HEFFERNAN INSURANCE BROKERS

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2025 SPRING LEGISLATIVE RECAP

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DOL

The Affordable Care Act (ACA)

FMLA

The DOL kicked off the New Year with an opinion letter, informing employers that they may not mandate use of paid time off (PTO) when an employee is taking a period of leave that is qualified under FMLA as well as state paid family leave. While the law permits employer policy to require use of PTO for leave that is qualified under FMLA (on the basis this leave is unpaid), the same is not true when the employee receives other sources of income replacement, such as via paid family leave benefits. This stance will likely require handbook updates for employers subject to FMLA, operating in states with paid family leave laws.

Transparency in Coverage

Despite the (not so new) Transparency requirements under the 2021 CAA, which are applicable to hospital and employer health plans, pharmacy benefit managers (PBMs) have been largely operating outside of these rules. In 2024, the House passed Patients Before Monopolies Act, which is a bipartisan effort to hold PBMs to the same rules as the rest of the industry. Notably the bill would "make it unlawful for any person to simultaneously own, operate, or control – either directly or indirectly – (1) a pharmacy; and (2) an insurance company or a PBM." There is renewed bipartisan support for this bill (including Senators Warren and Hawley), but it will need to be reintroduced during the current Congress to see the light of day.

Additionally, the Trump Administration has signaled its dedication to increased price transparency with a February 25th Executive Order[3] that enhances his 2019 EO[4] addressing the same. The Departments are directed to enforce the transparency mandates by May 25th as follows:

- **a.** Requiring the disclosure of the actual prices of items and services (estimates will not suffice)
- **b.** Issuing updated guidance ensuring pricing information is standardized and easily comparable across hospitals and health plans; and
- **c.** Issuing guidance updating enforcement policies designed to ensure compliance with the transparent reporting of complete, accurate, and meaningful data.

In the text of the new EO, the potential cost savings associated with enforcement of these transparency mandates are summarized:

"The impact of these regulations, if fully implemented, could result in as much as $80 billion in healthcare savings for consumers, employers, and insurers by 2025. Another report from 2024 suggested healthcare price transparency could help employers reduce healthcare costs by 27 percent across 500 common healthcare services."[5]

Marketplace Subsidies

Ever since the 2021 ARPA passed to ease the burden on employees during the global pandemic, individuals enrolling in the Public Marketplace have enjoyed enhanced premium subsidies. These subsidies have contributed to a high enrollment rate and correspondingly a lower number of uninsured Americans. The Congressional Budget Office estimates[2] it will cost $335 billion between now and 2035 to maintain the enhanced subsidies. As of December 31, 2025, these enhanced subsidies are set to expire, which may drive more employees to enroll in their employer-sponsored plans or go without coverage altogether. It is unclear if the administration will extend them or let them lapse as scheduled.

[1] *CMS reports record Marketplace enrollment of 24.2 million as of January 15, 2025*

[2] *CBO report dated June 24, 2024*

[3] *Making America Healthy Again by Empowering Patients with Clear, Accurate, and Actionable Healthcare Pricing Information*

[4] *Executive Order 13877*

[5] *White House Executive Order Section1. Purpose*

DOL

Mental Health Parity Addiction Equality Act (MHPAEA)

Following fiscal year 2023, the Employees Benefits Security Administration (EBSA) released their MHPAEA enforcement report to Congress. The report summarized the most commonly occurring violations of the law:

a. **Annual dollar limits:** dollar limitations on the total amount of specified benefits that may be paid in a 12-month period under a group health plan or health insurance coverage for any coverage unit.
b. **Aggregate lifetime dollar limits:** dollar limitations on the total amount of specified benefits that may be paid under a group health plan or health insurance coverage for any coverage unit.
c. **Benefits in all classifications:** requirement that if a plan or issuer provides mental health or substance use disorder benefits in any classification described in the MHPAEA final regulations, mental health or substance use disorder benefits must be provided in every classification in which medical/surgical benefits are provided.16
d. **Financial requirements:** deductibles, copayments, coinsurance, or out-of-pocket maximums.
e. **Treatment limitations:** limits on benefits based on the frequency of treatment, number of visits, days of coverage, days in a waiting period, or other similar limits on the scope or duration of treatment. Treatment limitations include both quantitative treatment limitations (QTLs), which are expressed numerically (such as 50 outpatient visits per year), and NQTLs (such as medical management standards), which otherwise limit the scope or duration of benefits for treatment under a plan or coverage.
f. **Cumulative financial requirements and cumulative QTLs:** financial requirements and treatment limitations that determine whether or to what extent benefits are provided based on certain accumulated amounts. They include deductibles, out-of-pocket maximums, and annual or lifetime day or visit limits.

Following the September 2024 Final Rule under MHPAEA, the ERISA Industry Committee (ERIC) filed a lawsuit against the DOL, HHS and IRS challenging the law. In their suit, ERIC states

"This rule goes far beyond the Tri-Departments' statutory authority, violates the Due Process Clause of the Fifth Amendment, is arbitrary and capricious, and otherwise violates the Administrative Procedure Act. …The Parity Rule also imposes entirely new, ambiguous requirements that are so burdensome and unworkable that they will discourage employers from offering MH/SUD benefits at all."[6]

At the time of this writing, we are still awaiting the government's response to the lawsuit (or lack thereof), which will determine the next steps for employer plan sponsors in this area. Either way, employers should continue to work with their benefits advisors to ensure their medical plans offer mental health benefits that are on par with other covered services, and that a comparative analysis of any treatment limitations has been performed by their carrier or ASO provider.

[6]*Case No. 25-cv-136, filed 1/17/2025*

IRS

SUPREME COURT

Notice 2025-4 Tax Treatment of PFL Benefits

While state-mandated paid leave programs are not new, there has been some confusion regarding tax treatment of the contributions and paid benefits related to the programs. The IRS reminds employers that benefits paid under state **paid family leave** are **taxable** as income to the employee, but are not 'wages', and need to be furnished on a 1099 to each employee receiving PFL benefits in a calendar year. Additionally, employee paid premiums (salary withholding) for PFL programs are 'wages' reportable on the employee W2.

In contrast, benefits paid pursuant to **paid medical leave** are like disability benefits, and their tax treatment depends on who and how the premiums were paid. Benefits attributed to *employee contributions* are NOT taxable to the employee, whereas payments attributed to *employer contributions* ARE taxable to the employee.

The guidance notes that any employers who have not been following this protocol should do so beginning with the 2025 calendar year, and no adjustments to prior W2 is generally required under this guidance.

Rev. Proc. 2025-15 'Alternative Method of Furnishing' Forms 1095-C

Days before the March 3 deadline, the IRS released Rev. Proc. 2025-15 directing employer plan sponsors how they may satisfy the newly announced 'alternative method of furnishing' full time employee 1095-C statements. The guidance explains that electronically posted notices with 3 components will comply with the new method:

a. An email address for employee outreach,
b. A physical address where a request for the 1095-C may be sent, and
c. A phone number to contact the employers or ACA reporting vendor for a copy of the 1095-C statement

Finally, employers are required to maintain this information as well a copy of the 1095-C until October 15th of each year. This relief is much appreciated by employers and will improve some of the burden related to ACA reporting for years to come.

United States v Skrmetti

The new administration and resulting flurry of Executive Orders have created uncertainty for employer plan sponsors when it comes to certain covered services under their health and welfare plans. This is especially true in the area of gender identity, protection, and gender affirming care. We are anxiously awaiting the High Court's decision in United States v Skrmetti[7], a case challenging a Tennessee state law prohibiting gender affirming care for minors. The law at issue specifically prohibits health care providers from "performing certain medical procedures on an individual younger than 18 (1) to enable the individual to identify with, or live as, a gender identity inconsistent with the individual's sex assigned at birth, or (2) to treat the individual's discomfort or distress from such incongruence."[8] Whether SCOUTS upholds, or strikes down this state law will have far reaching consequences for employer health plans. Notably, HHS has rescinded their 2022 guidance on Privacy of Gender Affirming Care Data pursuant to Executive Order 14187, formally stating they would not 'promote, assist, or support gender affirming care.'[9] The Court's decision is still pending at the time of this writing.

[7] *U.S. v. Skrmetti, No. 23-5600 (6th Cir. Sep. 28, 2023; cert. pet. granted Jun. 4, 2024, No. 23-477)*

[8] *Tennessee's Senate Bill I, enacted in 2023*

[9] *HHS Official Statement released February 20, 2025*

CALIFORNIA

Reference Based Pricing

The Federal Court's holding in Regents of the University of California v The Chefs Warehouse Benefit Plan signals that reference based pricing is permissible under all applicable law. The provider in this case billed $397,519.31 to the patient employee's plan (a self-insured health plan with a reference-based pricing structure). The plan subsequently paid $74,512.84 (the higher of either 112% of the hospital's reported costs or 120% of Medicare rates). The provider sued the plan, challenging the permissibility of this pricing model under both ERISA and the Affordable Care Act. In rendering its decision, the court clearly restated the validity of this pricing model as a 'cost containment tool' under self-insured employer health plans. The court also notes that balance billing by out of network providers (in non-emergency situations) is not protected by the ACA's surprise billing and other reforms.

Senate Bill 729

In September 2024, California passed an expansive bill, changing the way infertility is both defined and covered by large group health plans. Plans that renew on or after 7/1/25 will need to provide coverage for specific infertility services under this new law. The definition of 'infertility' under Section 2 (b) is expanded to include 'the inability to reproduce, either as an individual or with a partner, without medical intervention'. Specifically, employers with 50 or more employees will need to offer plans that cover the diagnosis and treatment of infertility including (IVF). It's important to note that the Governor has requested an extension until January 2026, which has not been announced as of the time of this writing.

Additionally, plan designs cannot require higher copays or deductible amounts for fertility services than for other covered services. As with most state insurance laws, this will apply to fully insured plans written in the state of California. Self-insured plans that are subject to ERISA are generally not subject to state insurance laws. The entirety of the bill may be viewed here.