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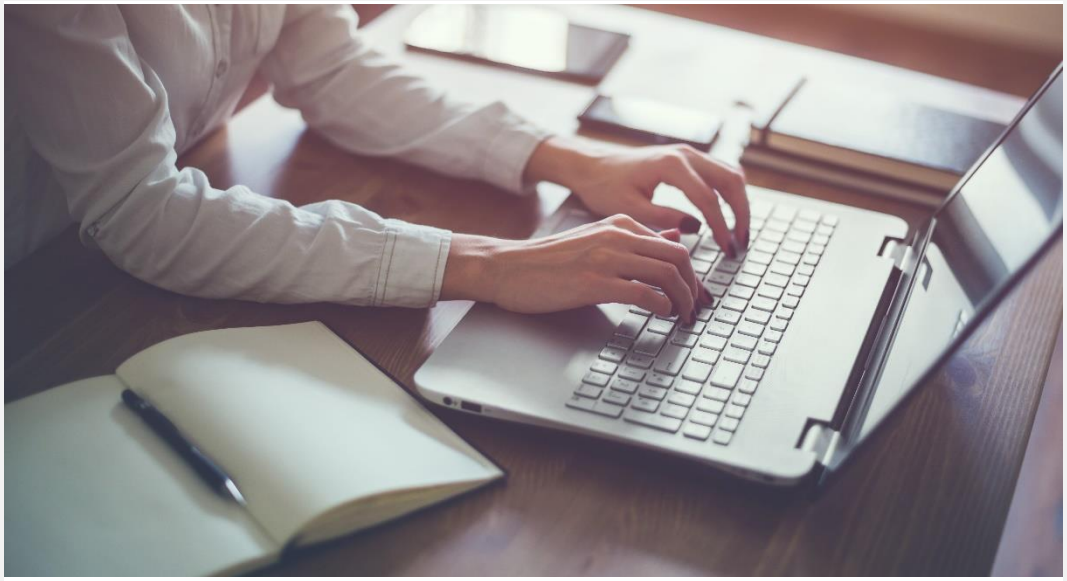

In this Issue:

Upcoming Compliance Reminders for Calendar Year Employee Benefit Plans

December 2025

7th: Medicare Open Enrollment Ends

31st: Gag Clause Prohibition Compliance Attestation Due

Note: This is meant to be a reminder of certain upcoming compliance deadlines for employee benefit plans operating on a calendar year basis. It is not an exhaustive list of compliance obligations. Specific plans may be subject to different obligations and deadlines depending upon a variety of factors, including the plan type, plan year, and whether or not the plan is subject to ERISA, among other things.

Standalone Fertility Benefits can be "Excepted Benefits"

Employer-provided fertility benefits can be "excepted benefits" that are exempt from certain Affordable Care Act (ACA) and other group health plan mandates, according to new ACA implementation "frequently asked questions" (FAQs) issued by the Departments of Labor, Health and Human Services, and Treasury (Agencies) on October 16, 2025.

Fertility benefits can be popular with employees, and employers have shown interest in offering such benefits separately from their group health plans, or in some cases even if they do not offer comprehensive group health benefits. But questions about how these types of fertility benefit arrangements are regulated may discourage some otherwise willing employers from offering them to their employees.

What are Excepted Benefits?

In general, "excepted benefits" are health-related benefits that are specifically exempt from the ACA's group health plan mandates and other federal rules for health plans that might otherwise be applicable. There are 4 distinct categories of "excepted benefits":

- Automobile insurance, workers' compensation insurance, accident and disability insurance, and other non-health insurance are always "excepted benefits":

- Limited "excepted benefits" such as limited-scope dental and vision plans, that are offered as standalone plans and satisfy other requirements;
- Independent, noncoordinated "excepted benefits," such as specified disease and hospital indemnity plans, that satisfy various requirements; and
- Supplemental "excepted benefits" such as Medicare supplemental plans, among others.

Current regulations outlining the categories of excepted benefits, and the requirements for each, do not specifically address fertility benefits.

Independent, Noncoordinated Excepted Benefits

Basically, the FAQs clarify that fertility benefits can be offered as "independent, noncoordinated excepted benefits" if the applicable conditions are satisfied. This category of excepted benefits is limited to specified disease or illness coverage, as well as hospital indemnity and other fixed-indemnity coverage, that satisfy the following basic requirements:

- The benefits are provided under a separate policy, certificate, or contract of insurance;
- There is no coordination between the provision of benefits and the exclusion of benefits by a group health plan maintained by the same plan sponsor; and
- The benefits are paid with respect to an event without regard to whether benefits are provided with respect to the event under any group health plan maintained by the same plan sponsor.

According to the FAQs, "an employer could offer a specified disease or illness policy that covers benefits related to infertility as a type of independent, noncoordinated excepted benefit," as long as these basic requirements are satisfied. The FAQs confirm that this is the case even if the employer does not offer a "traditional group health plan." If an employer does offer a group health plan, employees do not have to be enrolled in the plan in order to take advantage of the infertility benefit.

Like other specified disease or illness benefits that are independent, noncoordinated excepted benefits, the FAQs confirm the infertility benefit could not be self-insured. However, the FAQs note that the Agencies intend to issue future proposed regulations "to provide additional ways that certain fertility benefits may be offered as a type of limited excepted benefit," which could be self-insured.

Excepted Benefit HRAs and EAPs

The rules relating to limited excepted benefits, another category of excepted benefits that satisfy certain specific requirements, also recognize "excepted benefit HRAs." In general, excepted benefit HRAs can only be offered by employers that also offer a comprehensive group health plan. They also must meet other requirements, including a limit on amounts that can be made newly available each year (i.e., $2,150 for plan years beginning in 2025).

The FAQs provide that excepted benefit HRAs may offer reimbursements for out-of-pocket expenses related to fertility, so long as those expenses otherwise qualify as medical expenses.

Additionally, the FAQs confirm that employee assistance plans (EAPs) that qualify as limited excepted benefits can offer "coaching and navigator services"

relating to fertility options. The FAQs clarify that an EAP offering such services would not be providing significant benefits in the nature of medical care, which is a key factor in determining if an EAP is an "excepted benefit."

Appeals Court Prohibits Employer from "Unilaterally" Adding Arbitration Clause to Health Plan

The Ninth Circuit Court of Appeals recently ruled that an employer may not create an arbitration requirement for its ERISA plan by unilaterally modifying the plan. Instead, the employer must obtain consent from participants to form an arbitration agreement. Even though the case involved an arbitration provision in a group health plan, the court's reasoning would apply to all ERISA plans, including retirement plans.

Background

In general, plan sponsors are permitted to set the terms of their ERISA plans, and to modify those terms at any time. Because employee benefit plans are intended to attract and retain workers, employers typically try to design plans that will be appealing to employees. However, employers generally do not consult with employees on plan details, especially those relating to how disputes between plan participants and fiduciaries will be resolved.

Recently, ERISA plan sponsors have faced a surge of class action lawsuits. As a result, some plan sponsors have added mandatory arbitration and class action waiver clauses to their plans in an effort to limit their exposure to litigation. Whether, and to what extent, these clauses are enforceable is a question numerous courts have addressed. So far, no consensus opinion has emerged.

Relevant here, the Federal Arbitration Act ("FAA") requires that parties consent to arbitration in order to form a valid arbitration agreement.

Employer Failed to Obtain Employee's Consent for Plan's Arbitration Provision

The Ninth Circuit case involves an employer with an ERISA-governed health plan that imposes a surcharge on participants who use tobacco products. As we have discussed in prior RPIs (including most recently in RPI 2025-19), tobacco surcharges are permissible so long as they meet certain statutory and regulatory requirements. In very general terms, the primary substantive issue in the case is whether the plan's tobacco surcharge satisfies these requirements.

However, in the year prior to the lawsuit the employer had added a mandatory arbitration clause to its plan. When the employee filed suit in this case, the employer tried to use this clause to force the case into arbitration.

The Ninth Circuit held that an employer cannot create a valid arbitration agreement by unilaterally modifying an ERISA-governed plan to add an arbitration provision. Instead, the employer must obtain consent from the "consenting party" – here, the employee – to form an arbitration agreement. The court reasoned that because ERISA does not conflict with the Federal Arbitration Act's (FAA) requirement of consent for arbitration, the FAA's requirement for consent applies here.

The court went on to conclude that the employee did not consent to arbitration because he did not receive sufficient notice of the provision itself or that his continued participation in the plan would be considered consent to arbitration. The employer argued unsuccessfully that the employee consented to arbitration by remaining in the plan after the employer sent an email and a letter in 2021 containing a Summary of Material Modifications, which alerted participants to the addition of an arbitration clause; however, the employer was unable to produce a copy of these communications. In contrast, the employee was able to show that he received an email in 2022 with a link to the new Summary Plan Description, which was 170 pages long, with the new arbitration provision on page 153.

The court concluded that, assuming the employee only received the 2022 email with the link, this was not sufficient notice of arbitration because it was unreasonable to expect the employee to notice the new provision buried in a lengthy document. The court also concluded that even if the employee received both the 2021 and 2022 communications, this was still not sufficient notice to establish consent because the employer did not explicitly state that continued participation in the plan would be taken as consent.

ANNUAL COMPLIANCE REMINDER: Group Health Plan "Gag Clause" Attestation Due by December 31, 2025

Group health plans and health insurance issuers must submit their annual attestations of compliance with rules banning certain "gag clauses" in contracts with providers and others by December 31, 2025.

Background

The Consolidated Appropriations Act, 2021 ("CAA 2021") amended the Internal Revenue Code ("Code"), ERISA, and the Public Health Service Act to prohibit group health plans and group health insurance issuers from entering contracts with health care providers, a network or association of providers, third-party administrators ("TPAs"), or other service providers offering access to a network of providers that include certain "gag clauses." For this purpose, a "gag clause" refers to any direct or indirect restrictions on:

- The disclosure of provider-specific cost or quality of care information or data to referring providers, plan sponsors, participants, beneficiaries, or enrollees, or individuals eligible to become participants, beneficiaries, or enrollees of the plan or coverage;

- Electronic access to de-identified claims and encounter information or data for each participant, beneficiary, or enrollee upon request and consistent with HIPAA and other privacy rules; and

- Sharing any information or data described above, or directing that such information or data be shared, with a business associate pursuant to the HIPAA privacy rule.

Additionally, the CAA 2021 requires group health plans and issuers to submit the Gag Clause Prohibition Compliance Attestation—an annual attestation of compliance—to the Agencies by December 31 of each calendar year.

Completing and Filing the Attestation

The annual attestation must be submitted by group health insurance issuers and by fully-insured and self-insured group health plans. This includes ERISA plans, non-federal governmental plans, and Church plans subject to the Code. Group health plans that are "grandfathered" for purposes of the Affordable Care Act are subject to the prohibition on gag clauses and also must file the annual attestation.

The Departments of Health and Human Services, Labor, and Treasury have established a website to receive the Gag Clause Prohibition Compliance Attestation. Instructions and other information, including a link to the page for submitting the Gag Clause Prohibition Compliance Attestation, is available here.

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