



New Guidance Released on Health-Contingent Wellness Programs, Including Tobacco Cessation Programs

By: Kate Belyayeva

On August 26, 2026, the U.S. Department of Labor ("DOL"), the Department of Health and Human Services, and the Department of Treasury (collectively, the "Departments") jointly released new guidance titled "FAQs about Affordable Care Act and Health Insurance Portability and Accountability Act Implementation Part 74" (the "FAQs"). The FAQs address longstanding questions regarding health-contingent wellness programs, including whether employers must provide wellness program rewards retroactively to the beginning of the plan year when an employee completes a reasonable alternative standard mid-year. The guidance comes amid a wave of class-action lawsuits challenging tobacco surcharges that some employers add to premiums for their group health plans through workplace wellness programs. This article provides a high-level overview of the FAQs and what employers should know about the Departments' updated enforcement approach.

Background

The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and the Affordable Care Act ("ACA") generally prohibit group health plans from discriminating against participants based on health status-related factors. However, an important exception allows employers to offer premium discounts, rebates, surcharges, or modifications to cost sharing in connection with wellness programs designed to promote health or prevent disease.

In 2013, the Departments issued final rules on wellness programs (the "2013 Final Rules"). While the regulatory text did not clearly require retroactive application of rewards, the preamble stated that an

individual who satisfies a reasonable alternative standard mid-year must receive the same full reward as individuals who met the initial standard for that plan year. Some interpreted this language to mean that, for example, if a participant completes a tobacco cessation program on April 1, the plan must refund surcharges paid for January through March.

This preamble language sparked more than 50 class-action lawsuits challenging employer-imposed tobacco surcharges, generally alleging that employers failed to provide a retroactive "full reward," inadequately disclosed the reasonable alternative standard, and breached ERISA fiduciary duties. Several federal courts have dismissed these claims, including *Plesha v. Ascension Health Alliance* (E.D. Mo.), *Noel v. PepsiCo, Inc.* (S.D.N.Y.), and *Greene v. Progressive Corp.* (N.D. Ohio), and held that prospectively removing the surcharge upon completion of the cessation program satisfies the "full reward" requirement without retroactive reimbursement. Notwithstanding these favorable rulings, the litigation continues, and other courts may reach different conclusions.

Key Takeaways

The FAQs address two primary issues that have been at the center of the tobacco surcharge litigation:

- ▶ **Retroactivity of the "Full Reward".** The Departments announced that, until further guidance or regulations are issued, they will not take enforcement action against a plan or issuer that does not provide a wellness program reward retroactively to the beginning of the plan year when a participant completes a reasonable alternative standard mid-year. Under this enforcement relief, plans and issuers need only provide the reward prospectively, corresponding to the period after the reasonable alternative standard is satisfied.

The Departments acknowledged that the preamble to the 2013 Final Rules suggested retroactive application was required but noted that the regulatory text did not clearly impose such a requirement. The Departments emphasized, however, that this enforcement discretion does not change the requirement that wellness programs must: (1) be reasonably designed to promote health or prevent disease; and (2) not be a subterfuge for discrimination or underwriting based on a health factor.

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Additionally, all the facts and circumstances must still be considered in determining whether a plan has furnished a reasonable alternative standard, and the wellness program must provide sufficient time for individuals to complete the alternative standard and receive a reward.

- ▶ **Disclosure Requirements.** The FAQs also clarify the scope of the obligation to disclose the availability of a reasonable alternative standard in plan materials. Under the 2013 Final Rules, a plan or issuer must disclose the availability of a reasonable alternative standard in all plan materials describing the terms of a health-contingent wellness program, including contact information and a statement that recommendations of an individual's personal physician will be accommodated. Importantly, the FAQs reiterate that if plan materials merely mention that a health-contingent wellness program is available, without describing its terms, the plan or issuer is not required to include the reasonable alternative standard disclosure. For example, a summary of benefits and coverage that notes cost sharing may vary based on participation in a wellness program, without describing the program's standards, would not trigger this disclosure obligation.

Employer Impact

The FAQs provide welcome clarity for employers that sponsor health-contingent wellness programs, particularly those that impose tobacco surcharges. For employers that currently provide wellness rewards on a prospective basis, the FAQs provide assurance that the Departments will not take enforcement action against such programs, which addresses one of the operational challenges employers as retroactive reward calculations can be administratively burdensome and costly. However, employers should be mindful that the FAQs represent the Departments' enforcement position and do not have the force of law. The FAQs do not directly impact private litigation, and participants retain their private right of action under ERISA to challenge wellness program administration. Although several courts have ruled favorably for employers on the retroactivity question, other courts may reach different conclusions, and additional cases remain pending.

In light of the FAQs and the evolving litigation landscape, employers that sponsor health-contingent wellness programs should assess whether their wellness programs, including tobacco surcharge programs, satisfy all applicable regulatory requirements and confirm that the required disclosure regarding the availability of a reasonable alternative standard is included in applicable program materials. For employers that currently provide retroactive rewards, it may be prudent to maintain that practice, as doing so remains permissible and may reduce litigation risk. Employers that do not currently provide retroactive rewards may now rely on the Departments' enforcement relief but should weigh the ongoing litigation risk before making program design changes.

Conclusion

The FAQs represent a meaningful step toward providing certainty for employers that sponsor health-contingent wellness programs. That said, the Departments have indicated that further guidance or regulations may be forthcoming. While the enforcement relief is a positive development, employers should continue to monitor regulatory and litigation developments and consult with benefits counsel to ensure that their wellness programs remain compliant.

IRS Proposes Regulations Clarifying Nondiscrimination Testing Rules for Dependent Care Assistance Programs

By: Abby Blankenship

On August 11, 2026, the Internal Revenue Service ("IRS") and the Department of the Treasury published proposed regulations providing much-needed guidance on the nondiscrimination testing requirements for Dependent Care Assistance Programs ("DCAP") under Internal Revenue Code ("Code") Section 129. Notably, the DCAP guidance was issued as part of a broader rulemaking package that also addresses employer contributions to the new Trump accounts under Code Section 128.

The proposed regulations are significant because they are intended to resolve ongoing ambiguities that have created compliance challenges for both employers and plan sponsors.

Background

Under Code Section 129, employees may exclude from gross income up to \$7,500 per year (\$3,750 for married individuals filing separately) in employer-provided dependent care assistance, so long as the DCAP satisfies four statutory nondiscrimination requirements.

The four nondiscrimination requirements under Code Section 129 are designed to ensure that the tax-favored benefit is not disproportionately concentrated among highly compensated employees ("HCEs") or business owners.

They include:

1. A contributions and benefits test (ensuring that benefits provided to HCEs are not disproportionately large compared to those available to non-highly compensated employees ("NHCEs"));
2. An eligibility test (ensuring the program does not discriminate in favor of HCEs or their dependents with respect to eligibility to participate);
3. A 25% ownership concentration test (capping the total benefits provided to shareholders or owners holding more than 5% of the business); and
4. A 55% average benefits test (requiring that the average benefits provided to NHCEs equal at least 55% of the average benefits provided to HCEs).

Despite these statutory requirements, the IRS had never issued comprehensive regulations specifically addressing how these tests should be applied in practice. As a result, employers were left to rely on a combination of guidance from the statutory text, informal IRS guidance, and the nondiscrimination rules applicable to other cafeteria plan benefits.

Overview of Proposed Regulations

The proposed regulations address several areas where existing guidance was either silent or ambiguous. Key provisions include:

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- **Contributions and Benefits Test.** One important threshold question the proposed regulations address is what it means for a DCAP not to discriminate with respect to contributions and benefits under Code Section 129(d)(2). The proposed rules confirm that this is a plan-design inquiry: the question is whether the program's terms make benefits available equally, not whether every employee ends up receiving the same dollar amount.
- **Eligibility Test.** The proposed regulations introduce a two-part framework for evaluating whether a DCAP's eligibility requirements improperly favor HCEs.
 - First, there is a numerical safe harbor. A DCAP's eligibility classification is automatically deemed nondiscriminatory if the plan's "ratio percentage" clears a numerical threshold. The ratio percentage is the proportion of NHCEs eligible for the plan divided by the proportion of eligible HCEs.
 - Second, if the safe harbor is not met, the classification can still be sustained under a facts and circumstances analysis. The IRS would look at whether the classification rests on legitimate business criteria – such as job category, compensation basis (hourly or salaried), work location, or similar objective factors – and would weigh how close the plan's ratio percentage comes to the safe harbor, how broadly the plan covers employees across compensation levels, and what business justification supports the classification.
- **Excluded Employees.** The proposed regulations codify two categories of employees that may be left out of both the eligibility and average benefits testing populations: (1) employees who are under age 21 and have less than one year of service; and (2) employees covered by a collective bargaining agreement under which dependent care benefits were the subject of good-faith bargaining, provided those employees do not actually participate in the DCAP.
- **55% Average Benefits Test.** The proposed regulations address one of the most persistent areas of confusion in DCAP testing: how to compute the average benefits that NHCEs receive for purposes of the 55% threshold. The key clarification involves the denominator. Under the proposed methodology, only employees who actually received dependent care benefits during the plan year are counted – employees who were eligible but chose not to participate are excluded from the calculation. The proposed regulations would also permit employers to disregard employees earning less than \$25,000 when computing the average benefits test for salary-reduction DCAPs.
- **Remediation.** A notable addition is a formal correction pathway for testing failures. Under proposed Treas. Reg. Section 1.129-2(j), an employer that fails the 55% average benefits test or the 25% ownership concentration test as of the end of the plan year can cure the failure by treating the excess amounts as taxable compensation to the affected HCEs (or, in the case of a concentration test failure, the relevant owners). The excess must be included in income and reported on Form W-2 by the applicable W-2 filing deadline.

Key Takeaways

After more than four decades without formal regulatory guidance, the proposed DCAP nondiscrimination testing regulations represent a significant step forward for employers and benefits practitioners alike.

The proposed regulations are subject to a 45-day public comment period, with written comments due by September 25, 2026.

Employers and plan sponsors should take this opportunity to review their current DCAP testing practices, evaluate whether their eligibility classifications meet the new safe harbor, and coordinate with their third-party administrators on any changes to testing methodology.

Court Issues First Ruling on Whether RSUs Must Be Included in Overtime Pay Calculations Under the FLSA

By Abby Blankenship

On June 11, 2026, in *Costa v. Apple, Inc.*, the U.S. District Court for the Northern District of California (the "District Court") became the first federal court to directly address whether restricted stock units ("RSUs") must be factored into the "regular rate of pay" when computing overtime under the Fair Labor Standards Act ("FLSA").

Background

In 2015, Apple, Inc. ("Apple") expanded its RSU program to cover all employees, even those who were classified as nonexempt and eligible for overtime. Under the program, Apple awarded RSUs at its discretion based on job level and function – not based on hours worked, production output, or individual performance. The awards vested over time during active employment, and Apple excluded their value when calculating the regular rate of pay it used to determine overtime for nonexempt employees.

Francis Costa, an hourly Apple employee, filed suit in March 2023 on behalf of himself and a putative class of nonexempt employees who had received RSU awards. The plaintiffs alleged that Apple's practice of excluding the value of vested RSUs from the regular rate violated the FLSA and analogous wage-and-hour laws in California and New York. After the court conditionally certified an FLSA collective and a class was certified under state law, both sides moved for summary judgment on the central question: whether RSU values must be included in the regular rate for overtime purposes.

The District Court's Analysis

The FLSA generally requires that all "remuneration for employment" be included in the regular rate of pay used to calculate overtime. However, the statute carves out several categories of compensation that employers may exclude. The District Court found that Apple's RSUs qualified under two of those exclusions.

First, the District Court held that the RSU awards satisfied the FLSA's equity compensation exception, which permits employers to exclude the value of stock options, stock appreciation rights, and bona fide employee stock purchase programs from the regular rate. Although RSUs are not specifically listed in the statutory text (which was enacted before RSUs became a prevalent form of equity pay), the District Court concluded that RSUs are functionally similar to the instruments Congress intended to cover and fall within the exception's intended scope.

Second, the District Court found that Apple's RSUs independently qualified for the FLSA's "gift" exception. Because Apple retained full discretion over whether to make awards at all, and because the size of each award was not tied to hours worked, production, or efficiency, the District Court characterized the RSUs as discretionary payments more closely resembling gifts than compensation promised in exchange for labor.

On that basis, the District Court granted Apple's motion for summary judgment. The District Court also addressed Apple's good faith and willfulness defenses, finding that Apple's payroll team had engaged in ongoing efforts to monitor legal developments affecting regular-rate calculations. Because no controlling authority had previously required inclusion of RSU values in the regular rate, the District Court concluded that a two-year statute of limitations (rather than the three-year period applicable to willful violations) would govern, and that liquidated damages were not warranted.

Notably, following this, on July 13, 2026, the plaintiffs filed a notice of appeal to the U.S. Court of Appeals for the Ninth Circuit (No. 26-4411), where the case is now pending.

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Implications for Employers

While the *Costa* ruling is a favorable outcome for employers, it is heavily fact-specific, and employers should not assume that their own equity programs will automatically receive the same treatment. Several practical steps are worth considering.

1. *Review Overtime Calculations.* Employers should confirm that their payroll systems are correctly configured to include all required forms of compensation in the regular rate – including nondiscretionary bonuses, commissions, shift differentials, and incentive pay – while properly excluding items that qualify for a statutory exception. Periodic payroll audits can help catch errors before they become systemic liabilities.
2. *Document Compliance Efforts.* One of the notable aspects of the *Costa* decision was the court's emphasis on Apple's documented, ongoing compliance efforts. Even though the regular-rate question was novel, Apple's payroll team had proactively monitored developments and conducted internal reviews.
3. *Monitor the Ninth Circuit Appeal.* Because the case is now before the Ninth Circuit, the district court's ruling is not yet final. Employers (particularly those in the Ninth Circuit's jurisdiction) should monitor the appeal closely. A reversal or narrowing of the district court's holding could significantly change the compliance landscape for equity programs that touch nonexempt workers.



Compliance Corner: Interaction Between HSAs and FSAs and How to Avoid Administrative Errors

By: Kate Belyayeva

Health savings accounts ("HSAs") and health flexible spending accounts ("FSAs") are among the most popular tax-advantaged benefits that employers offer today. When administered correctly, they provide meaningful savings for both employers and employees. However, the rules governing these accounts, particularly the interaction between HSAs and FSAs, are complex, and administrative errors can create significant compliance implications. This article provides a high-level overview of the key requirements for HSAs and limited-purpose FSAs, addresses common administrative errors, and offers practical tips for preventing mistakes before they happen.

The HSA Basics

An HSA is an individually owned, tax-advantaged account that allows eligible individuals to save for qualified medical expenses on a pre-tax basis. Unlike FSAs, HSA funds roll over from year to year and are never forfeited, making them a powerful long-term savings vehicle. Contributions may be made by the employer, the employee, or both, but total contributions from all sources may not exceed the applicable annual limit. For 2026, the maximum annual HSA contribution limit is \$4,400 for

self-only coverage and \$8,750 for family coverage, with a \$1,000 catch-up contribution available for individuals who are age 55 or older by the end of the tax year.

Eligibility Rules

To be eligible to contribute to an HSA, an individual must: (1) be covered under a high-deductible health plan ("HDHP"); (2) not be covered by any other health plan that is not an HDHP (with limited exceptions); (3) not be enrolled in Medicare; and (4) not be claimed as a dependent on another person's tax return. For 2026, the IRS defines an HDHP as a plan with a minimum annual deductible of \$1,700 for self-only coverage or \$3,400 for family coverage, and maximum out-of-pocket expenses of \$8,500 for self-only coverage or \$17,000 for family coverage.

The HSA-FSA Compatibility Rule

One of the most important (and frequently misunderstood) rules is that an individual who is covered by a general-purpose health FSA is generally not eligible to contribute to an HSA. This is because a general-purpose health FSA typically reimburses a broad range of medical expenses before the HDHP deductible is satisfied. Because that arrangement provides first-dollar medical coverage, it is generally disqualifying coverage for HSA contribution purposes. This rule applies even if the individual never actually uses the general-purpose FSA to pay for medical expenses — mere coverage under the FSA is enough to disqualify the individual from making or receiving HSA contributions for the months of disqualifying coverage.

HSA-Compatible FSA Designs

A limited-purpose FSA ("LPFSA") is a special type of health FSA that restricts reimbursements to dental, vision, and preventive care expenses only (and, in some plans, post-deductible medical expenses). Because the LPFSA does not reimburse general medical expenses before the HDHP deductible is satisfied, it preserves the individual's HSA eligibility. LPFSAs are governed by the same general rules as other health FSAs under Code Section 125, including the requirement that elections generally must be made before the beginning of the plan year, the use-it-or-lose-it rule (subject to any applicable grace period or carryover provision), and COBRA continuation coverage requirements. However, the critical difference is the scope of eligible expenses: an LPFSA must be designed so that it only reimburses expenses that do not compromise HSA eligibility.

Common Administrative Errors

Despite the best of intentions, HSA and FSA errors frequently arise during open enrollment, plan-design changes, and transitions between third-party administrators ("TPAs"). Common examples include:

Incorrect FSA Enrollment

Employees who elect an HSA and LPFSA may be incorrectly coded or enrolled in a general-purpose FSA. If the error actually makes general-purpose benefits available, the employee may be ineligible to contribute to an HSA for the affected months. If the employee elected an LPFSA and the incorrect designation was only a recordkeeping error, the employer should review the plan terms, election records, and actual administration before determining the employee's HSA eligibility.

Excess HSA Contributions

Mid-year coverage changes, incorrect catch-up calculations, and failure to count employer contributions can produce excess HSA contributions. An excess generally is subject to a 6% excise tax for each year it remains in the account. The individual may avoid the tax on an amount timely withdrawn, together with attributable earnings, by the due date of the individual's tax return, including extensions.

Carryover and Grace-Period Mistakes

A carryover from a general-purpose FSA generally creates disqualifying

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coverage for the following plan year, even after the balance is exhausted. Plan terms may instead provide for the balance to be converted to an LPFSA or permit the participant to waive the carryover before the new plan year. General-purpose FSA grace periods also must be coordinated carefully with HSA eligibility.

▸ Dual Coverage Errors

Employees may overlook disqualifying coverage available through a spouse's general-purpose FSA or another employer-sponsored arrangement. Enrollment materials should remind employees to consider all coverage under which their medical expenses may be reimbursed.

Correcting and Preventing HSA and FSA Errors

When an error is discovered, prompt corrective action is essential. The IRS does not provide a single, specific correction procedure for HSA/FSA enrollment errors, and the appropriate approach will depend on the nature and scope of the mistake. However, there are several guiding principles and preventive measures employers should keep in mind.

- *Protect HSA Eligibility.* Determine HSA eligibility month by month, stop any impermissible contributions, and address potential excess contributions under the applicable HSA rules.
- *Educate Employees.* Provide clear, plain-language communications during open enrollment that explain the HSA-FSA compatibility rules. Employees who understand these rules are less likely to make incorrect elections and more likely to flag potential errors early.
- *Review Plan Documents.* Ensure that the employer's Section 125 cafeteria plan document accurately reflects the LPFSA design and includes provisions authorizing corrective actions if administrative errors occur.
- *Conduct a Post-Enrollment Audit.* Verify that each participant's account type matches their elections, particularly for employees who elected both an HSA and an LPFSA. A simple reconciliation between election forms and the TPA's enrollment records can catch errors before they become costly.

Conclusion

HSAs and FSAs can work together, but only when the FSA is designed and administered to preserve HSA eligibility. The most effective compliance strategy is prevention: clear plan terms, targeted employee education, and routine reconciliation among vendors. When an error does occur, employers should act quickly, determine exactly what coverage and contributions were provided, and implement a coordinated correction based on the governing documents and applicable IRS guidance.



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- The U.S. Department of Labor published a proposed rule on July 23, 2026, that would give group health plan administrators a new option for delivering required ERISA disclosures electronically. The approach is similar to one that retirement plans have been using since 2020: instead of mailing paper documents, administrators could make them available on a website and notify participants where to find them. Participants must still be able to request paper copies or opt out of electronic delivery. The public comment period closes on September 21, 2026, and if the rule is finalized later this year, plans could begin relying on it as early as January 1, 2027.
- The U.S. Department of Health and Human Services moved the proposed HIPAA Security Rule overhaul to its long-term agenda, with final action now targeted for July 2027 rather than May 2026; however, that date is only an estimate. If finalized substantially as proposed, the rule would impose more prescriptive cybersecurity requirements on HIPAA-covered group health plans and business associates, including asset inventories, encryption, and multifactor authentication. The existing Security Rule remains in effect and actively enforced, so plans should continue risk assessments and remediation efforts that support current compliance and may mitigate enforcement exposure.
- On August 21, 2026, the Office of Federal Contract Compliance Programs published three coordinated final regulations that formally rescinded the implementing regulations for Executive Order 11246 — which for over sixty years had required federal contractors to maintain affirmative action programs for women and minorities — while also narrowing Section 503 of the Rehabilitation Act's affirmative action requirements for individuals with disabilities and updating coverage thresholds under the Vietnam Era Veterans Readjustment and Assistance Act (VEVRAA). The rescission of EO 11246 regulations takes effect October 26, 2026, while the Section 503 and VEVRAA changes generally take effect September 21, 2026. These rules follow President Trump's January 2025 revocation of EO 11246 via Executive Order 14173 and effectively dismantle the longstanding regulatory framework that required covered federal contractors and subcontractors to develop and maintain race- and gender-based affirmative action plans.

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