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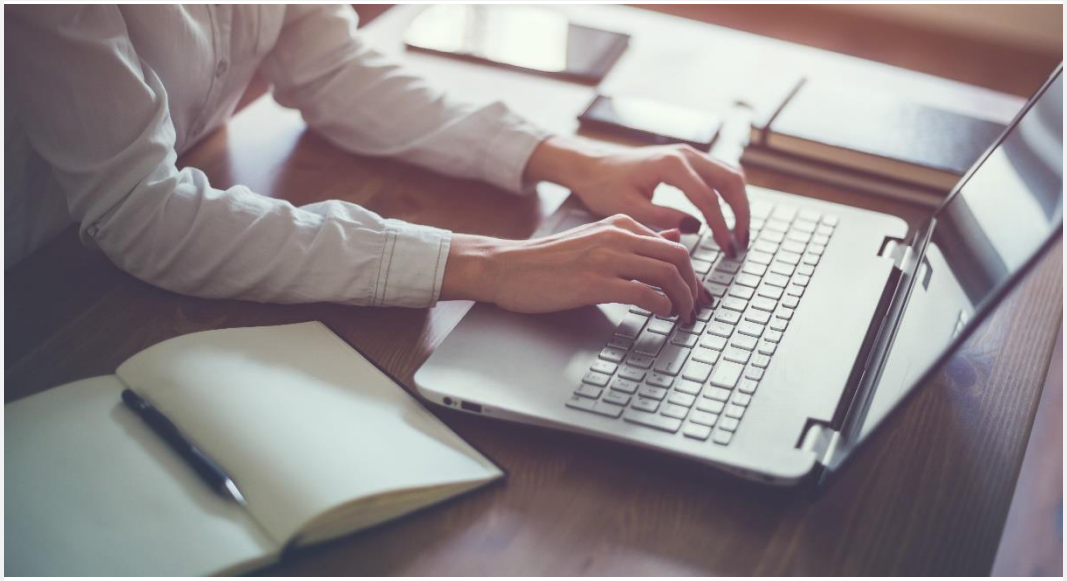

In this Issue:

Supreme Court Upholds ACA Preventive Services Mandate

On the final day of its current term, the U.S. Supreme Court rejected a challenge to the Constitutionality of the Affordable Care Act's preventive services mandate, which generally requires group health plans to provide coverage for certain preventive services at no cost to participants. The Court's decision in *Kennedy v. Braidwood Management Inc.* confirms that the ACA's preventive services mandate continues in effect without change.

Overview of the ACA Preventive Services Mandate

In general, the ACA requires group health plans to cover the following preventive services without cost-sharing:

- Evidence-based items or services with an A or B rating by the United States Preventive Services Task Force ("USPSTF")
- Immunizations for routine use as recommended by the Centers for Disease Control's Advisory Committee on Immunization Practices (ACIP)
- Preventive care and screenings for children as provided for in guidelines supported by the Health Resources and Services Administration (HRSA)
- Preventive care and screenings for women as provided for in guidelines supported by the HRSA

The USPSTF periodically updates its ratings. As the ratings change, so too do the relevant preventive services that group health plans must cover pursuant to the ACA.

Case Summary

The question before the Supreme Court relates to the enforceability of the USPSTF ratings.

A Texas district court previously held that the preventive services mandate with respect to USPSTF ratings of A or B issued on or after March 23, 2010 (the date the ACA was enacted) violates the Constitution's Appointments Clause. That holding was subsequently confirmed by the 5th Circuit Court of Appeals.

The Appointments Clause provides that certain officers of the U.S. must be appointed by the President with the "advice and consent" of the Senate. In previous cases, the Supreme Court has distinguished between "principal" officers and "inferior" officers, noting that the latter can be appointed by the President or agency heads without Senate confirmation. UPSPSTF members are appointed by the Secretary of Health and Human Services for 4-year terms.

Essentially, the plaintiffs claimed that USPSTF members are "principal" officers who should require Senate approval. But the fact they are appointed by the Secretary of HHS without any Senate confirmation process means their appointment is unconstitutional, and thus their recommendations cannot form the basis for legally mandated coverage of preventive services pursuant to the ACA.

By a 6-3 majority, the Supreme Court disagreed. Briefly, the Court ruled that UPSTF members are "inferior" officers who can be appointed by the Secretary of HHS, and also removed by the Secretary at any time. Furthermore, the Court

noted that the UPSPSTF's recommendations are reviewable by the HHS Secretary before they take effect. As such, there is no Constitutional problem with the ACA preventive services mandate cross-referencing the USPTF's recommendations.

Appeals Court Rules that Courts Cannot Enforce Dispute Resolution Awards under the No Surprises Act

In a pair of cases, the Fifth Circuit Court of Appeals ruled that courts do not have the power to review or enforce an award that was determined under the No Surprises Act's ("NSA") independent dispute resolution ("IDR") process, under which an arbitrator resolves surprise billing disputes that arise between health care providers and insurers.

No Surprises Act

In 2020, Congress enacted the NSA, which protects patients in job-based and individual health plans from surprise medical bills when receiving emergency care, non-emergency care from out-of-network providers at in-network facilities, and air ambulance services from out-of-network providers. The NSA establishes an IDR process to resolve billing disputes between health care providers and insurers over the appropriate reimbursement for services when the NSA applies. If an out-of-network provider disagrees with a payment amount offered by an insurer for the services that were provided to the patient, it can initiate the IDR process, which is overseen by an independent dispute resolution entity that determines the amount the plan owes the provider.

Case Background

In one lawsuit, air ambulance providers asked a district court to enforce awards that were issued to them as part of an IDR process involving reimbursements for air ambulance transports; they alleged that the insurer failed to pay the awards in a timely manner. In a second lawsuit brought by the same air ambulance providers, the plaintiffs sought to have an IDR award involving a different set of insurers vacated. The plaintiffs argued that the IDR award should be thrown out because the insurers misrepresented and failed to disclose the applicable qualifying payment amounts ("QPAs") – generally, the median rate for a service in a particular market – that insurers must calculate and disclose to providers as part of the IDR process.

In both cases, the district courts dismissed most of the air ambulance providers' claims. The plaintiffs appealed to the Fifth Circuit.

Appeals Court Ruling

On June 12, 2025, the Fifth Circuit issued a pair of rulings affirming that the district courts were correct in dismissing the cases. The major takeaway from the rulings is that the Fifth Circuit found that the NSA does *not* create a private

right of action – in other words, courts do not have the power to review or enforce an award that was determined using the NSA's IDR process (except in very narrow circumstances involving fraud, as described below).

The court also ruled that the IDR awards should not be vacated because a court can only set aside an IDR award if it was the result of fraud or corruption (for example, the case involved bribery or the willful destruction or withholding of evidence). Here, the court found that the plaintiffs did not sufficiently show that the alleged misrepresentation and failure to disclose by the insurers involving the QPAs rose to that level.

Currently, different judicial jurisdictions are divided on the issue of whether the NSA provides a private right of action, and there are many similar lawsuits pending in other courts. It is expected that other appeals courts may rule on this issue in the near future, possibly creating further divisions. As it stands, regardless of whether the NSA creates a private right of action, the Department of Health and Human Services is authorized to enforce noncompliance with the NSA by penalizing insurers that fail to comply with the law.

Final Reconciliation Bill Includes Various Employee Benefits-Related Provisions

The "One Big Beautiful Bill Act," which President Trump signed on July 4th, includes a number of provisions relating to employee benefits. Following is a quick summary of some of the most important changes, all of which will take effect in 2026.

Health Savings Accounts

The House-passed version of the bill included a number of enhancements to HSAs and HSA-compatible high-deductible health plans (HDHPs), as well as new statutory option to allow employers to offer health reimbursement arrangements (HRAs) that could be integrated with individual health insurance. Most of these provisions were dropped by the Senate, and thus did not make the final bill.

However, the final bill did include the following provisions:

- Coverage by Direct Primary Care Service Arrangements and HSA Eligibility. Individuals who are otherwise eligible to contribute to HSAs will no longer be disqualified simply because they are covered by a "direct primary care service arrangement" that meets certain specific requirements. In general, a direct primary care service arrangement is one where individuals are eligible to receive primary care services directly from primary care practitioners in exchange for payment of a fixed periodic fee. The total fees for all "direct primary care service arrangements" the individual participates in could not exceed $150 per month for this rule to apply.
- Use of HSA Distributions to Pay Direct Primary Care Service Arrangements. Participants in direct primary care service

arrangements will also be able to pay the associated fees from their HSAs on a tax-favored basis.

- ACA Exchange Bronze and Catastrophic Plans Treated as HDHPs. Individuals who purchase bronze level plans and catastrophic plans on ACA exchanges will be treated as being covered by an HDHP for HSA purposes. As long as they satisfy the other applicable eligibility rules, these individuals will be eligible to fund an HSA.

Significantly, the final bill also includes a permanent extension of the special telehealth safe harbor for HSA-compatible HDHPs. Under the safe harbor, HDHPs can provide first-dollar coverage for telehealth services. The temporary safe harbor that originated during the COVID-19 pandemic expired at the beginning of 2025.

Trump Accounts

The bill creates a new type of tax-deferred savings account for children, called a "Trump Account." These accounts can be established for any child before they attain age 18, and distributions would not be permitted until age 18. Employers can make non-taxable contributions of up to $2,500 (indexed) to a Trump Account of an employee or an employee's dependent.

Fringe Benefits

Education Assistance Programs. The bill permanently extends the ability of employers to help employees make their student loan payments through educational assistance programs. Beginning in 2027, the gross income exclusion limit for employer-provided educational assistance will be indexed annually for inflation. The current limit is $5,250.

Dependent Care Assistance Programs. The bill increases the annual gross income exclusion for employer-provided dependent care assistance programs from $5,000 to $7,500 (or $3,750 for separate returns filed by a married individual). The increased limit will also be available for employees who participate in dependent care flexible spending arrangements (FSAs).

Qualified Transportation Fringe Benefits. The bill makes a small change to the base year for calculating inflation adjustments to the annual limits on qualified transportation fringe benefits. The change should result in an increase to the gross income exclusion limits, which for 2025 are $325 per month for qualified parking, and $325 per month for commuter vehicles and transit passes.

Paid Family and Medical Leave Tax Credit

Also of interest, the bill makes the paid family and medical leave tax credit permanent, along with other changes to enhance the credit. Most importantly, employers will now be allowed to claim the credit for premiums they pay for insurance policies that provide paid family and medical leave benefits to employees. Previously, the credit was available only if employees directly paid wages to qualifying employees while they were on family and medical leave. Additionally, employers will now be able to count leave paid by a state or local government program (or required to be paid pursuant to a state or local law) towards eligibility for the credit, but these amounts cannot be used to determine the credit amount. This has the effect of making the credit available in all states, and not just those that do not have a paid family and medical leave program.

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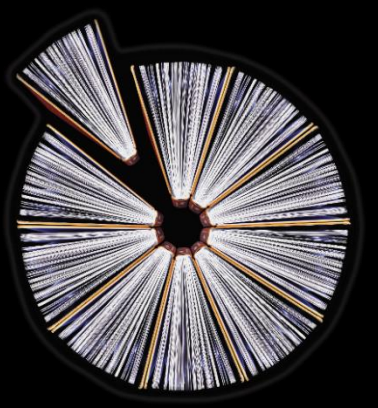

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