



Employee Benefits Webinar Series

Insights to ***Impact***

Elevating Ideas. Empowering Decisions.

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Employee Benefits Compliance Decoded:

Actionable Insights for HR Leaders



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The 2026 Employee Benefits Enforcement Landscape

The 2026 Employee Benefits Enforcement Landscape

WHAT THIS MEANS

The enforcement landscape is the combined pressure affecting employer health and welfare plans from three directions:

- **Regulatory enforcement** – Agency oversight of plan compliance and administration.
- **Litigation pressure** – Legal challenges to plan decisions, communications, and oversight.
- **Operational defensibility** – The operational process and records used to support plan decisions.



WHY THIS MATTERS

Enforcement is broader.

- The Agencies (DOL, IRS, and HHS) are not only looking for missing notices or filing failures. They increasingly expect plan sponsors to demonstrate a real governance process around parity, privacy, security, and vendor oversight.

Litigation is more creative.

- Lawsuits involving health plans are increasingly testing whether employers monitored plan options, explained tradeoffs clearly, and evaluated cost-management strategies in a defensible way.

Documentation is decisive.

- A defensible compliance position is built on process, not perfection. A documented record of review, follow-up, escalation, and thoughtful decision-making creates the strongest position.

Current Enforcement Priorities



MHPAEA Final Regulations

What is paused, what is not, and what plan sponsors should be doing now.



GLP-1 Employer Strategy

How to approach current operational risk and the trends that may define the next year.



PBM Transparency Reform

How recent regulations are reshaping the PBM landscape.



Fiduciary Oversight

How recent litigation is reframing oversight of plan design, vendors, and participant communications.



HIPAA Security

HIPAA security final rule and when this is expected to be provided by the agencies.

Mental Health Parity and Addiction Equity Act (MHPAEA)

Core rule

- MHPAEA does not require a plan to offer mental health or substance use disorder benefits.
- If a plan covers MH/SUD benefits, it generally cannot apply more restrictive terms than it applies to medical/surgical benefits in the same classification.
- Parity is measured in both written plan terms and real-world administration.

Key Areas of Parity Measurement

Plan Benefit Financial Requirements

- ✓ Deductibles
- ✓ Copays and coinsurance
- ✓ Out-of-pocket maximums

Quantitative Treatment Limits (QTLs)

- ✓ Visit limits
- ✓ Day limits
- ✓ Treatment frequency caps

Non-Quantitative Treatment Limits (NQTLs)

- ✓ Prior authorization
- ✓ Medical necessity criteria
- ✓ Network and formulary rules
- ✓ Exclusions

Parity is less about whether benefits exist and more about whether access is managed comparably.

What Changed in Enforcement

A pause in some newer rule provisions is not a pause in parity compliance.

Subject to Compliance/Enforcement	Currently in the Non-Enforcement Policy	DOL Applicable Enforcement Actions
• Parity for financial requirements • Parity for quantitative treatment limitations (QTLs) • Parity for non-quantitative treatment limitations (NQTLs) under the long-standing 2013 framework • Written NQTL comparative analyses currently required under the CAA	• Two-part test for NQTLs – Design and application (inputs) and relevant data evaluation (outcomes) • Meaningful benefits requirement • Revised definition of MH/SUD • Obligation to produce relevant NQTL comparative analysis in response to an adverse benefit decision (all plans) • Obligation to produce NQTL comparative analysis in response to a participant request (ERISA plans only) • Fiduciary certification	• Audit plans and requests comparative analyses, claims, and related data • Solicit plan documentation including: – NQTL comparative analysis – MH/SUD claims and related data • Seek to address remedies through “equitable relief,” including reprocessing claims and participant notices. • Focus attention on operational gaps, not just paper compliance. • May impose civil penalties or require settlements in serious violations.

Note: The non-enforcement policy does not limit or prevent lawsuits by participants.

MHPAEA Actionable Insights

Employers need to understand how the plan is administered in practice, not just how the benefits are described on paper.



- Focus on DOL-identified priority issues
 - o Confirm applied behavioral analysis (ABA) therapy (treatment for autism) benefits parity
 - o Test network adequacy for MH/SUD
 - o Align nutritional counseling coverage with MHPAEA
 - o Verify plan documentation matches operations
- Monitor ongoing developments
 - o Departments intend to issue new proposed rules by 12/31/26
 - o Changes in administration could affect timing
 - o Be aware of federal agency guidance (DOL, IRS, HHS/CMS)
 - o Track court challenges

Plans should continue to maintain or work toward compliance with MHPAEA's core statutory provisions.

GLP-1 Employer Strategy

Employer GLP-1 strategy is shaped by plan design terms, funding arrangement, market segment, and vendor/PBM administration.

GLP-1 Coverage Pathways for Employer Plans:

- Diabetes treatment coverage
 - o GLP-1 coverage for diabetes is typically evaluated under ordinary medical necessity, formulary, and plan-term rules.
 - o Plans cannot restrict GLP-1s for diabetes treatment.
- Obesity / weight-management coverage
 - o Coverage for GLP-1s prescribed for obesity or weight management is generally a plan design decision, subject to applicable mandates and consistent administration.
- Direct-to-employer / carve-out programs
 - o Employer-sponsored point solutions and DTE models can expand access, but they should be reviewed for ERISA, tax, privacy, stop-loss, and vendor-contracting implications.

It is important to evaluate plan design implications (for example, potential effects on HSA eligibility and possible HRA or group health plan treatment).

GLP-1 Compliance Considerations

MHPAEA

Review whether exclusions, prior authorization, step therapy, or related access limits raise parity concerns for comparable MH/SUD benefits.

ACA Essential Health Benefits (EHB)

ACA and EHB implications may differ by market segment, especially for insured small-group and individual market coverage.

HIPAA / ADA Nondiscrimination and Plan Administration

Coverage criteria and amendments should be applied consistently and communicated clearly; midyear reductions warrant added caution.

Vendor and Fiduciary Oversight

Employers should review direct-to-employer (DTE) and specialty vendor arrangements for plan-document alignment, data sharing, fees, and fiduciary oversight responsibilities.

GLP-1 utilization for diabetes cannot be carved out. GLP-1s prescribed for diabetes are medically necessary standard-of-care treatments. Restricting them may expose plans to ADA non-discrimination claims, ERISA fiduciary liability, and legal challenges. Coverage for the diabetes indication is not discretionary.

GLP-1 Actionable Insights

GLP-1 decisions are not only about cost; they also raise governance questions.

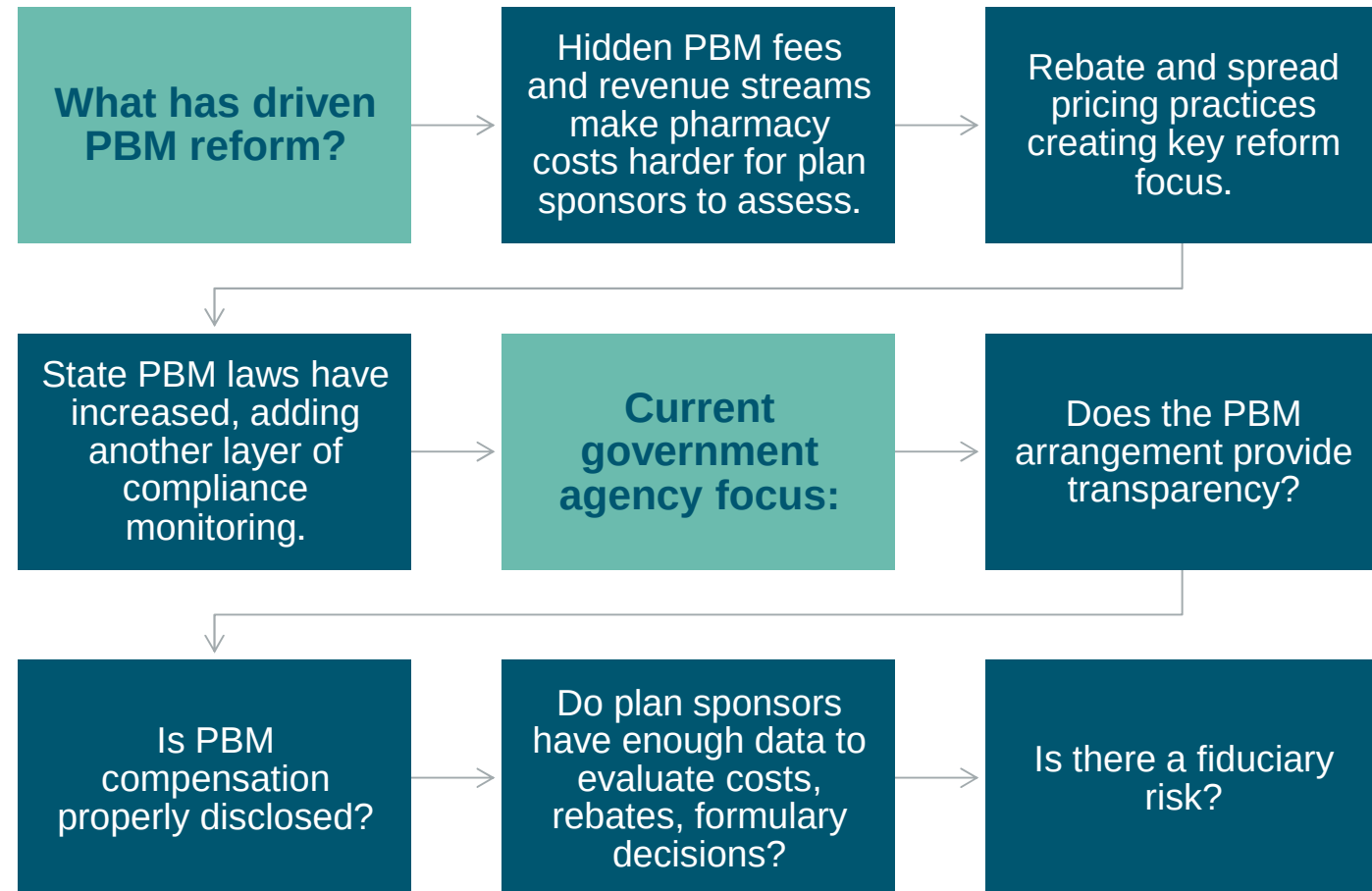


- Employers should develop:
 - o a coherent position on why coverage is offered, limited, excluded, or conditioned
 - o an approach that aligns with business goals, participant needs, and the rest of the plan design
- Identify key issues:
 - o What problem is the plan trying to solve?
 - o What access rules apply, and are they consistent?
 - o What data will be reviewed to measure cost and outcomes?
 - o How will the approach be explained to employees?

The stronger legal and practical position is a documented strategy rather than a reactive policy that evolves through exceptions and one-off decisions.

Pharmacy Benefit Manager (PBM) Reforms

PBM reform matters not only as a pharmacy-pricing issue, but also as a plan governance and fiduciary oversight issue for employer-sponsored health plans.



PBM Reforms

CAA of 2026

Provisions include:

- PBM Compensation Disclosures
- PBMs Full Rebate Pass Through
- Mandatory PBM Reporting
- Group Health Plan Notices
- Civil Penalties
- Most provisions – effective for plan years beginning on or after Aug. 3, 2028, or Jan. 1, 2029, for calendar-year plans (30 months from enactment)
- Fee disclosure requirements – effective immediately for new contracts/policies or upon renewal (absent further guidance)

DOL Proposed Rule PBM Compensation Disclosure

Currently in “proposed” state. The proposal would require PBMs to disclose the following:

- Rebates and other payments from drug manufacturers
- Compensation received when the price paid by the plan for a prescription drug exceeds the amount reimbursed to the pharmacy
- Payments recouped from pharmacies in connection with prescription drugs dispensed to the plan
- If finalized, it will be effective for plan years beginning on or after July 1, 2026

State PBM Laws Expand

States led early PBM reform efforts:

- Rutledge v. PCMA (2020) affirmed states’ ability to regulate PBMs
- Triggered rapid state law expansion, now with all 50 states regulating PBMs in some way
- State laws generally focus on:
 - o Transparency and reporting
 - o Reimbursement practices (e.g., spread pricing)
 - o Pharmacy network and access requirements
- Varying regulations increase complexity for plan sponsors and PBMs

PBM Reforms Actionable Insights

PBM reform is raising the bar from promised savings to verifiable accountability.



While most of the PBM reforms are focused on the PBM, employers should:

- o Monitor regulatory developments (DOL rulemaking, CAA 2026, FTC enforcement)
- o Track ERISA litigation trends related to PBM oversight
- o Recognize increased fiduciary expectations as transparency and PBM data expand
- o Assess whether PBM arrangements align with fiduciary obligations and total cost-of-care objectives
- o Consider independent validation (e.g., audit or advisory support) to assess PBM performance and compensation

Recent federal reforms signal that plan sponsors should expect clearer reporting, more auditable data, and greater scrutiny of compensation, rebate, and affiliated-party arrangements that drive pharmacy spend.

Fiduciary Oversight

Fiduciary oversight remains a core compliance priority, with agencies focused on whether plan sponsors can demonstrate prudent governance, active monitoring, and well-documented decision-making.

Why are health and welfare fiduciary practices a current focus?

- For years, fiduciary duties under ERISA were primarily associated with retirement plans, while health and welfare plans remained largely overlooked—until recently.
- Recent transparency requirements under the ACA and the CAA have made **plan cost and quality data more accessible**.
- This has brought **increased scrutiny to how employers make decisions** about their health plans.
- This newfound visibility has led to a **rise in lawsuits** alleging that fiduciaries have failed to use this information to act in participants' best interests.

THE ENTIRE NEXT SEGMENT IS FOCUSED ON FIDUCIARY OVERSIGHT AND THE NEW LANDSCAPE.

HIPAA Security

HIPAA Security is back in focus as HHS pushes a major cybersecurity update and covered entities wait to see how much of the proposed overhaul will be finalized.

Where HIPAA Security is headed:

- HHS's Office for Civil Rights (OCR) published a **proposed rule** on January 6, 2025, to strengthen the HIPAA Security Rule, marking the first major proposed update to the rule in about two decades.
- The proposal would make the Security Rule more specific and structured, with broader cybersecurity requirements and less flexibility than entities have today.
- In practice, that could require entities to take a more standardized approach to implementing and documenting safeguards.
- A final rule has not yet been issued, but ongoing review and enforcement activity by the OCR shows that HIPAA Security remains an active priority.

THE ENTIRE LAST SEGMENT IS FOCUSED ON HIPAA SECURITY AND THE FINAL REGULATIONS.



Strategic Plan Governance / Fiduciary

Strategic Plan Governance / Fiduciary

WHAT THIS MEANS

- ERISA requires health plans to designate a “named fiduciary” to assume certain responsibilities relating to administration of the plan.
- **The plan administrator is typically the named fiduciary.**
- For health and welfare plans, the fiduciary responsibility does not mean employers must always choose the cheapest option or the richest option. It means:
 - use a reasoned process
 - monitor service providers
 - understand plan design tradeoffs
 - communicate material information accurately



WHY THIS MATTERS

Recent litigation has tested whether employers and committees are adequately overseeing benefit plan operations, including:

- plan costs
- vendor selection
- health plan design features
- wellness plan features
- voluntary benefit plan designs

THE COMMON THREAD: FIDUCIARY PROCESS



WHAT REGULATORS AND PLAINTIFFS INCREASINGLY ASK

- Who reviewed the issue?
- What data did they receive?
- What follow-up questions were asked?
- What action items were assigned?
- What did the final documentation say?



CURRENT LITIGATION

- Plan design can be challenged.
- All types of benefits are being litigated.
- Employee communications matter and can become part of the factual record.



WHAT EMPLOYERS OFTEN UNDERESTIMATE

- Assumption – using a sophisticated vendor equals strong oversight
- Reality – vendor support is not the same as employer governance
- Fiduciary duty – a consistent decision-making process and documentation



PBM Fee Cases

Allegations that employer health plan fiduciaries breached their ERISA duties by failing to prudently negotiate and monitor pharmacy benefit manager (PBM) contracts, causing the plan to overpay for prescription drugs and PBM services (including specialty and mail-order pharmacy arrangements).

Synopsis:

- Plaintiffs allege plan sponsor overpaid for prescription drugs and deferred too much to PBM on plan design and engaging affiliates for services (e.g., specialty pharmacy, mail order, etc.)

Status:

- 2 of 3 dismissed for “lack of standing” (failure to show that lower fees would have flowed to participants instead of employer)
- Final case allowed to proceed to discovery (much more expensive, greater likelihood of settlement)
 - Standing based on cost-sharing
 - Discovery permitted to determine whether “prohibited transaction” occurred
 - Court adhered to plan design (non-fiduciary) / administration (fiduciary) distinction, reaffirming the importance of a clear, written delegation of plan responsibilities



“Voluntary Benefit” Fee Cases

These lawsuits claim that some voluntary benefit programs (such as supplemental life, accident, or other employee-paid coverages) charge employees more than necessary by imposing high commissions and delivering poor value for the coverage provided.

Synopsis:

- Plaintiffs allege that sponsors’ voluntary benefits carry:
 - Excessive commissions
 - Poor “loss ratios”
- Review of ERISA voluntary plan “safe harbor”:
 - No employer contributions (or pre-tax employee premiums)
 - Participation is “voluntary”
 - No employer “endorsement”
 - Employer receives no/limited compensation

Observations:

- Appears to solve “standing” issue in PBM cases
- Many employers mischaracterize voluntary plans as non-ERISA
- Reaffirms that ERISA fiduciary principles extend to all ERISA benefits, regardless of whether they are labeled as such



“Financial Domination” Cases

Financial domination means a coverage is consistently less favorable financially than another option offered under the same employer health plan, so participants pay more without receiving commensurate additional value in benefits or risk protection.

Synopsis:

- Plaintiffs allege that sponsor breached its fiduciary duty in designing a PPO option that is “financially dominated” by the HDHP option
- Alleges a failure to disclose material financial imbalance between the options

Observations:

- Plaintiffs are attempting to impose fiduciary principles on design (non-fiduciary) decisions

Current Status:

- Court denied Northwestern’s motion to dismiss
 - Plaintiffs sufficiently pled financial harm through increased cost-sharing
 - Boundary between design (non-fiduciary) and fiduciary actions is highly fact-specific



Tobacco Surcharge Cases

These lawsuits challenge extra premiums or surcharges that health plans impose on employees who use tobacco, usually as part of a wellness program.

Synopsis:

- Plaintiffs allege plan sponsor charged tobacco surcharge in violation of federal law

Key Points

- Focus remains on compliance with HIPAA guidelines
 - Limit on incentives
 - Opportunity to qualify once per year
 - Reasonable alternative standard
 - Participant notice

Status:

- Mixed rulings on whether “reward” must be retroactive

Fiduciary Actionable Insights



*The standard is not perfection.
It's thoughtful review, reliance on
appropriate expertise, and follow-up!*

Fiduciary obligations focus more on the process than on the result/outcome.

Document decisions – and the reasoning behind them.

- Helpful when revisiting decisions years later, after memories have faded or decision-makers are no longer there

Consider establishing a committee.

- Creates the cadence of a meeting and minutes to reference
- Be careful about appointing committee members with apparent conflicts of interest

Focus on use of plan assets.

- Use them exclusively to provide plan benefits or pay reasonable plan administration expenses
- Selection of lowest-cost vendor is not required if you have a reasonable basis for selection

Remember duty of prudence.

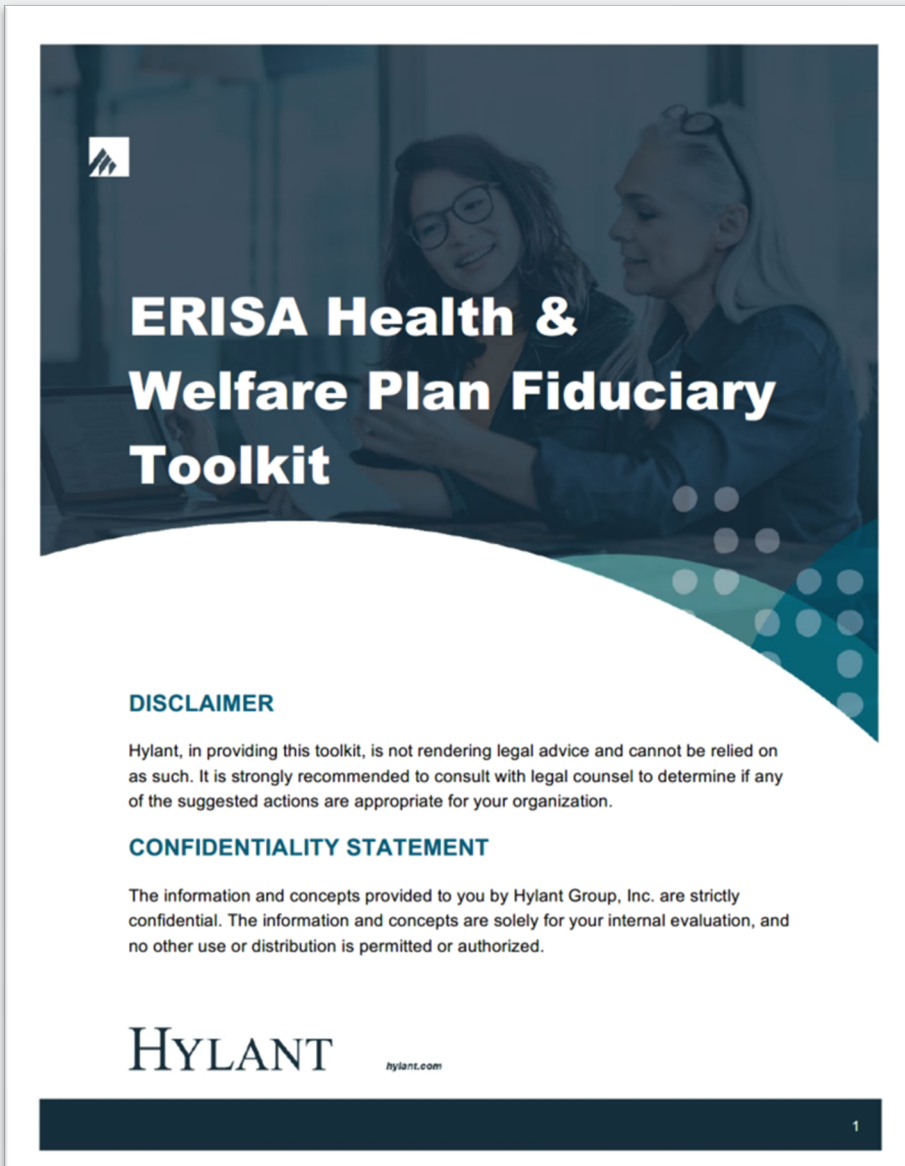
- Fiduciaries must either have the expertise to run the plan or engage qualified experts
 - o Fiduciaries must actively oversee the service providers and delegates they select

Fiduciary Governance Toolkit

The Hylant Toolkit provides essential resources, expert guidance, and practical tools to help you fulfill your obligations with confidence:

- Fiduciary Toolkit Overview
- Fiduciary Process Guide
- Sample Health & Welfare Committee Charter
- Sample Health & Welfare Committee Minutes
- Frequently Asked Questions

Each component is structured to simplify complex fiduciary concepts, offering clear guidance, actionable recommendations, and practical tools to support effective plan management.





New HIPAA Data Security Standard

New HIPAA Data Security Standard

WHAT THIS MEANS

- HHS Office for Civil Rights (OCR) issued a proposed rule in December 2024 to strengthen the HIPAA Security Rule focused on **ePHI**.
- The proposal would:
 - remove much of the distinction between “required” and “addressable” specifications,
 - require written documentation of policies and analyses, and
 - require a more specific risk analysis process tied to a technology asset inventory and network map.
- The proposal also includes more explicit expectations around technical controls and compliance activities.



WHY THIS MATTERS

- For employer plan sponsors, this matters when the group health plan, directly or through service providers:
 - creates,
 - receives,
 - maintains, or
 - transmits ePHI.
- This can occur through internal processes and external processes with service providers

HHS Proposed Changes to HIPAA Security



On 12/27/24, HHS proposed a rule that would modify the HIPAA Security Rule to strengthen cybersecurity protections for electronic protected health information (ePHI).

This includes:

- Enhanced documentation and risk management
- Stronger technical safeguards
- Strengthened contingency planning
- Annual reviews and audits
- Timely access management



If the rule is finalized, it would become effective 60 days after publication in the Federal Register, and regulated entities would then have 180 days from their plan effective date to comply.

Additional time would be provided to modify business associate agreements (BAAs).



Employers should continue monitoring developments and planning for potential implementation needs, including substantial support from their IT systems department.

Where the Proposal Would Impact Employers Most

Documentation and Risk Analysis:

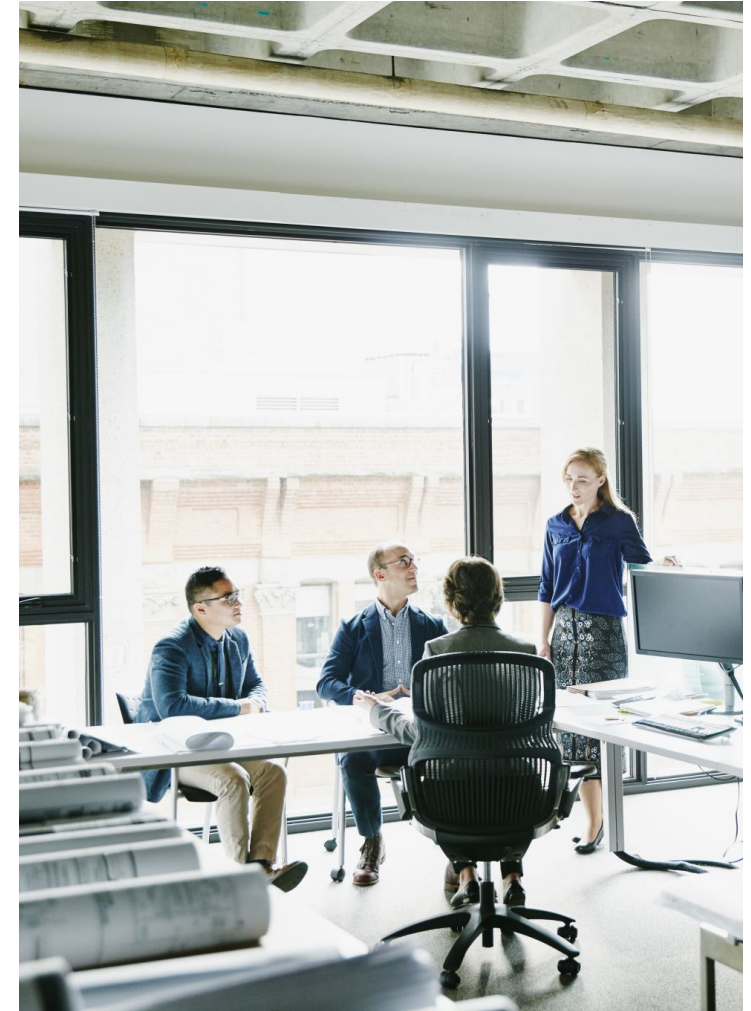
- Plans and vendors may need more formal written policies, analyses, and evidence of compliance activities. The proposal also ties risk analysis more directly to a technology asset inventory and network map.

Technical and Operational Controls:

- The proposal includes more specific expectations around encryption, multifactor authentication, vulnerability scanning, security testing, contingency planning, and incident response procedures.

Vendor and BAA Oversight:

- Employers should expect closer review of which vendors create, receive, maintain, or transmit ePHI, whether BAAs reflect actual operations, and how plan sponsors receive support from IT and security teams.



HIPAA Security Actionable Insights



You do not need to wait for a final rule to do reasonable preparation!

Even before a final rule, employers can pressure-test current HIPAA Security Readiness:

Map the data.

→ Identify where the plan ePHI lives, how it travels and which systems or vendors receive the data across the benefits ecosystem.

Map the relationships.

→ Identify who the plan vendors are (e.g., TPAs, PBMs, wellness vendors, etc.).

→ Confirm that agreements match actual operations.

Map the ownership.

→ Determine who owns access reviews, security decisions, escalation, and coordination across Benefits, HR, Privacy, IT, and Security.

Review current HIPAA policies and procedures to ensure they match actual operations.

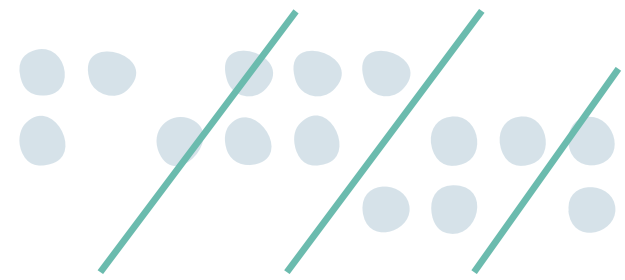
Breaking News – Security Standards Final Rule Delayed into 2027.



Future Trends

Employee Benefit Compliance

Future Trends to Watch



Mental Health Parity will remain in the spotlight.

Even with rule uncertainty, plans should expect continued pressure around NQTL comparative analysis, documentation quality, and actual operational parity.

HIPAA Security expectations are moving toward more specificity.

Whether through final rules, investigations, or guidance, the direction of travel is toward stronger proof of cybersecurity governance.

Health plan fiduciary requirements will likely keep developing.

As a result, committee records, vendor oversight, and participant-facing materials deserve more attention than many employers have historically given them.

Plan sponsors should expect continued scrutiny of vendor oversight.

Employers should prepare for more questions about what their TPAs, PBMs, and other vendor partners are doing and how that work is being monitored.

Thank you!

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please visit us at hylant.com.

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