her health plan's insurance administrator after it denied coverage based on a plan exclusion for weight-loss medications. The participant alleged that the exclusion violated ACA Section 1557 by discriminating against her on the basis of disability. The First Circuit concluding the participant had not plausibly shown that the exclusion disproportionally impacts people with disabilities. The court noted that the medications are also approved for overweight individuals who are not disabled, so the "fit" between the excluded service and the protected class was not sufficiently close. The court also rejected the claim of intentional discrimination, concluding the exclusion was facially neutral because it applied to all enrollees seeking weight-loss drugs, not just those with obesity.
- While litigation involving ACA Section 1557 claims are in flux, these holdings state that a broad exclusion for weight-loss drugs does not, by itself, state a claim for disability discrimination under ACA Section 1557. So, these decisions offer some reassurance to plan sponsors that have similar weight-loss drug plan exclusions.

2027 Medicare Part D benefit parameters released, and CMS exempts HRAs from Part D creditable coverage disclosure and reporting requirements. As background, most group health plan sponsors offering prescription drug coverage to Medicare Part D eligible individuals must disclose to those individuals (and to CMS) whether the plan coverage is creditable or non-creditable. For coverage to be creditable, its actuarial value must equal or exceed the actuarial value of the defined standard Medicare Part D coverage. Employers are not required to offer creditable coverage, but they are required to provide Part D eligible individuals with a notice indicating whether the plan offerings are creditable or not. The purpose of the notice is to help individuals make informed decisions about Medicare enrollment and avoid incurring a late enrollment penalty. Reporting to CMS enables the agency to apply the late enrollment penalty to individuals who delay Part D enrollment beyond their initial period triggered by their 65th birthday and who lack creditable coverage for at least 63 days.

- On April 6, CMS published final regulations relieving health reimbursement arrangements (HRAs) and individual coverage HRAs (ICHRAs), effective beginning in 2027, of the obligation to provide notices of creditable coverage to Medicare Part D eligible individuals and to CMS. CMS reasoned that since HRAs are designed to provide cost savings through pre-tax reimbursements and to supplement other coverage—applying creditable coverage concepts is inapplicable, confusing, and burdensome. In short, CMS views HRAs as inherently distinct from prescription drug plans and as being designed to supplement prescription drug coverage rather than function as prescription drug coverage themselves.
- The final regulations also update the simplified method that group health plans not receiving a retiree drug subsidy may use to demonstrate creditable coverage. Plan sponsors can determine creditable status using either the simplified determination method or an actuarial evaluation. Under the final rule, for plan years beginning in 2027, a plan's prescription drug coverage will be deemed creditable under the simplified method if it: (1) provides reasonable coverage for brand name and generic prescription drugs and biologicals, (2) provides reasonable access to retail pharmacies, and (3) is designed to pay on average at least 73% (adjusted annually) of participants' prescription drug expenses.
- CMS also announced the 2027 parameters for the defined standard Medicare Part D prescription drug benefit which continue to reflect the Inflation Reduction Act's changes to the structure of the Part D benefit. Key 2027 parameters include an annual deductible of $700 (up from $615 in 2026) and an annual out-of-pocket threshold of $2,400 (up from $2,100 in 2026).

Other 2027 parameters include the cost-sharing amounts for certain low-income subsidy-eligible individuals and the cost threshold and limit for the retiree drug subsidy program.

HHS releases HIPAA Security Rule risk management educational video. On April 8, HHS released an educational video (titled "Risk Management Under the HIPAA Security Rule") detailing the risk management requirements under HIPAA as well as findings and conclusions from HHS' HIPAA investigations. As background, HHS previously released a webinar (titled "The HIPAA Security Rule Risk Analysis Requirement") on how covered entities and business associates should conduct a comprehensive risk analysis of all electronic protected health information (ePHI) to identify potential risks and vulnerabilities to its confidentiality, integrity, and availability. Covered entities and business associates then must create a risk management plan (based on the risk analysis) to implement appropriate safeguards that reduce identified risks to a reasonable and appropriate level. This newly released video is intended to raise awareness and provide practical guidance on the risk management requirement (in addition to the risk analysis requirement). HHS emphasizes that risk management is not a one-time compliance exercise or paperwork obligation. Instead, risk management by HIPAA covered entities and business associates must implement, maintain, and document ongoing security measures that actually reduce risks to ePHI.

DOL announces shift in enforcement priorities. The DOL's Employee Benefits Security Administration (EBSA), that regulates and investigates ERISA plans, issued Field Assistance Bulletin (FAB) 2026-01 on April 14 reforming its employee benefit plan enforcement priorities. The FAB titled "Guiding Principles for EBSA Enforcement Priorities" sets out the following four priorities in that the EBSA will:

- Focus enforcement on the most egregious conduct and significant harm by plan fiduciaries, namely matters of conflicts of interest and self-dealing rather than matters of prudence. Specifically, the FAB states, "[given] that ERISA is a law of process and not results, EBSA must avoid cases that unfairly second-guess process-based fiduciary judgments."
- Ensure, whenever possible and consistent with its mission, that it does not regulate by enforcement and instead promotes fairness, prior notice and clarity to the regulated community, stating, "novel legal theories or interpretations of ERISA should not be first articulated during enforcement actions. Instead, they should be subject to the ordinary regulatory and sub-regulatory processes."
- Require proper review by senior agency officials of all critical enforcement initiatives, including enforcement where the legal theories or enforcement is novel, where there is (or is reasonably likely to be) a split in the circuits or where the enforcement would represent a change in EBSA's position.
- Strive for timely and responsive enforcement. As the FAB states, "[routine] investigations involving less complicated issues, such as delinquent employee contributions, disclosure and bonding violations, should be completed within 18 months, unless there are exigent circumstances that are communicated to the Director of Enforcement. … More complex investigations must be completed within 30 months unless there are exigent circumstances." As with the 2nd priority above, this principle addresses much of the recent open-ended audit activity, with some cases that have lasted as long as eight years.

IRS provides updated FAQs and a sample plan document for Section 127 education assistance programs. As background, under an IRS Code Section 127 educational assistance program, an employer can provide up to $5,250 per year (indexed annually) in tax-free qualified education benefits to employees for tuition, fees and similar expenses, books, supplies, equipment, and principal and interest

payments on qualified education loans. This month, IRS provided FAQ guidance about educational assistance programs and also provided a sample plan document.

- On April 20, the IRS issued Fact Sheet 2026-10 with updated FAQs about educational assistance programs reflecting changes made by the 2025 One Big Beautiful Bill (OBBB) Act. In particular, the FAQs state that the current $5,250 tax exclusion limit for 2026 will be adjusted for inflation beginning in 2027. The FAQs also clarifies the permanent extension for tax-free employer contributions toward qualified education loans (that previously had a sunset date at the end of 2025).
- The IRS also issued Publication 5993, that provides a sample plan document for qualified educational assistance programs that satisfies the requirements under IRS Code Section 127. Employers are required to have a plan document in place in order to establish an education assistance program. So, employer who have a Section 127 education assistance program (or who are planning to adopt one), may want to use the new IRS sample plan document as their template.