Mid-Year Regulatory Update

Presented by Lumelight

July 2026

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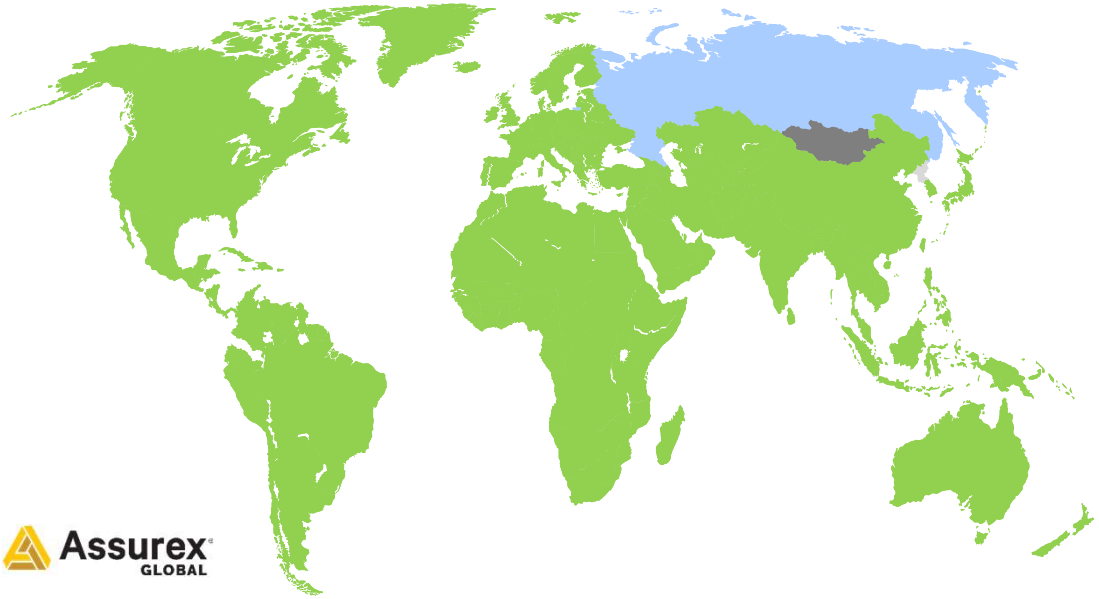

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AGENDA

- Proposed Change Fertility Benefits
- Tobacco Surcharges
- NJ & Medicaid Enrollees Penalty
- CVS Wins AR ERISA Preemption Appeal

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Proposed Changes for Fertility Benefits

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Proposed Rule: Fertility Services & Excepted Benefits

GENERAL STATUS: Comments Open Until July 13, 2026

When would this apply?	Would apply to plans starting on or after January 1, 2027.
What does this mean?	If finalized – certain fertility services would be categorized as excepted benefits and exempt from some compliance obligations related to ACA, HIPAA, and more.
Why is this being introduced?	Related to Executive Order to Expand Access to In Vitro Fertilization and expanding avenues to affordable fertility benefits

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Benefits Are Excepted Benefits If They Meet Conditions:

- ❑ **Scope:** limited to items and services related primarily to diagnosis, mitigation, or treatment of infertility or infertility-related reproductive health conditions

- ❑ **Maximum Lifetime Dollar limit**: $120,000 per participant

- ❑ **Separate Policy Or Not Integral to Plan:** separate policy, certificate, or contract OR otherwise not an integral part of the major medical plan.

- ❑ **Notice:** plans would need to provide written notice to participants that describes how this coverage works including limitations, network access, and how to submit claims.

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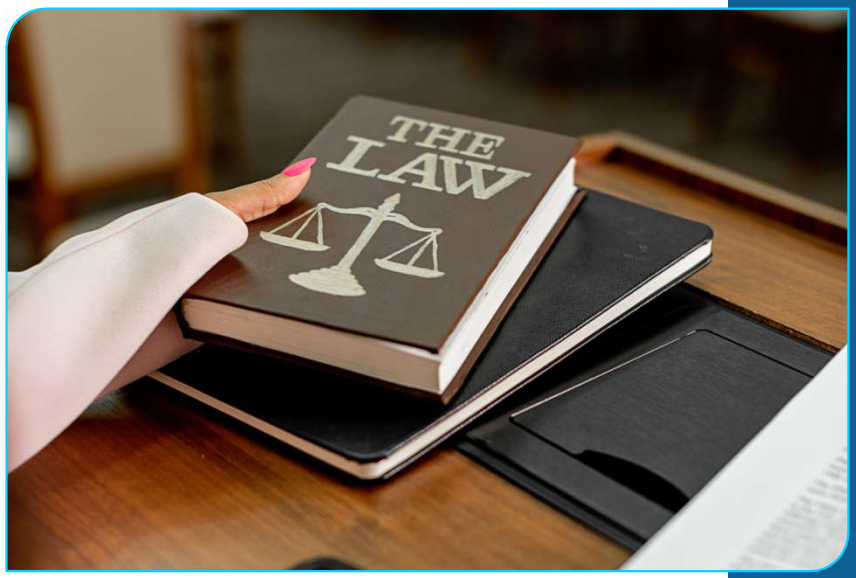
What Does the Exemption Include?

Excepted benefits are generally exempt from **HIPAA portability requirements** and **many Affordable Care Act (ACA) market reforms** HOWEVER they are typically still subject to ERISA, and in some cases, COBRA.



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Exemption from HIPAA Portability Rules

Generally, under the rules group health plans must:

Allow mid-year enrollment aligning with HIPAA special enrollment rights

Cannot impose restrictions on enrollment or coverage based on pre-existing conditions

Cannot discriminate based on health status

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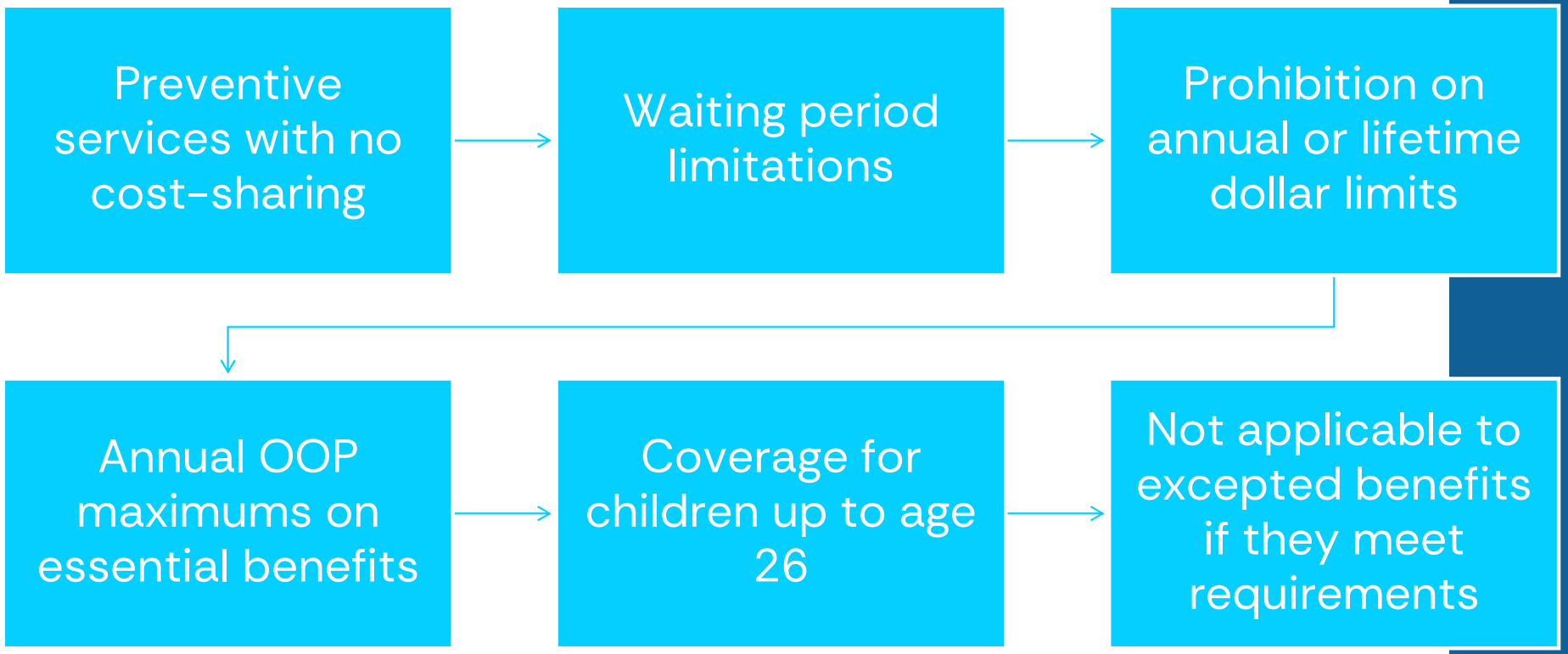
Exemption from ACA Market Reforms



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Increased Action on Tobacco Surcharge Cases

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Tobacco Surcharges

Employers may provide incentives to employees for not smoking or using tobacco or nicotine products to encourage healthier habits

Employers may also impose higher premiums on employees who are tobacco users to incentive the same

Many employers do not know this often creates a **wellness program making them subject to HIPAA wellness rules.**

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Wellness Program Rules

Wellness programs with incentives tied to a group health plan must meet certain requirements to avoid violating HIPAA nondiscrimination rules

These requirements include:

Incentive limitations

Reasonable alternative standards (RAS)

Confidentiality notices if medical testing is involved

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Types of Tobacco-Related Incentives

- HSA, HRA, or FSA contributions
- Decease in employee contributions toward medical coverage ("surcharge")
- Cash, gift cards, or entries into a prize drawing

If the incentive does NOT affect the group health plan

then HIPAA wellness rules do not apply

no limit unless medical testing is involved

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If Tied to Group Health Plan:

Employers more likely to impose tobacco surcharge on monthly employee contributions:

Triggers HIPAA wellness rules

50% incentive limit

Requirement to offer an RAS to earn the incentive

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Incentive Limitations

Tobacco related incentive limit:

50% of the total cost of coverage (employer + employee contributions combined)

If the incentive is applicable to only the employee: the incentive limit is calculated based on the cost of single coverage

If both the employee and spouse are eligible: the incentive limit is calculated based on the cost of whichever tier of coverage the employee and spouse enroll in

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Reasonable Alternative Standard (RAS)

Wellness rules require that those who do not satisfy the original standard (tobacco related or otherwise) must be offered an opportunity to earn the full incentive by satisfying a RAS

The employer should allow for a period of time for completion of the RAS and then if satisfied must provide the full incentive available to non-tobacco users

Tobacco cessation class or using tobacco cessation products are common options to provide a RAS

If tobacco cessation classes – must be provided at no cost & time commitment must be reasonable

Tobacco cessation products – no related cost requirement, but some coverage may be provided under the medical plan as preventive coverage

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Uptick in Litigation

- In 2025 plaintiffs filed more than 50 class action lawsuits challenging the legality of tobacco surcharges on their plans
- 2026 lawsuits are trending to match or surpass those numbers

Why?

Some believe these unfairly penalize employees who struggle with addiction

Employers continue to use this strategy to curb plan costs

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Litigation Summary

Class action lawsuits targeting tobacco-related wellness programs

Alleged violations of HIPAA's wellness program rules based on:

- Failure to properly offer,
- Disclose,
- Or administer a reasonable alternative standard (RAS).

Court decisions depend heavily on:

- Plan language
- Administrative procedures
- Judicial interpretation of applicable regulations

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NJ Medicaid Enrollee Fee

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What is It?

New law charging fees to companies that have at least 50 employees covered by Medicaid

Bill calls for large employers to pay annual fees of varying amounts for each worker on Medicaid and for each of their family members covered by the publicly funded health insurance program

The cost of the fee depends on how many of the company's staff are insured through Medicaid

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Where Did This Regulatory Action Come From?

According to a 2024 report from the state Department of Human Services – the overseeing body of Medicaid – nearly 750 companies, nonprofits, and government offices would be subject to the fine

Medicaid claims for the 382,000 people associated with these companies cost $427 million over just three months of time with $137 million of that coming from state funds

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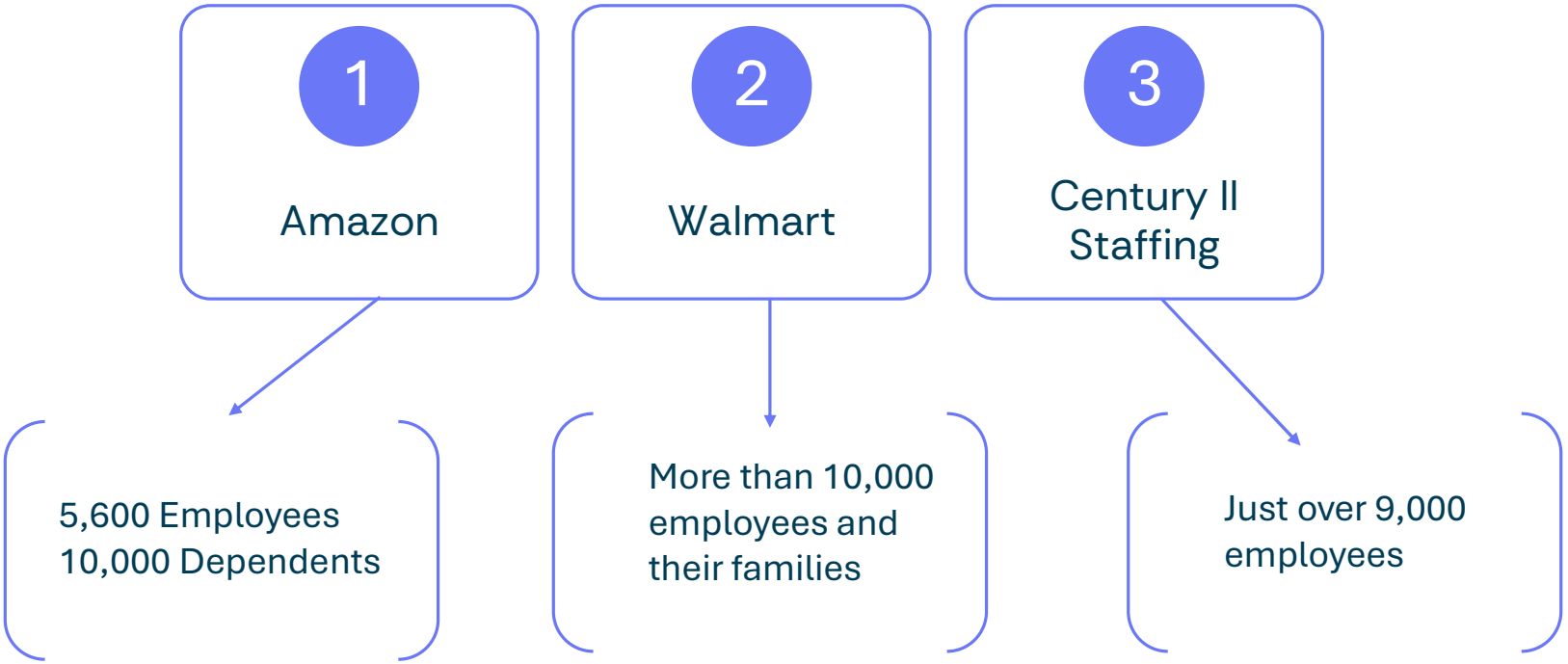
Targets Employers with Larger Populations on Medicaid

This report included large employers with Medicaid recipients including:



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Annual Fees Apply Based on # Employees

50-249 employees → $325 per employee and dependent

250-499 employees → $525 per employee and dependent

500+ employees → $725 per employee and dependent

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Counts and Timing

On March 1, annually the state will inform the employer of the number of employees on State Medicaid and total payment required

Future updates will be provided for how payments will be made and methods available by the April 15th deadline of the same year.

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Certain Exceptions

- Individuals with a developmental disability
- Individuals with an intellectual disability
- Individuals with a permanent physical disability
- An employee who has worked fewer than 90 days at the time the fee is levied
- A part time employee
- A seasonal employee

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Planning Ahead

- Law went into effect July 1, 2026
- Status of employees begins on July 1, 2027
- Employers can dispute any fees calculated but will need to track their supporting information

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New or Trending Regulatory Actions?

Other states may follow suit to offset cost of state insurance programs:

- California has already proposed taking a similar annual charge approach to recoup costs
- Connecticut governor has also called for a similar implementation in his state budget plans
- Massachusetts enacted but did not renew a similar rule in 2017
- Maryland took a similar approach in 2006 specifically targeted at Walmart

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CVS Wins ERISA Preemption Appeal

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Flowers v. Caremark Appeals Court Update

June 29, 2026 Eighth Circuit Court of Appeals rules that an element of the Arkansas statute regulating PBMs was preempted by ERISA

The geographic coverage requirements were rules as preempted by ERISA

Mandated that PBMs servicing a health plan ensure that a high percentage of covered individuals live within a relatively short distance from a network pharmacy.

90% for urban or suburban plans, 70% for rural

Two miles for urban, five miles for suburban, fifteen miles for rural

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Ruling

- The practical effect of the geographic coverage requirements was to require PBMs to tailor and retailor their networks and perhaps even build additional brick and mortar pharmacies to comply with the standard

- Court rules this interfered with plan administration uniformity

- Only limited to this circuit – may soon impose significant limitations on state regulations of PBMs in this circuit with similar geographic requirements

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Tennessee PBM Litigation

Major PBMs challenged Tennessee legislation restricting vertical integration between PBMs and pharmacies

Arguments include:

Federal preemption

Constitutional challenges

Limits on state authority over employer-sponsored benefit plans

The litigation follows legal strategies previously used successfully in other jurisdictions.

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ERISA Preemption Big Picture:

PBM regulation remains a rapidly evolving legal landscape.

Recent court decisions strengthen ERISA-based challenges.

States retain authority in some areas but face increasing judicial limits.

Employers, carriers, PBMs, and providers should closely monitor ongoing litigation before making long-term compliance decisions.

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Key Takeaways

State PBM regulation continues to expand despite increasing legal challenges.

Two recent court cases may significantly reshape the scope of state authority.

ERISA preemption remains one of the strongest legal arguments against state PBM laws.

Litigation involving pharmacy ownership restrictions and network requirements is expected to influence future legislation nationwide.

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Questions

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Webinar Wrap-Up

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