Employee Benefits Report

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Compliance

Compliance Update: Gag Clause Attestations, Contraceptive Coverage Ruling, and SF Ordinance Impacts

As Q4 begins, benefits managers face a trio of compliance developments with implications for plan design, documentation, and year-end filings. Two are federal in scope, while one local ordinance continues to affect employers nationwide.

Gag Clause Prohibition Attestations Due by December 31

Under the Consolidated Appropriations Act (CAA), employer-sponsored group health plans must submit an annual attestation confirming that no "gag clauses" exist in their provider contracts. These clauses—often embedded in third-party administrator agreements—can restrict access to cost and quality data, undermining transparency efforts.

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This Just In ...

Trump Administration Reshapes Health Plan Oversight

The Trump administration has issued a series of executive orders aimed at recalibrating federal oversight of employer-sponsored health plans. These directives target unpublished rules and agency enforcement priorities, signaling a shift toward deregulation and increased flexibility for plan sponsors.

In tandem with these policy moves, leadership changes at key agencies are already influencing the regulatory tone. Robert Kennedy as Secretary of Health and Human Services (HHS), and Laurie Chavez as head of the Department of Labor (DOL) are both steering their departments toward reduced administrative burden and narrower interpretations of ERISA enforcement.

Early indicators suggest a pause on certain rulemaking initiatives and a renewed emphasis on employer discretion in plan design and documentation. However, the long-term impact remains uncertain, especially as agencies recalibrate their audit protocols and guidance materials.

The attestation is due by December 31, 2025, and applies to fully insured and self-funded plans. Plans must confirm that they do not include contractual language that prevents disclosure of provider-specific cost or quality information. The attestation is submitted through the CMS portal, and noncompliance may result in penalties.

Employers are encouraged to review their agreements and coordinate with carriers or TPAs to ensure compliance.

Court Ruling Reshapes Contraceptive Coverage Exemptions

A recent federal court decision has vacated a key exemption that previously allowed employers to opt out of contraceptive coverage based on religious or moral objections. This ruling reopens questions around plan design, ERISA documentation, and employee communications.

While the decision may be subject to appeal, employers who previously relied on the exemption should assess their current coverage and prepare for potential updates to Summary Plan Descriptions (SPDs). The ruling may affect grandfathered plans, religious institutions, and closely held corporations, particularly those operating across multiple states.

Legal counsel may be needed to evaluate the impact and ensure alignment with federal and state requirements.

SF Health Care Ordinance: A Local Rule with National Reach

San Francisco's updated Health Care Security Ordinance (HCSO), which outlines 2025 expenditure rates and reporting requirements, initially flew under our radar due to its local scope. However, its impact reaches employers nationwide.

Any employer with workers averaging 8+ hours per week in San Francisco—including remote or hybrid employees—may be subject to the ordinance. The required health care expenditure rate is now $3.85/hour for large employers and $2.56/hour for medium employers, with annual reporting due by May 2, 2025. In 2026, reporting for 2025 will be due May 2, 2026.

Importantly, employer size is calculated based on global employee count, meaning a company with a single SF-based employee may still be classified as a "Large Employer" if it has 100+ employees worldwide.

Employers should audit their workforce footprint and determine whether any staff trigger HCSO obligations. The ordinance also includes exemptions for high earners and specific plan types, which may affect compliance strategies.

Employers should monitor agency bulletins and enforcement updates closely, particularly those affecting fiduciary obligations, mental health parity, and transparency mandates. As priorities shift, staying informed will be key to maintaining compliance and anticipating future changes.

Final Takeaway

These updates reflect the evolving landscape of benefits compliance. From federal transparency mandates to local ordinances with national implications, staying informed is essential. Employers should review plan language, assess workforce geography, and prepare for key deadlines as the year draws to a close.

LIMRA Research: Broker Role Expanding as Strategic Benefits Advisors

New research from LIMRA reveals a significant shift in how employers engage with benefits brokers. Once viewed primarily as transactional intermediaries, brokers are now increasingly relied upon for consultative support—especially in the areas of plan design, cost containment, and digital tools. This evolution reflects a broader trend toward strategic benefits advising, where brokers help employers navigate complexity, optimize offerings, and enhance employee experience.

Plan Design: Tailoring Benefits to Workforce Needs

Employers are turning to brokers for guidance on customizing plan structures that align with workforce demographics, industry benchmarks, and budget constraints. Whether it's choosing between PPOs and HDHPs, integrating voluntary benefits, or layering in wellness incentives, brokers help employers strike the right balance between coverage richness and cost sustainability.

Effective plan design also supports recruitment and retention. Brokers can help employers assess competitor offerings, identify gaps in coverage, and introduce benefits that resonate with key employee segments—such as mental health support, fertility benefits, or financial wellness programs.

Cost Containment: Managing Spend Without Sacrificing Value

With medical trend rates continuing to rise, cost containment remains a top priority. Brokers are playing a central role in helping employers analyze claims data, evaluate funding strategies, and negotiate with carriers. Self-funding, level funding, and reference-based pricing are gaining traction, and brokers are often the ones guiding employers through feasibility assessments and implementation.

In addition, brokers help employers identify cost-saving opportunities through pharmacy benefit management (PBM) audits, network optimization, and dependent eligibility verification. These strategies can yield substantial savings while preserving plan integrity and employee satisfaction.

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Digital Tools: Enhancing Access and Engagement

The rise of digital benefits platforms has transformed how employees interact with their plans—and brokers are key facilitators of this shift. From enrollment portals and mobile apps to decision support tools and virtual care integrations, brokers help employers select and implement technologies that improve access, transparency, and engagement.

Digital tools also streamline administration. Brokers assist with vendor selection, data integration, and compliance tracking, reducing the burden on HR teams. For employees, intuitive platforms mean easier navigation, better understanding of benefits, and more informed choices during open enrollment and beyond.

Final Takeaway

The LIMRA findings underscore a broader redefinition of the broker's role—from product placement to strategic partnership. As employers face mounting regulatory, financial, and workforce pressures, brokers are stepping up as trusted advisors who deliver insight, innovation, and impact. This shift not only elevates the broker-client relationship but also enhances the overall value of employee benefits programs.

Benefits Administration Update: MLR Rebates, Texas SB 1332, and Year-End Priorities

As the final quarter of 2025 begins, several developments in benefits administration are reshaping how employers manage compliance, coverage, and communications. From rebate distribution rules to state-level legislation, benefits managers should take note of key updates that may affect plan operations and documentation heading into year-end.

Medical Loss Ratio (MLR) Rebates Released

Health insurance carriers have begun issuing annual Medical Loss Ratio (MLR) rebates, as required under the Affordable Care Act. These rebates are triggered when insurers fail to spend at least 80–85% of premium dollars on clinical services and quality improvement.

For employers, the critical question is whether the rebate—or a portion of it—is considered a plan asset under ERISA. If so, fiduciary rules apply, and the employer must allocate the rebate to participants in a fair and timely manner. This may involve cash refunds, premium reductions, or benefit enhancements.

The determination hinges on factors such as who paid the premiums (employer vs. employee), plan funding structure (fully insured vs. self-funded), and contractual arrangements. Employers should review their plan documents and consult legal or compliance advisors to ensure proper handling.

Texas SB 1332 Expands Termination Flexibility

A new Texas law—Senate Bill 1332—has introduced greater flexibility for employers in terminating health coverage for employees. Effective September 1, 2025, the legislation allows coverage to end on the date of termination rather than extending through the end of the month, provided the plan documents support this approach.

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This change affects several administrative touchpoints:

- **COBRA Triggers:** The termination date now becomes the qualifying event date, which may shorten the coverage window and impact COBRA notices.
- **Eligibility Audits:** Employers must ensure their systems accurately reflect termination dates and align with carrier rules.
- **Plan Documentation:** Summary Plan Descriptions (SPDs) and employee handbooks may need updates to reflect the new termination logic.

While the law applies only in Texas, it may influence plan design decisions in other states, especially for employers with multi-state operations seeking consistency.

Year-End Compliance and Reporting

In addition to MLR and termination updates, several year-end tasks are approaching:

- **Gag Clause Prohibition Attestations:** Due by December 31, 2025, plans must confirm they do not include contractual language that restricts access to cost or quality data.
- **San Francisco HCSO Reporting:** Employers with workers in San Francisco must prepare for 2025 expenditure tracking and submit compliance reports by April 30, 2026.
- **ACA -Reporting Prep:** Employers should begin gathering data for 1094/1095 filings, including coverage offers, affordability metrics, and safe harbor documentation.

Final Takeaway

Benefits administration continues to evolve, with new rules affecting rebate handling, termination timing, and compliance workflows. Employers should review plan documents, audit systems, and prepare for key deadlines to ensure smooth operations and regulatory alignment. Staying ahead of these changes helps protect plan integrity and supports a positive employee experience.

Compliance & Coverage Clarifier: Gag Clauses and Contraceptive Rules

As year-end compliance tasks ramp up, two areas of regulatory scrutiny deserve closer attention: gag clause attestations and recent changes to contraceptive coverage exemptions.

What Counts as a Gag Clause?

Under the Consolidated Appropriations Act, employer-sponsored health plans must attest by December 31, 2025 that they do not include "gag clauses" in contracts with third-party administrators or provider networks. But what exactly qualifies?

A gag clause is any provision that restricts access to or disclosure of:

- **Provider-specific cost or quality data**
- **De-identified claims information**
- **Network composition or reimbursement terms**

Common examples include language that prohibits sharing negotiated rates with plan participants or blocks access to benchmarking tools. Plans must ensure that contracts allow transparency and data sharing, especially for price comparison platforms and reporting requirements.

Fully insured and self-funded plans are subject to this rule. Employers should review service agreements and confirm that carriers or TPAs will submit the attestation on their behalf—or prepare to file directly via the CMS portal.

Who's Affected by the Contraceptive Coverage Ruling?

A recent federal court decision vacated a key exemption that allowed employers to opt out of contraceptive coverage based on religious or moral objections. While the ruling may be appealed, it currently affects:

- **Religious institutions**
- **Closely held corporations**
- **Employers with grandfathered plans**

Organizations that previously relied on this exemption should reassess their plan design and consult legal counsel. Updates to Summary Plan Descriptions (SPDs) and employee communications may be required to reflect new coverage obligations.

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