



Enhanced ACA Premium Subsidies Lapse Following Legislative Inaction

By: Dawnielle Wright

On December 31, 2025, the enhanced premium tax credits available under the Affordable Care Act ("ACA") expired following the conclusion of their temporary extension. Legislative efforts to extend or reinstate the enhanced subsidies did not result in enacted legislation before year-end, resulting in a return to pre-pandemic subsidy levels for individuals purchasing coverage through the ACA marketplaces. While the expiration does not change employer-sponsored plan requirements under the ACA, it has drawn renewed attention to marketplace coverage costs and affordability for individuals purchasing insurance outside of employer plans.

Background on ACA Premium Tax Credits

The ACA provides premium tax credits to eligible individuals who purchase health insurance coverage through the federal or state-based health insurance marketplaces. These credits are intended to make coverage more affordable by limiting the percentage of household income that an individual must pay toward monthly premiums for benchmark plans.

In 2021, Congress temporarily expanded the premium tax credit framework through the American Rescue Plan Act, later extending those enhancements through the Inflation Reduction Act. The expanded subsidies increased the amount of financial assistance

available to lower-income individuals and removed the prior income cap that limited eligibility for premium tax credits. Under the temporary framework, individuals with household income above 400% of the federal poverty level could qualify for premium assistance based on the cost of coverage.

The enhanced subsidy provisions were enacted on a temporary basis and expired at the end of 2025, reverting premium tax credit eligibility and amounts to the pre-2021 structure beginning with the current coverage year.

What Changed Following the Expiration of the Enhanced Subsidies

With the expiration of the enhanced subsidies, premium tax credits for ACA marketplace coverage are now calculated under the prior income-based formula. This framework generally provides lower levels of assistance and reinstates an income threshold above which premium tax credits are no longer available.

As a result, many individuals purchasing coverage through the marketplaces may experience increased out-of-pocket premium costs, and some individuals who previously qualified for subsidies may no longer be eligible. The extent of the impact varies based on household income, family size, geographic location, and the cost of available marketplace plans. In certain regions, premium increases may be significant.

In response to the expiration, a number of states have initiated or expanded their own subsidy programs to help residents maintain more affordable coverage, though these state efforts are not uniform and may not fully offset the loss of federal assistance.

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Employer Impact

Although the expiration of the enhanced ACA subsidies primarily affects the individual insurance marketplace, it may have indirect effects in the employer-sponsored coverage context. Employees who previously relied on marketplace coverage, or who compared employer coverage to subsidized marketplace options, may raise questions regarding affordability, eligibility, or enrollment decisions.

Importantly, the expiration of the enhanced subsidies does not change an employer's obligations under the ACA's employer shared responsibility provisions. Requirements related to offering coverage, affordability standards, reporting, and plan administration remain in effect. However, employers may see increased interest in understanding how employer-sponsored coverage compares to marketplace options as premium costs shift. Considerations for Plan Sponsors

In light of the expiration of the enhanced subsidies, employers should be prepared for employee inquiries regarding coverage options and associated costs. Clear communication regarding the availability and terms of employer-sponsored plans, as well as the distinction between employer coverage and marketplace coverage, may help reduce confusion.

Employers should also continue to focus on core compliance obligations, including accurate affordability determinations, timely ACA reporting, and consistent administration of plan terms. These requirements remain unchanged despite developments in the individual marketplace.

Conclusion

The expiration of the enhanced ACA premium tax credits represents a meaningful change for individuals purchasing coverage through the ACA marketplaces, particularly with respect to affordability. While employer-sponsored health plan requirements under the ACA remain unchanged, the broader policy landscape continues to evolve. Efforts to extend or reinstate enhanced premium tax credits are being discussed by lawmakers early in the 2026 congressional session, creating ongoing uncertainty for the individual marketplace.

As with many ACA-related developments, awareness and preparation can help ensure that employers are positioned to respond effectively and maintain compliance amid changing circumstances.



IRS Notice 2026-05: Expansion of Health Savings Accounts Under the One Big Beautiful Bill Act

By: Kate Belyayeva

On December 9, 2025, the Department of Treasury and the Internal Revenue Service ("IRS") issued IRS Notice 2026-05 ("Notice"), which provides critical guidance on changes to health savings accounts ("HSAs") under the recently enacted One Big Beautiful Bill Act of 2025 ("OBBBA"). This article explains the background of and key takeaways from the Notice as well as what employers and plan sponsors should know to remain compliant and optimize HSA-related benefits for employees.

Background

HSAs are tax-favored accounts that allow eligible individuals to save and pay for qualified medical expenses on a tax-free basis. The provisions governing HSAs are primarily set forth in Section 223 of the Internal Revenue Code of 1986, as amended ("Code"). Only individuals eligible under Code Section 223(c)(1) may make contributions to an HSA or receive contributions from an employer to their HSA. To be eligible to contribute to an HSA, among other requirements, individuals generally must be covered under a high deductible health plan ("HDHP") and have no disqualifying coverage.

There are also various requirements that a plan must meet to be considered an HDHP. For instance, some plans, such as bronze and catastrophic plans offered as individual coverage through an Exchange (also known as the Marketplace) established under the Affordable Care Act, because the plans' out-of-pocket maximum exceeded the statutory limits for HDHPs. In addition, an HDHP is generally not permitted to provide benefits for a plan year until the applicable minimum annual deductible has been satisfied. However, Code Section 223(c)(2)(C) establishes an important safe harbor for preventive care. Under this provision, a plan will not fail to qualify as an HDHP solely because it provides preventive care benefits without requiring satisfaction of the minimum deductible.

The OBBBA, which was enacted on July 4, 2025, has expanded access to HSAs by modifying the definition of HDHPs and eligibility requirements. The Notice implements this expansion through a Q&A format to assist taxpayers and plan sponsors in applying the new expansion.

Key Takeaways

The Notice focuses on several areas where the OBBBA modifies HSA eligibility and what constitutes an HDHP:

(1) Telehealth and Other Remote Care Services. As previously noted, prior to the OBBBA, HDHPs could offer only preventative care benefits without a deductible, meaning that HDHPs were not permitted to cover other services before the minimum deductible was met. HDHPs paired with HSAs are now permanently allowed to cover telehealth and other remote care services pre-deductible without affecting HSA eligibility. This relief was first implemented (and extended) during the COVID pandemic and has now been implemented permanently, retroactive to December 31, 2024. The Notice explains that telehealth benefits may include: (i) the list of telehealth services payable by Medicare that is published annually by

the Department of Health and Human Services (“HHS”) under Section 1834(m)(4)(f) of the Social Security Act (“SSA”); and (ii) services not included on the HHS list as long as the principles of section 1834(m) of the SSA, its implementing regulations at 42 CFR Section 410.78, and other guidance issued by HHS defining “telehealth services” and related terms are applied thereto.

(2) Bronze and Catastrophic Plans. Effective for months beginning after December 31, 2025, the OBBBA has expanded the definition of an HDHP to include certain bronze and catastrophic plans available through the Exchange. The Notice further confirmed that these plans can be treated as HDHPs for HSA eligibility purposes and clarified that “a bronze or catastrophic plan that is available as individual coverage will not fail to be an HDHP because an employer-sponsored ICHRA is used to purchase the coverage.” The Notice also provided clarity with respect to an employer’s ability to treat individual coverage purchased on the individual coverage market but not on the Exchange the same as such plans purchased on the Exchange.

(3) Direct Primary Care (“DPC”) Arrangements. DPC arrangements allow patients to pay fixed periodic fees to primary care providers to receive certain health services without incurring a separate charge for those services. The Notice clarifies how certain DPC arrangements interact with HSA eligibility rules. Under the updated guidance, enrollment in an eligible DPC arrangement no longer automatically disqualifies a covered individual from contributing to an HSA, so long as other coverage qualifies as an HDHP. Note that medical care must be provided by “primary care practitioners” as defined in Section 1833(x)(2)(A) of the SSA, and the following services are not considered “primary care services” for purposes of determining a DPC arrangement: (i) procedures that require the use of general anesthesia; (ii) prescription drugs other than vaccines (therefore, vaccines are permitted primary care services); and (iii) laboratory services not typically administered in an ambulatory primary care setting.

In addition, prior to the passage of the OBBBA, a participant using a DPC arrangement was ineligible for an HSA, and DPC expenses could not be reimbursed by an HSA. Under the OBBBA, effective January 1, 2026, funds from an HSA can be used to pay for DPC arrangements on a tax-free basis (limited to \$150 for an individual and \$300 for a family), and participants in a DPC arrangement will remain HSA-eligible. While the limits are monthly, a DPC arrangement can be billed for periods of more than a month, but not more than a year, provided that the aggregate fees are fixed, periodic, and do not exceed the monthly limit on an annualized basis. Notwithstanding the above, the Notice clarifies that the sole compensation for care provided under a DCP arrangement must be the fixed periodic fee and does not include “an arrangement that provides certain healthcare items and services to individuals on the condition that they are members in the arrangement and have paid a fixed periodic fee, but bills separately for those items and services (through insurance or otherwise).”

Employer Impact

Employers sponsoring HDHPs linked to HSAs must carefully review plan terms in light of the Notice.

(1) Telehealth Services. Plans can continue to provide telehealth benefits without jeopardizing HSA eligibility. Although this safe

harbor was extended retroactively to include any telehealth services provided in 2025 and forward, those plan sponsors who have yet to adopt this safe harbor may want to apply this change only prospectively as retroactive coverage would be administratively burdensome and require extensive adjustments for the telehealth benefits provided up to date (e.g., recalculation of deductibles).

(2) Bronze and Catastrophic Plans. Although the expansion of the definition of an HDHP to include bronze and catastrophic plans does not directly impact the HDHPs currently sponsored by employers, employers should nevertheless be aware that the OBBBA has expanded access to HSAs to certain individuals who otherwise may lack HDHP coverage. This expansion means that employers may also make contributions to the HSAs of those employees who have obtained bronze and catastrophic plans on the individual market coverage or the Exchange.

(3) Direct Primary Care (“DPC”) Arrangements. Employers interested in offering innovative care models should evaluate how the interaction of HSAs and HDHPs with DPC arrangements can enhance their current benefit (1) offerings. For instance, employers should review how medical expenses are currently defined in their cafeteria plan and/or any applicable HSA-related documents to ensure that the definition of medical expenses thereunder includes eligible DPC arrangements as a reimbursable expense payable with HSA funds in accordance with the OBBBA. Notably, a broad reference to medical expenses as defined in Code Section 2223 and as allowed under Code Section 105 as well as the rulings and Treasury regulations thereunder should be sufficient to cover eligible DPC arrangements; however, targeted review of applicable documents is nevertheless recommended, especially with respect to cafeteria plans that inadvertently use the same definition of medical expenses for HSAs and the health flexible spending accounts to ensure that only allowable expenses are reimbursed under each tax-favored arrangement.

Conclusion

If an employer has operationally implemented, or plans to adopt, any of the aforementioned changes, the employer should contact its third-party administrator and/or vendors regarding next steps and engage benefits counsel, if necessary, to ensure that current HDHP offerings align with the Notice and the IRS’ interpretations of HSA-related changes pursuant to the OBBBA. Furthermore, employers should be proactive in communicating any changes to impacted employees and, if possible, assist employees in evaluating personal coverage options, including with respect to the HDHPs, HSAs, and the interaction between the two. Additional guidance may be forthcoming, and continued monitoring of IRS notices and related regulatory developments remains essential to responsible benefit administration in 2026 and beyond.



Employer Use of Tobacco Surcharges Affirmed by Recent Court Ruling

By: Colin Clark

Introduction

Tobacco surcharges continue to be a hot topic in the ERISA world. Various courts have heard various cases and arguments from plaintiffs and defendants as to what constitutes a permissible tobacco surcharge. So far, courts have not all agreed on the several nuanced aspects of tobacco surcharges. Some courts have allowed claims of this nature to proceed, while others have stopped these claims in their tracks. It is an inherently difficult topic and there could be some regional differences in play as well. Let's take a look at a recent case, *Williams v. Bally's Mgmt. Grp., LLC*, from a Rhode Island federal court where a participant sued their employer alleging a breach of ERISA fiduciary duties and a violation of ERISA's nondiscrimination provisions.

The Case

Williams worked at Bally's and was a participant in the Bally's health and welfare plan. As a tobacco user, Williams paid a tobacco surcharge of \$780 a year. The plan had a provision whereby users who complete a tobacco cessation program would not be charged the surcharge after completion of the program. Williams sued her employer, Bally's, claiming that by imposing such a surcharge Bally's breached their ERISA fiduciary duty and further violated ERISA's nondiscrimination provisions. Bally's moved to dismiss all claims before the court.

In reviewing the fiduciary breach claim, the court first addressed whether or not Williams even had standing to pursue such a claim. The court quickly determined that "Because Ms. Williams has failed to properly allege any concrete, non-speculative, and redressable injury to the Plan, the Court finds that Ms. Williams lacks standing to assert her claims under Count II of her Amended Complain, which must therefore be dismissed." The court found her arguments speculative and found no injury to the Plan (perceived or otherwise).

In addressing the nondiscrimination claim, Williams argued that anyone who completed the tobacco cessation program should be awarded *retroactively* however much they had paid in surcharge fees, arguing that the "full reward" requirement is not met an award that is only applied *prospectively*. She further argued that there was no notice as to a Reasonable Alternative Standard. The court took it upon itself to interpret the "full reward" language found in ERISA. In doing so, the court disagreed with Williams again, noting that the "full reward" language found in ERISA was not designed to include retroactive reimbursements, noting that "...the terms 'discount...of a premiums' and 'absence of a surcharge' provided in 42 U.S.C § 300gg-4(j)(3)(A) as possible reward do not mandate a retroactive reimbursement of previously paid surcharges."

As to the apparent lack of notice of a Reasonable Alternative Standard, Bally's was able to show that their Summary Plan Documents (SPDs) did indeed include such a notice, and that the notice met all requirements. In fact, the notice matched the sample language provided by the Department of Labor, a fact that the court specifically highlighted.

Looking Ahead

While employers and sponsors will likely see the outcome of this particular case as a positive, it highlights the importance of following all pertinent requirements when imposing a tobacco surcharge. Courts have not agreed on the nuanced topic of tobacco surcharges and had this case been before a different court, the likelihood of a different outcome would have been high. Tobacco surcharge cases have received varied treatment, and it is important that employers and sponsors remain steadfast in developing solid notices and procedures in order to place themselves in the best possible position should their surcharge ever be challenged.



Compliance Corner: Summary Annual Report

By: Colin Clark

If a plan is required to file a Form 5500, then they are also required to provide a Summary Annual Report (SAR). An SAR must be given to all plan participants for every year a Form 5500 is filed. SARs contain information about the employee benefit plan, and distribution of the SAR is required by ERISA. An SAR will generally mirror the information provided in Form 5500. The purpose of the SAR is to provide participants and beneficiaries with pertinent information about their health and welfare plan and allow them to request further information if they so desire.

Required Information

According to the Department of Labor's sample SAR, the following information is required to be included in an SAR furnished to participants:

- Funding and Insurance Information
- Basic Financial Information
- Rights to Additional Information
- Offer of Assistance in Non-English Language

For funding and insurance information, the SAR must detail all contracts with insurance carriers, types of claims the contract is designed to pay, and the total premiums for the applicable plan year. Additional information is required if the contract is experience rated. Note that this information is likely included in Form 5500. For basic financial information, the SAR must clearly summarize the financial picture of the plan, including the value of all plan assets at the beginning of the plan year, and the value of all plan assets at the end of the plan year. This applies to funds held in a trust or separate fund.

Additional information required includes the total income during the plan year (including employer and employee contributions), realized gains and losses from any sales or investment earnings, as well as a breakdown of all plan expenses. The SAR must include a notice detailing participant rights to additional information, and a method for obtaining all relevant information. This information would include the full annual report, any pertinent schedules or attachments, payments to service providers, insurance information related to sales commissions paid out by insurance carriers, a statement of plan assets and liabilities and/or income and expenses, and a statement that participants may examine the full report at the primary office of the plan, and a statement detailing how to obtain any pertinent information from the department of Labor. The SAR may also be obligated to provide assistance in languages other than English, in the case of either:

- A plan which covers fewer than 100 participants at the beginning of a plan year in which 25 percent or more of all plan participants are literate only in the same non-English language; or
- A plan which covers 100 or more participants in which 500 or more participants or 10 percent or more of all plan participants, whichever is less, are literate only in the same non-English language—

If either of these are met, the administrator must provide the affected participants with an English-language SAR, along with a notice in the appropriate non-English language, which offers the additional assistance and details out how to utilize the assistance.

Who, When, and How?

Generally, SARs must be provided to participants under the plan. Other individuals may also be entitled to receive an SAR (such as COBRA beneficiaries). If an individual is entitled to receive a summary plan description (SPD), then they must also receive an SAR. When considering how to properly distribute or disseminate an SAR, sponsors may use any method that is permissible for SPDs. If a plan sponsor is compliantly distributing SPDs, then the same method may be used to distribute an SAR.

SARs must be distributed within nine months of the end of the applicable plan year. If an employer received an extension on their Form 5500, then the SAR can be distributed 2 months after the last day of the extension. Note that an SAR must still be provided for a terminated plan.

Exemptions

If a plan is not required to file a Form 5500, then the plan would not be required to send an SAR to participants or others who may be entitled to receive an SAR. If a plan is totally unfunded, they are likely exempt from the SAR requirement (even those with over 100 participants). The following plans are generally not required to furnish an SAR:

- A totally unfunded welfare plan described in 29 CFR 2520.104-44(b)(1)(i);
- A welfare plan which meets the requirements of 29 CFR 2520.104-20(b);
- An apprenticeship or other training plan which meets the requirements of 29 CFR 2520.104-22;
- A pension plan for selected employees which meets the requirements of 29 CFR 2520.104-23;
- A welfare plan for selected employees which meets the requirements of 29 CFR 2520.104-24;

- A day care center referred to in 29 CFR 2520.104-25;
- A dues financed welfare plan which meets the requirements of 29 CFR 2520.104-26;
- A dues financed pension plan which meets the requirements of 29 CFR 2520.104-27; and
- A plan to which title IV of the Act applies.

While there is no penalty specifically designed for not furnishing an SAR, severe penalties are available for those who willfully violate ERISA requirements, or for those who ignore participant requests. Affected participants and beneficiaries may also bring a lawsuit under ERISA to enforce their rights to receive an SAR.

Conclusion

SAR requirements go hand-in-hand with the Form 5500 obligation. Employers should carefully ensure they are providing all required information in the SAR to all those entitled to receive it. The Department of Labor provides a model SAR notice. Along with the 5500 information employers, sponsors, and administrators already have, compliantly providing the SAR is an important step in meeting yearly compliance obligations.



STAY IN THE KNOW...

- For the first one, please use the following: “On December 17, 2025, bipartisan lawmakers introduced the Pharmacy Benefit Manager (PBM) Fiduciary Accountability, Integrity, and Reform (FAIR) Act, which would require PBMs to be treated as ERISA fiduciaries for employer health plans. The bill has been read twice and referred to the Senate Committee on Health, Education, Labor and Pensions, where it awaits further action before coming to a floor vote in 2026.”
- For the second one: “The U.S. Department of Health and Human Service has issued a Request for Information and is thereby seeking “broad public input” on how its regulatory, reimbursement, and research and development authorities can be leveraged to support AI-driven tools in order to accelerate the adoption and use of AI in clinical care. The agency is particularly interested in modernizing digital health and regulatory frameworks to account for such innovative technologies while maintaining patient safety and efficient structures already in place.”
- For the third one: “Eli Lilly, the makers of the popular GLP-1 Zepbound, recently announced they are lowering direct-to-consumer prices to as low as \$299 per month for certain doses of the weight loss drug.”
- For a fourth one: “In early January, the U.S. Department of Labor announced that the Employee Benefits Security Administration expanded its Delinquent Filer Voluntary Compliance Program to include Multiple Employer Welfare Arrangements (MEWA) that have failed to file their annual Form M-1s, a change that makes it much easier for MEWA administrators to catch up on compliance oversights.”

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