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QUARTER 2 2025

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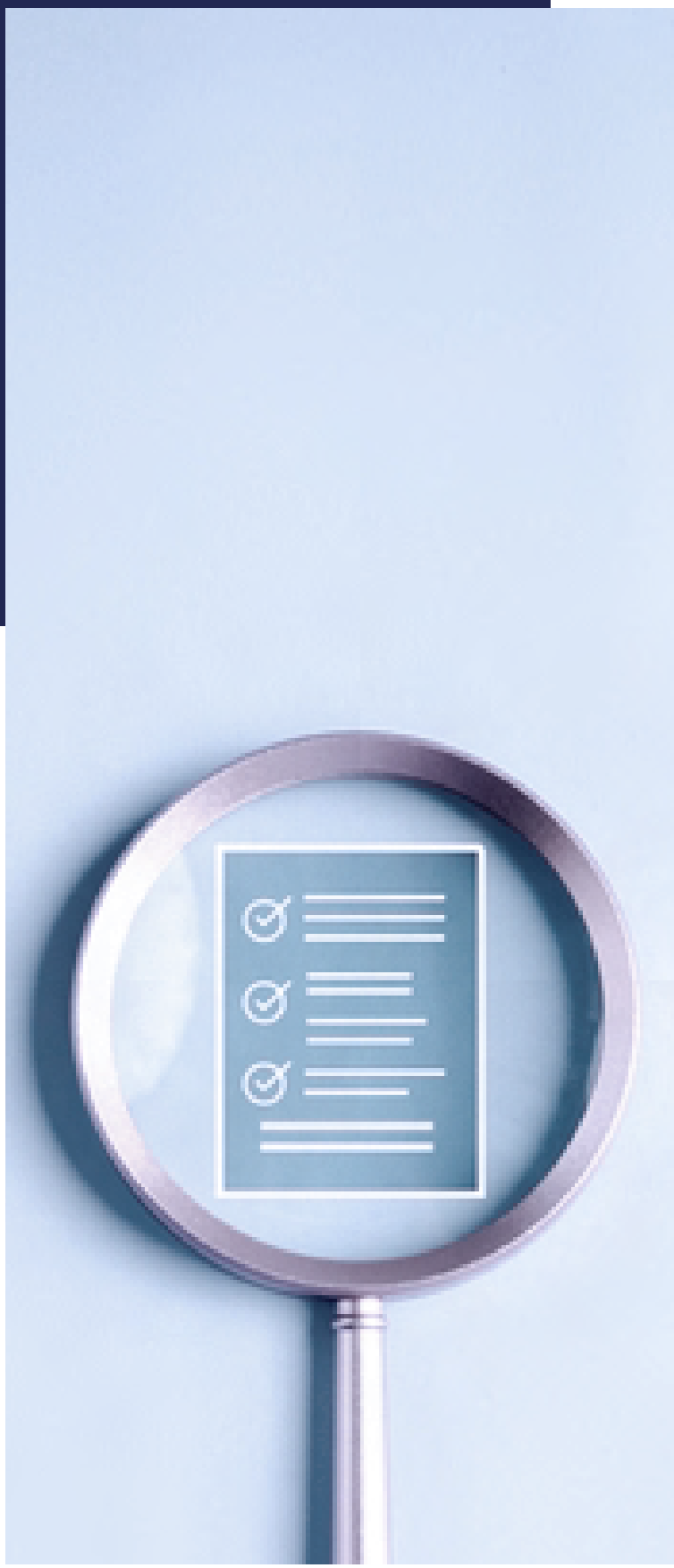

FAULK COMPANY V. HHS: A GAME-CHANGER FOR ACA EMPLOYER MANDATE ENFORCEMENT?

Michelle Barki, RN, JD
Senior Legal Counsel

Faulk Company, Inc. v. United States Department of Health and Human Services is a legal case that challenges how employer mandate penalties are assessed under the Affordable Care Act's (ACA) employer shared responsibility provision.

Faulk Company, a Texas-based janitorial service provider, previously offered minimum essential health insurance coverage to its employees, as required by the ACA. However, in 2019, the company ceased providing this coverage, leading to an excise tax assessment by the IRS under Section 4980H(a), commonly known as the "Sledgehammer" penalty.

Faulk challenged the IRS's assessment, arguing that the federal regulation enforcing the employer shared responsibility provision was contrary to statutory text and an arbitrary exercise of rulemaking authority. Violation of due process was also cited. The issue was a lack of notification by CMS when an employee went to the Marketplace and received a subsidy. Under the statutory provisions of the ACA, the Department of Health and Human Services is the agency responsible for notifying the employer if an employee went to the Marketplace. The notice must advise the employee that they may be liable for an Employer Shared Responsibility Benefit, and the notice must also provide information about the employer's right to appeal. This never happened. The only penalty notice was Notice 226J, provided by the IRS.

The company sought:

- A refund of the tax penalties paid
- A declaration that the regulation was unlawful
- The vacating of the regulatory provision

On April 10, 2025, the Northern District of Texas ruled in favor of Faulk on Counts I and III, granting summary judgment and ordering the IRS to refund $205,621.71 for the excise tax assessed for 2019. However, Faulk's request for attorney's fees was denied.

If upheld, this ruling could negate revenue for taxpayers and jeopardize incentives for employers to maintain health coverage for certain employees. It also raises key questions about the enforcement of the ACA's employer shared responsibility payment (ESRP), particularly regarding the timing and process of ESRP penalty notifications.

This case could significantly change how these penalties are applied and enforced for applicable large employers. Now we wait to see how the Trump administration reacts to this decision.

View a copy of the Court ruling: https://law.justia.com/cases/federal/district-courts/texas/txndce/4:2024cv00609/391607/38/.

IRS ANNOUNCES 2026 HSA LIMITS

Mara Braunberg
Marketing Manager

The IRS has released the updated 2026 limits for Health Savings Accounts (HSAs), High Deductible Health Plans (HDHPs), and Excepted Benefit Health Reimbursement Arrangements (EBHRAs) under **Revenue Procedure 2025-19**. These annual cost-of-living adjustments affect contribution caps, minimum deductibles, and maximum out-of-pocket costs — and this year, we're seeing increases across the board. Check out the shift from 2025 to what's changing for 2026:

	2026	2025
HSA Contribution Limits	$4,400 Individual $8,750 Family $1,000 Catch-up (55+)	$4,300 Individual $8,550 Family $1,000 Catch-up (55+)
HDHP Max Out-of-Pocket Limits	$8,500 Individual $17,000 Family	$8,300 Individual $16,600 Family
HDHP Minimum Deductible Limits	$1,700 Individual $3,400 Family	$1,650 Individual $3,300 Family
Excepted Benefit HRA Contribution Limits	$2,200	$2,150

These updated limits offer valuable planning opportunities for you and your clients. As contribution and coverage thresholds rise, so does the potential for tax savings, employee engagement, and benefit optimization. Now is the time to start conversations with clients about updating plan designs, maximizing HSA contributions, and ensuring compliance for the year ahead.

COBRA & FLEXIBLE SPENDING ACCOUNTS

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Senior Legal Counsel

COBRA allows you to continue your group health coverage for a limited time after a qualifying event, such as termination of employment. A Health FSA is considered a group health plan under COBRA. However, the rules for continuing a Health FSA through COBRA have some key differences compared to standard health insurance plans.

An employer subject to COBRA (typically those with 20 or more employees) must offer COBRA coverage for a Health FSA if the account is considered "underspent" at the time of the qualifying event. An FSA is underspent if the amount you have contributed to the FSA by the termination date is greater than the amount you have been reimbursed. Conversely, if you have been reimbursed more than you have contributed ("overspent"), COBRA for the FSA is usually not required.

If your Health FSA is underspent when you leave your job, you may elect to continue participating in it through COBRA. However, here are some important considerations to keep in mind:

01 Unlike medical, dental, or vision plans, where COBRA can extend for 18 to 36 months, COBRA coverage for a Health FSA typically lasts only for the remainder of the plan year in which the qualifying event occurred.

02 If you elect COBRA for your Health FSA, contributions are on an after-tax basis, and a 2% administration fee may be charged.

03 By electing COBRA, access to the full remaining balance that was elected for the planned year becomes immediately available.

04 Each qualified beneficiary (e.g., the employee, spouse, and dependent children who were covered under the FSA) has an independent right to elect COBRA coverage for the health FSA. This means that even if one family member chooses not to continue the FSA, others can still elect to do so.

05 Since each qualified beneficiary can independently elect COBRA for the FSA, the total potential amount accessible under COBRA across all electing family members could theoretically be higher than just the original employee's election. However, each individual's access is still limited to the annual election amount.

06 Qualified Beneficiaries can also elect COBRA as a result of losing coverage through divorce or when a dependent ages out of the plan. Contributions are after tax, and a 2% administration fee may be added.

07

The regulations indicate that when a qualifying event (such as a divorce) results in more than one family unit, the family deductible (and therefore the annual limit) may be computed separately for each family unit based on the family members in each unit.

In conclusion, the intersection of FSAs and COBRA presents unique considerations for employees undergoing a qualifying event. While COBRA generally allows for the continuation of group health plans, its application to Health FSAs is often limited to the remainder of the plan year and is contingent on the account being underspent. Electing COBRA for an underspent FSA provides access to the remaining elected funds upon continued premium payments, offering a way to utilize those dollars for ongoing eligible expenses. However, failing to elect COBRA typically results in the forfeiture of any remaining FSA balance due to the "use-it-or-lose-it" rule. Understanding these rules, the independent election rights of qualified beneficiaries, and proactively managing FSA spending before a job transition are crucial for making informed decisions and maximizing the benefits.

MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT UPDATE

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Senior Legal Counsel

The final Rules for the Mental Health Parity and Addiction Equity Act, which were published on September 9, 2024, and were due to go into effect in 2025 and 2026, have now been postponed following a lawsuit by the ERISA Industry Committee (ERIC). The Trump Administration has asked the lawsuit to be held in abeyance while the 2024 rules are reviewed and potentially modified or rescinded. In addition, it has been announced that the 2024 rules will not be enforced until 18 months after the final decision in litigation is made.

Moreover, the government is reviewing the provisions amended by the Consolidated Appropriations Act in 2021. The government has advised that plans and issuers refer to the 2013 rule while this all gets sorted out. Please see below for the exact text from the Department of Health and Human Services, the Department of Labor, and the Treasury regarding the holding in abeyance of the new rules dated May 15, 2015.

May 15, 2025

STATEMENT OF U.S. DEPARTMENTS OF LABOR, HEALTH AND HUMAN SERVICES, AND THE TREASURY REGARDING ENFORCEMENT OF THE FINAL RULE ON REQUIREMENTS RELATED TO THE MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT

On September 9, 2024, the Departments of Labor, Health and Human Services (HHS), and the Treasury (the Departments) issued a final rule titled "Requirements Related to the Mental Health Parity and Addiction Equity Act," (2024 Final Rule).1 The 2024 Final Rule amended the 2013 final rule2 implementing the Mental Health Parity and Addiction Equity Act (MHPAEA) and added new rules implementing the nonquantitative treatment limitation (NQTL) comparative analyses requirements under MHPAEA, as amended by the Consolidated Appropriations Act, 2021 (CAA, 2021). The 2024 Final Rule, which became effective on November 22, 2024, has staggered applicability dates of plan years starting on or after January 1, 2025, and plan years (in the individual market, policy years) starting on or after January 1, 2026.

On January 17, 2025, the ERISA Industry Committee (ERIC) filed suit in the U.S. District Court for the District of Columbia challenging certain provisions of the 2024 Final Rule on multiple grounds, including on the grounds that they are arbitrary and capricious and contrary to law.

Additionally, Executive Order 14219, titled "Ensuring Lawful Governance and Implementing the President's 'Department of Government Efficiency' Deregulatory Initiative, directs federal agencies to review regulations to identify those that may undermine the national interest, including by imposing undue burdens on small businesses or significant costs upon private parties that are not outweighed by public benefits. In such cases, federal agencies must exercise enforcement discretion to ensure lawful governance.

The Departments have requested that the ERIC litigation be held in abeyance while the Departments reconsider the 2024 Final Rule, including whether to issue a notice of proposed rulemaking rescinding or modifying the regulation through notice and comment rulemaking.

Article continues on next page.

The Departments will not enforce the 2024 Final Rule or pursue enforcement actions, based on a failure to comply that occurs prior to a final decision in the litigation, plus an additional 18 months. This enforcement relief applies only with respect to those portions of the 2024 Final Rule that are new in relation to the 2013 final rule. The Departments note that MHPAEA's statutory obligations, as amended by the CAA, 2021, continue to have effect. HHS encourages states that are the primary enforcers of MHPAEA with respect to issuers to adopt a similar approach to enforcement. HHS will not consider a state to be failing to substantially enforce MHPAEA, as amended, because the state adopts such an approach.

The Departments will also undertake a broader reexamination of each department's respective enforcement approach under MHPAEA, including those provisions amended by the CAA, 2021. Plans and issuers may continue to refer to the 2013 final rule (as it appeared in the Federal Register on November 13, 2013), FAQs About Mental Health and Substance Use Disorder Parity Implementation and the Consolidated Appropriations Act, 2021 Part 45, available at https://www.dol.gov/sites/dolgov/files/ebsa/about-ebsa/our-activities/resource-center/faqs/faqs-about-mental-health-parity-implementation-and-consolidated-appropriations-act-2021-part-45.pdf, and other sub regulatory guidance issued by the Departments under MHPAEA. However, in connection with the process of reconsidering the 2024 Final Rule, the Departments may make updates to the sub regulatory guidance implementing MHPAEA, including FAQs Part 45.

MHPAEA provides critical protection for workers, individuals, and their families who need treatment for mental health conditions and substance use disorders. During this period of nonenforcement as the Departments revisit the 2024 Final Rule, the Departments remain committed to ensuring that individuals receive protections under the law in a way that is not unduly burdensome for plans and issuers.

FLEXIBLE SPENDING ACCOUNTS & MID-YEAR ELECTION CHANGES

Michelle Barki, RN, JD
Senior Legal Counsel

Flexible Spending Accounts (FSAs) allow employees to set aside pre-tax funds for eligible healthcare and dependent care expenses. However, a key rule governing FSAs is the irrevocable election rule: once an employee makes an election for the plan year, they generally cannot change that election mid-year.

Recognizing that life happens, the IRS allows exceptions through qualifying life events (QLEs). These events permit employees to adjust their FSA elections during the plan year, but only in specific circumstances. Understanding these rules is critical for both employees and employers to ensure compliance and maximize the value of these accounts.

Let's explore some possible scenarios...

SCENARIO 1

An employee elected $1,000 for their General-Purpose FSA. In October, their spouse starts a new job and becomes eligible for benefits. The spouse enrolls in their employer's HDHP and HSA with employee + spouse coverage, making them ineligible for a General-Purpose FSA. They want to revoke their General-Purpose FSA election. **Is this a permitted mid-year election change?**

Yes, because this was due to a change in the spouse's employment status, the employee may decrease or cease election under the FSA if coverage is gained under the spouse's or dependent's plan.

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FLEXIBLE SPENDING ACCOUNTS & MID-YEAR ELECTION CHANGES

SCENARIO 2

An employee elected $1,000 for their General-Purpose FSA in January when the plan year commenced. Their spouse has a plan year that commences in July. In July, the spouse enrolled both the spouse and the employee in HDHP and HSA. **Can the employee drop the FSA in this scenario?**

No, while the employee can drop medical coverage, they cannot drop the FSA under this scenario, as this is not a change in employment status.

SCENARIO 3

Can an employee who becomes entitled to Medicare mid-year make changes to their Flexible Spending Account (FSA) contributions?

Yes. Generally, an employee who becomes entitled to Medicare mid-year can make changes to their Flexible Spending Account (FSA) contributions. Becoming entitled to Medicare is considered a qualifying life event (QLE) under IRS regulations governing Section 125 cafeteria plans, which include FSAs. This QLE allows an employee to make a mid-year election change, provided the change is consistent with the event. In this specific scenario, the employee who becomes entitled to Medicare **can decrease or terminate** their FSA contributions. This is because their healthcare coverage situation has changed significantly, and continuing the same level of FSA contributions may no longer be suitable or beneficial. However, due to Medicare entitlement, FSA contributions **cannot be increased**.

SCENARIO 4

An employee elected $1,000 for their General-Purpose FSA. In October, the employee's spouse gets a new job and becomes eligible for benefits. The spouse enrolls in their employer's HDHP and HSA with employee + spouse coverage, making them ineligible for a General-Purpose FSA. **The employee wants to change the General-Purpose FSA to a Limited-Purpose FSA mid-year for the remaining amounts. Can this be done?**

The ability of an employee to change a General-Purpose FSA to a Limited-Purpose FSA mid-year to enable HSA contributions in this specific scenario is complex and lacks definitive formal IRS guidance.

IRS Notice 2005-86, regarding HSA eligibility during a health FSA grace period, suggests that allowing employees to elect a prospective election between a General-Purpose FSA and an HSA-compatible Limited-Purpose FSA may not be permissible. However, others point to the permitted election change regulations and the IRS's subsequent treatment of the similar issue for health FSA carryover purposes as support for the position that an election to convert a General-Purpose FSA to a Limited-Purpose FSA should be allowed (when the amount of the employee's health FSA salary reduction remains the same). An IRS official has informally commented that an employee could make a mid-year change from a General-Purpose FSA to a Limited-Purpose FSA, so long as there is no change in the employee's pre-tax salary reduction amount.

Scenarios continue on next page.

FLEXIBLE SPENDING ACCOUNTS & MID-YEAR ELECTION CHANGES

SCENARIO 5

An employee enrolls in their employer's high- deductible plan in January along with the HSA, for which the employer also contributes. In addition, the employee enrolls in a limited-purpose FSA. In July, the employee becomes entitled to Medicare and is no longer eligible to contribute to the HSA. **Can he change the FSA from a Limited-Purpose FSA to a General- Purpose FSA mid-plan year?**

No. While existing guidance does not directly address this question, an IRS official has informally commented that he was not comfortable allowing an employee to make a mid-year change from a Limited-Purpose health FSA to a General-Purpose Health FSA (even with no change in the employee's pre-tax salary reduction amount) because the change would increase the expenses for which the employee could be reimbursed. Formal IRS guidance on this issue would be welcome.

This is different from the informal guidance provided when changing from a General-Purpose FSA to a Limited-Purpose FSA to gain eligibility for an HSA.

What if the employee is prepared to keep their pre-tax salary reductions the same, in other words, switch from a General-Purpose FSA to a Limited-Purpose health FSA, but maintain the same level of pre-tax salary reductions? Existing guidance does not directly address this question. An IRS official has informally commented that an employee could make a mid-year change from a General-Purpose FSA to a Limited-Purpose health FSA, so long as there is no change in the employee's pre-tax salary reduction amount. Formal IRS guidance on this issue would be welcome.

SCENARIO 6

During open enrollment, an employee elected $1,500 for their Health Care FSA. **In June, the employee gets married and wants to increase their election to $3,000 to cover their spouse's medical expenses. Is this a permitted mid-year election change?**

Yes. A change in marital status is a qualifying life event that allows an employee to make a corresponding change to their Health Care FSA election. The increase, up to the annual maximum of $3,300 for 2025, must be on account of and consistent with the change in status (e.g., to cover the spouse's eligible expenses).

SCENARIO 7

During open enrollment, an employee intended to elect $500 for their General- Purpose FSA but mistakenly entered $3,300 (the maximum for 2025). They realized the error two months into the plan year and have only incurred $100 in eligible medical expenses. **Can they correct their election mid-year?**

Generally, no. A mistake in the initial election amount is typically not a qualifying life event that permits a mid-year election change. Once the election is made and the plan year begins, it is generally irrevocable unless a specific qualifying life event occurs. Some employers may have very limited exceptions for clear administrative errors where there is documented proof of the intended election, but this is not a standard requirement under IRS regulations. The employee would likely be responsible for the full $3,300 selection, subject to the "use-it-or-lose-it" rule. Also, time is of the essence, and not noticing for two months is too long to correct an administrative error. Typically, errors should be corrected in a couple of weeks.

Scenarios continue on next page.

FLEXIBLE SPENDING ACCOUNTS & MID-YEAR ELECTION CHANGES

SCENARIO 8

At the beginning of the calendar year plan, an employee enrolled in an HMO and an FSA. In July, the employee moved out of the HMO area and enrolled in HDHP. **Can the employee drop the FSA to enroll in an HSA?**

No. This is not a permitted election change for FSA.

In conclusion, while the IRS provides specific, limited circumstances under which mid-year election changes to Flexible Spending Accounts (FSAs) are permissible, health plan administrators must exercise caution. It is crucial to thoroughly understand and strictly adhere to these regulations to avoid potential compliance issues. Overly permissive allowances for election changes beyond these defined events can lead to administrative burdens, increased costs, and potential violations of IRS rules governing cafeteria plans. Therefore, administrators should ensure their plan documents clearly outline the allowable reasons for mid-year changes and consistently apply these rules to maintain the integrity and compliance of the FSA.

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UPCOMING DEADLINES

JULY 31, 2025 | Report & Pay PCORI Fee

Employers with self-insured health plans are required to pay an annual fee to support the Patient-Centered Outcomes Research Institute (PCORI). Employers report and remit these fees using **IRS Form 720**, with payments due **July 31** of the year following the end of the plan year.

JULY 31, 2025 | File Form 5500

Employers with ERISA-covered welfare benefit plans must file Form 5500 annually unless exempt. The form is due by the last day of the seventh month following the end of the plan year (July 31 for **calendar-year plans**).

Employers can request a one-time automatic extension of 2.5 months (October 15) by submitting IRS Form 5558 by the original due date of Form 5500.

SEPTEMBER 30, 2025 | Medical Loss Ratio (MLR) Rebates

Employers with insured health plans may be eligible for rebates if their issuers do not meet the required Medical Loss Ratio (MLR) percentage. Rebates must be provided to plan sponsors by Sept. 30 following the end of the MLR reporting year. Employers receiving rebates should carefully consider their legal options for using the rebate. Any rebate amount that qualifies as a plan asset under ERISA must be used solely for the benefit of the plan's participants and beneficiaries. Additionally, to avoid ERISA trust requirements, the plan asset portion should be used within three months of receipt.

SEPTEMBER 30, 2025 | Distribute a Summary Annual Report (SAR)

Employers required to file Form 5500 must provide participants with a summary of the information in the form, known as a Summary Annual Report (SAR). The SAR must be distributed within nine months after the close of the plan year. For **calendar-year plans**, this deadline is September 30. If an extension to file Form 5500 is granted, the plan administrator must provide the SAR within two months after the extension period ends.

OCTOBER 3, 2025 | Provide Individual Coverage Health Reimbursement Arrangement (ICHRA) Notice for 2026

Employers offering ICHRAs are required to provide eligible employees with a notice outlining the ICHRA coverage. This notice must be given at least 90 days prior to the start of each plan year. For ICHRAs that follow a **calendar year**, the notice must be provided by October 3, 2025, for the 2026 plan year.

OCTOBER 14, 2025 | Provide Medicare Part D Notices

Employers with group health plans offering prescription drug coverage must inform Medicare Part D-eligible individuals by October 14 each year whether their prescription drug coverage is at least equivalent to Medicare Part D coverage (i.e., whether the coverage is "creditable" or "noncreditable").

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