McGOHAN BRABENDER'S

COMPLIANCE IN MOTION

JUNE 2025

New Mental Health Parity Rules on Pause: What Employers Need to Know

On May 15, 2025, the federal government announced that, for now, it will not enforce the new mental health parity rules issued in September 2024. This pause comes while the administration reviews a legal challenge filed by the ERISA Industry Committee (ERIC) and evaluates potential updates to the rules.

WHO THIS APPLIES TO:

- All employers with more than 50 employees that sponsor a group health plan covering mental health and/or substance use disorder (MH/SUD) benefits.

GO DEEPER:

The following new requirements from the 2024 final MHPAEA rules are paused for at least 2025 and 2026:

- Fiduciary certification confirming you have reviewed your plan's required comparative analysis
- Expanded comparative analysis requirements for the plan's non-quantitative treatment limits (NQTLs)
- New rules that pertain to the "meaningful benefits" standard, discriminatory factors and evidentiary standards, and data evaluation requirements

"The Departments will not enforce the 2024 Final Rule or otherwise pursue enforcement actions, based on a failure to comply that occurs prior to a final decision in the litigation, plus an additional 18 months. This enforcement relief applies only with respect to those portions of the 2024 Final Rule that are new in relation to the 2013 final rule. The Departments note that MHPAEA's statutory obligations, as amended by the CAA, 2021, continue to have effect."

PRACTICAL IMPLICATIONS TO EMPLOYERS:

This pause only applies to the new 2024 rules. Employer health plans are still required to follow:

- The 2013 final MHPAEA rules
- Mental health parity obligations imposed by the Consolidated Appropriations Act, 2021 (CAA, 21)
- Existing guidance such as FAQs Part 45

Ultimately, no plan should impose cost-sharing (deductible, copay, etc.), a quantitative treatment limit (QTL, such as a limited number of visits) or NQTL (prior authorization, step therapy or fail-first requirement, etc.) on a MH/SUD benefit without being able to first justify it is no more restrictive than what you apply to medical/surgical benefits in the same classification.

Now is a good time for employers to engage vendors or service providers to review their plan's financial requirements, quantitative treatment limitations, and NQTL comparative analysis, particularly for high-risk benefit areas like:

- Autism spectrum disorder,
- Eating disorders, and
- Medication-assisted treatment for opioid use disorder.

"The One, Big, Beautiful Bill" Includes Several Enhancements to Employee Benefits

On May 13, 2025, the House Ways and Means Committee introduced the One, Big, Beautiful Bill, delivering on the President's campaign promise to extend the 2017 tax cuts. The Bill introduces several provisions impacting employee benefits. The Bill has since passed in the House and is currently in the Senate.

GO DEEPER:

The Bill will go through additional iterations and specific details may change, but a first look at the bill reveals several benefit provisions which generally have bipartisan support:

ICHRA: Codifying Individual Coverage Health Reimbursement Arrangements (ICHRAs) into law, renaming them as Custom Health Option and Individual Care Expense ("CHOICE Arrangements") and making the following adjustments:

- 60-day advance notice instead of 90
- W-2 reporting
- Allows pre-tax payment for Exchange individual premiums (currently employers can only amend their cafeteria plan to allow pre-tax paycheck deductions for Medicare or off-Exchange individual premiums)
- A new two-year credit for an employer who is not an Applicable Large Employer (non-ALE) for a newly installed CHOICE Arrangement ($100 per enrolled employee per month the first year with intent to index, and half credit the second year)

Revised Tax Credits for Leaves and Child Care: Updating the Paid Family and Medical Leave (PFML) tax credit and employer-provided child care credit.

Education Assistance: Indexing the education assistance plan's $5,250 annual limit and permanently allowing student loan repayments to be reimbursable.

HSA and FSA: Making adjustments to Health Savings Accounts (HSA) and Flexible Spending Accounts (health FSA):

- Allows up to 60 days to establish an HSA after first enrolling in a QHDHP, and makes expenses reimbursable back to the date in which the QHDHP began
- Allows Medicare Part A, bronze or catastrophic Exchange plans, and limited on-site clinic access to be HSA-compatible
- Allows Direct Primary Care (DPC) to be HSA-compatible if it does not exceed $150/month (double for family, to be indexed for inflation) and does not include services requiring general anesthesia, Rx, or labs not typically administered in an ambulatory primary care setting
- Allows DPC fees to be a §213(d) medical expense reimbursable from health FSAs and HSAs

- Allows HSA reimbursement for qualified sports and fitness, including some gym memberships, up to $500/year ($1,000 for joint filers), to be indexed for inflation, divided up as an equal monthly allowance (unclear if these are §213(d) medical expenses also reimbursable from health FSAs)
- Allows both spouses enrolled in a family QHDHP to make catch-up contributions to the same HSA
- Allows employees to contribute an extra $4,300 single, $8,550 family (to be indexed for inflation) to their HSA, subject to income phase-outs starting at $75,000 ($150,000 for joint filers)
- Allows FSAs or HRAs to convert to newly established HSAs if not enrolled in a QHDHP for the last 4 years, up to the annual FSA salary reduction contribution cap (double for family coverage). If done mid-plan year, would treat the remainder of that plan year as not having health FSA or HRA disqualifying coverage.
- Allows an HSA-holder's spouse to have an FSA without disqualifying the individual's HSA

PRACTICAL IMPLICATIONS TO EMPLOYERS:

There are a number of enhancements to employee benefits in this bill. However it is not yet law and is now with the Senate, with an unknown future, so changes will likely develop. However, this gives employers a view into provisions Congress may be considering for 2026 and beyond. We will keep a close eye on developments and final impacts to employee benefit plans.

Executive Order Addressing Prescription Drug Costs: "Most-Favored-Nation-Pricing"

On May 12, 2025, the President issued an Executive Order and fact sheet aimed at reducing prescription drug costs in the U.S., with the goal that Americans should pay no more than people in other developed countries for the same medications.

This "*most-favored-nation pricing*" strategy could reshape how drugs are priced and delivered, with possible impact on employer health plans.

GO DEEPER:

The order directs federal agencies to implement a number of aggressive steps:

- **Establish Most-Favored-Nation Pricing:** Announce targeted pricing to prescription drug manufacturers, propose rulemaking to implement price changes, and potentially even put pressure on drug manufacturers by modifying or revoking FDA approval of certain drugs
- **Tackle Anti-Competitive Behaviors:** Investigate whether foreign countries or exporters are contributing to unfair price differences and ramp up enforcement a against anti-competitive practices in the drug supply chain
- **Direct-to-Consumer Sales:** Allow pharmaceutical manufacturers who agree to most-favored-nation pricing to sell and ship directly to consumers
- **Drug Importation:** Provide more flexibility to allow importation when manufacturers do not align with most-favored-nation pricing

PRACTICAL IMPLICATIONS TO EMPLOYERS:

The first step toward most-favored-nation pricing was already announced May 20 by expressing intent to focus on such pricing "for all brand products across all markets that do not currently have generic or biosimilar competition." Legal challenges are expected by drug manufacturers, and any lasting provisions implementing this executive order will likely require acts of Congress. However, the presidential administration is clearly seeking to impact prescription drug pricing in a manner that could impact employer health plans.

PCORI Fees Due by July 31, 2025

Each year by July 31, employers sponsoring certain self-funded health plans must file and pay an annual fee to the IRS to fund the Patient Centered Outcomes Research Institute (PCORI). Employers must report the fee on the second quarter IRS Form 720.

The IRS usually releases the second quarter Form 720 in mid-June, but this year they published early before the start of June. Employers can gather their enrollment counts from their third-party administrator (TPA) for their health plan year that ended during calendar year 2024, and can take care of the filing and payment using the updated form anytime between now and July 31.

WHO THIS APPLIES TO:

- Employers sponsoring any self-funded medical plan, including a level-funded plan, a Health Reimbursement Arrangement (HRA) paired with a fully insured plan, or an Individual Coverage HRA (ICHRA).
- Insurance carriers are responsible for PCORI fees for fully insured plans.

Exempt: Excepted benefits such as stand-alone vision or dental, HSAs or health FSAs.

GO DEEPER:

The PCORI fee must be reported each year on the second quarter version of IRS Form 720 and paid electronically or mailed to the IRS using the Form 720-V payment voucher. Employers that are subject to PCORI fees but no other types of excise taxes should file Form 720 only for the second quarter. In other words, no filings are needed for the other quarters, only the second quarter.

For plan years ending in 2024 before October 1, the PCORI fee due this July is $3.22 per covered life. For plan years ending between October 1, 2024 and December 31, 2024, the PCORI fee due this July is $3.47 per covered life.

How to Calculate the Number of Covered Lives?

The PCORI fee is based on the number of employees, spouses and dependents that are covered by the plan (for an HRA, it is based only on the number of enrolled employees, not spouses and dependents). The employer can use the actual count method, snapshot method, snapshot factor method, or Form 5500 method to determine the average number of covered lives. Below is more information on each of the approved counting methods:

Actual Count Method: This method calculates the average of covered lives by adding the number of lives covered each day of the plan year divided by the number of days in the plan year.

For example, a plan that starts on January 1 calculates the sum of covered lives (including spouses and dependents) as 3,285,000 divided by 365, which is 9,000. Thus, the PCORI fee for plan year ending in 2024 is 9,000 times $3.47, or $31,230.

Snapshot Method: This method calculates the average by adding the total number of lives covered on a date during the first, second, or third month in each quarter, or an equal number of dates during each quarter, and dividing by the number of dates. The date chosen in each quarter must be within 3 days of the date used in other quarters.

For instance, on January 4, 2024, the plan covers 2,000 lives; on April 5, 2024, 2,100 lives; on July 5, 2024, 2,050 lives; and on October 4, 2024, 2,050 lives, which totals 8,200. Since the plan ends on December 31, 2024, the employer multiplies $3.47 by 2,050 (8,200/4), which equals $7,113.50.

Snapshot Factor Method: This method uses the number of participants with other than self-only coverage (e.g., family, EE + spouse, EE + child, etc.) on the designated quarterly dates discussed above under the snapshot method, multiplied by 2.35, and adds the number of employees on each date with self-only coverage to come up with the enrollment total for each date.

As another example, on January 10, 2024, the plan has 600 employees with self-only and 800 with coverage other than self-only. On April 11, 2024, 608 with self-only and 800 with other. On July 11, 2024 and October 10, 2024, there were 610 with self-only and 809 with other. Since the plan ends December 31, 2024, the total is 9,988 [(600 + (800 x 2.35)) + (608 + (800 x 2.35)) + (610 + (809 x 2.35)) + (610 + (809 x 2.35))] divided by 4, which is 2,497. Thus, the PCORI fee for the 2024 plan year is $3.47 multiplied by 2,497, which equals $8,664.59.

Form 5500 Method: This is based on the average number of covered lives reported on Form 5500 for the plan year. This can only be used if the Form 5500 is filed no later than the due date for the PCORI fee imposed for that plan year. In other words, if the plan files a Form 5500 (or requests an extension to file) after July 31, 2025, this method cannot be used.

Under this method, the total number of lives is calculated by adding the total participant counts at the beginning and end of the year and dividing by 2 for a plan that only offers single coverage. If a plan offers single coverage along with other coverage (e.g., family coverage), the total number of lives is determined by adding the total participant counts at the beginning and end of the year (without dividing by 2). For instance, a calendar year plan with single and family coverage tiers files a Form 5500 for the plan year ending December 31, 2024 and files the corresponding 5500 as of July 31, 2025 (no extension), which reports 4,000 plan participants on the first day of the plan year and 4,200 plan participants on the last day of the plan year. This group must treat the number of lives covered for the plan year ending December 31, 2024, as equal to the sum of 4,000 and 4,200, or 8,200. To calculate the PCOR fee, they would multiply $3.47 by 8,200, which equals $28,454.

What if the employer did not pay in prior years?

The IRS has not provided express guidance on how to address late PCORI payments. Based on the forms and instructions, it appears that employers should use prior year forms (found here) that correspond to the due date of the fee. If the IRS notifies the employer plan sponsor of their intent to impose a penalty, the group should have the opportunity to appeal if the failure was due to reasonable cause.

Where to get assistance with calculating the number of covered lives?

Employers should rely on the TPA to assist with the calculation. Even if the employer uses a TPA or a vendor to assist with the calculation, the PCORI fee for a self-insured plan, ICHRA or HRA is the responsibility of the plan sponsor and must be paid by the employer to the IRS directly. Failure to file likely carries the same penalty for failure to pay other taxes due on Form 720.

2026 HSA, HDHP and Excepted Benefit HRA Limits Announced

The IRS announced under Revenue Procedure 2025-19 cost-of-living adjustments for Health Savings Accounts (HSA), High-Deductible Health Plans (HDHP) and Excepted Benefit Health Reimbursement Arrangements (EBHRA) for 2026.

All of the dollar limits currently in effect for 2025 will increase for 2026, with the exception of the HSA catch-up contribution limit for individuals ages 55 and older. The catch-up contribution will not change as it is not subject to cost-of-living adjustments.

The following table compares 2025 limits for the HSA, HDHP and EBHRA to the new limits for 2026. HSA contribution limits are for the calendar year, regardless of when the health plan renews. All other indexing applies to plan years beginning during 2026.

Plan Limit	2025	2026
HDHP Minimum Deductible:		
Self-Only	$1,650	$1,700
Family	$3,300	$3,400
Note, for plans with an embedded per-person deductible for family coverage, it must be at least as high as the minimum family deductible		
HDHP OOP Max:		
Self-Only	$8,300	$8,500
Family	$16,600	$17,000
Note non-grandfathered plans are subject to a per-person OOP Max	*$9,200*	*$10,150*
HSA Contribution Limit:		
Self-Only	$4,300	$4,400
Family	$8,550	$8,750
Catch up Contribution *(age 55+ on December 31)*	*$1,000*	*$1,000*
Excepted Benefit HRA: Annual Benefit Limit	$2,150	$2,200

CMS Updates Medicare Part D Benefit Parameters and Simplified Creditability Determination for 2026

The Centers for Medicare and Medicaid Services (CMS) published 2026 updates to Medicare's Part D benefits parameters. Each year, employers sponsoring a plan that provides or reimburses prescription drugs must disclose to employees and their beneficiaries, including those on COBRA or retiree coverage, whether their prescription drug coverage is creditable compared to Medicare Part D (i.e., whether it expects to pay as well as Part D pays on average). The Part D parameters are needed each year to help employers determine whether their plans are creditable or non-creditable so they can provide the correct notice.

WHO THIS APPLIES TO:

- All size employers sponsoring a plan that provides or reimburses prescription drugs.

GO DEEPER:

CMS's announcement and two fact sheets (here and here) lay out the updates for 2026, including the following:

- Part D deductible increasing from $590 to $615
- Part D out-of-pocket maximum increasing from $2,000 to $2,100
- A revised simplified determination methodology that adds an expectation of reasonable coverage of biologics, removes a test on the plan's deductible and updates how much a creditable group health plan must be expected to pay toward prescription drug claims from the current 60% to 72% (to more accurately reflect enhancements brought by the Inflation Reduction Act)

PRACTICAL IMPLICATIONS TO EMPLOYERS:

Employers working on their 2026 benefit plans now have Part D benefit parameters and revised simplified determination methodology to help determine whether their prescription drug coverage is creditable or non-creditable.

While the carrier or Pharmacy Benefit Manager (PBM) will typically determine creditability for employer group health plans, there are instances where an employer must hire an actuary to certify creditable coverage status. When the employer must engage an actuary, the revised simplified determination methodology may help in making plan design decisions to comply with either existing simplified determination rules (such as being reasonably expected to pay 60% of prescription drug claims) or the revised rules (such as being reasonably expected to pay 72% of prescription drug claims and cover biologics). CMS expects the current simplified determination methodology to no longer be available in 2027, so employers who cannot quite reach the revised simplified determination goals in 2026 need to plan on doing so in 2027.

FAQ:

How does an employer correct FSA administrative errors?

Eligible Employee Mistakenly Excluded from Enrollment:

There is no "formal" guidance from the IRS regarding correcting the employer's administrative error of excluding an eligible employee from enrollment in the FSA. However, unofficial commentary from IRS officials advises that if there is "clear and convincing" evidence of a mistake, correction could occur. Officials advise that an employer's administrative or clerical error can typically satisfy "clear and convincing evidence" which would be permissible to correct.

In the instance of an employee's election not occurring, the employer has more leverage to correct since pre-tax deductions are not yet involved. Most FSA benefits are equal to the salary reduction election amount. An employee who was mistakenly not allowed to enroll in an FSA will not have the benefit of pre-tax reimbursement for qualified expenses and instead end up paying the expenses themselves with after-tax dollars. For this reason, retroactive enrollment and prospective salary deduction could be an option, but it may not be the best solution for the employee. For example, the employee may have difficulty substantiating eligible expenses they did not expect to submit appropriate records for reimbursement (i.e., throwing away receipts for medication).

As an alternative, an employer might provide the employee with additional taxable compensation to offset the loss. This approach involves an additional cost to the employer, but may be easier to implement versus attempting to retroactively enroll an individual, considering the burden to the employee of having to reassess expenses that need to be reimbursed and go through the associated claims process.

Ineligible Employee Mistakenly Allowed to Enroll:

The appropriate correction is to reverse the employee's participation as if it never happened by accounting for past contributions and reimbursements and then determining whether the employee owes the plan money or the employer owes the employee a taxable refund.

Reimbursement of Ineligible Expenses:

Handling reimbursement of ineligible expenses depends on if the error was discovered before or after the end of the plan year:

Error Found Before Year End

Per the IRS, the following steps must be performed in the instance of a reimbursement error found before the end of the year:

1. **Deny access to debit card (if applicable).** To ensure that no further violations occur, the card must be deactivated until the amount of the improper payment is recovered. In the meantime, the participant must request reimbursements through other methods.
2. **Require payment.** The employer must demand that the participant repay the improper payment. A letter should be sent to the participant as soon as possible, identifying the amount, the reasons for requiring repayment and the timeframe in which the repayment must be made.

3. **Withhold from pay.** An amount equal to the improper payment must be withheld from the participant's pay or other compensation, to the full extent permitted under applicable law. Appropriate authorization should be included as part of the plan document, summary plan description (SPD), and card enrollment materials. Employers should check with legal counsel to determine whether state law permits such a process.
4. **Apply offset.** The employer must apply a substitution or offset approach against subsequent valid claims, up to the amount of the improper payment. The regulations provide an example in which a participant who received an improper card payment of $200 and later submitted a substantiated claim for $250 incurred during the same coverage period would receive reimbursement of only $50.
5. **Treat payment as other business indebtedness.** If the preceding correction efforts prove unsuccessful, then the employee remains indebted to the employer for the amount of the improper payment. If the payment is not recovered, then as a last resort, the employer may forgive the indebtedness, in which case the payment should be reported as wages on Form W-2 for the year in which the indebtedness is forgiven and is subject to withholding for income tax, FICA, and FUTA.

Error Found After Year End

The mistaken payment should be treated as business indebtedness which, if forgiven, must be included in income and reported as wages on Form W-2 (subject to wage withholding) in the year in which the debt is forgiven. Presumably, the employer can seek repayment of the indebtedness from the participant on an after-tax basis through repayment by check or after-tax payroll withholding in the year in which the error is discovered.

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REIMAGINING EMPLOYEE BENEFITS