Ten Health Care Developments Employers Should Be Monitoring in 2026

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Key Takeaways

- Health care will very likely continue to dominate the conversation in Washington throughout 2026, particularly with the midterm elections looming in November.
- Congress is likely to address proposals related to the expiration (or extension) of expanded Affordable Care Act (ACA) subsidies, alternatives to the ACA, and other health care cost initiatives.
- The Trump Administration's regulatory priorities include additional disclosures of health plan costs and service provider compensation, implementation of legislative provisions in the One Big Beautiful Bill Act (OBBB Act), changes to the No Suprises Act (NSA), addressing mental health parity requirements, potential additional guidance related to fertility benefits, and facilitating direct-to-consumer drug pricing.
- Courts will continue to weigh in on ERISA preemption related to state laws regulating Pharmacy Benefit Managers (PBMs) and PBM practices that impact ERISA-covered group health plans (GHPs), as well as lawsuits against plan fiduciaries for violations of ERISA's fiduciary duties and HIPAA wellness rules.

As 2025 winds down, Congress, the Trump Administration, and the courts have unfinished business related to several key health priorities important to sponsors of GHPs. These issues will likely continue to dominate the health care conversation in Washington in 2026, particularly in light of the midterm elections later in the year. Additionally, litigation related to ERISA preemption of state laws regulating PBMs continues in the courts, as well as litigation against plan fiduciaries for violations of ERISA and the implementation of wellness programs. Here are the top health care issues we are watching and that employers should monitor in 2026:

1. Health Legislation in Congress

As part of the American Rescue Plan Act and the Inflation Reduction Act, Congress increased the premium tax credit subsidies available for individual health plans on the ACA Exchanges between 2021 and 2025. These enhanced premium tax credit subsidies are set to expire at the end of 2025. If the subsidies expire, premiums for coverage in the ACA Exchanges are likely to increase, which in turn will have a downstream impact on the cost of employer-sponsored GHPs.

While Congress debates whether to extend the enhanced subsidies permanently, temporarily, or not at all, additional health care proposals remain in play. As an alternative to the enhanced subsidies for premiums in the ACA Exchanges, some members of Congress have proposed to fund Health Savings

Accounts (HSAs) to help offset costs for individuals with coverage through the Exchanges. Such a proposal is unlikely to have bipartisan support, and, in any event, any HSA-related or other proposals would be difficult to implement before the subsidies expire at the end of 2025. Therefore, it remains to be seen whether Congress will temporarily extend the enhanced subsidies while alternatives are debated, passed, and implemented, and if so, for how long. If the enhanced subsidies do expire at the end of the year, the result will be increases in the cost of coverage in the Exchanges, leading to increased costs for employer-sponsored GHPs through an increase in enrollment (for those individuals that have existing health care needs) or cost-shifting of uncompensated care costs from health care providers.

Congress is also debating other health care initiatives including (i) restrictions on certain PBM practices, (ii) transparency into health care pricing, and (iii) additional HSA expansion provisions that were ultimately left out of the OBBB Act, the budget reconciliation bill passed last summer. Many of these proposals, in particular provisions related to transparency, have bipartisan support but are unlikely to be part of stand-alone health care legislation. Instead, a likely vehicle for these proposals is "must-pass" legislation such as the spending bill that Congress will take up in January to continue to fully fund the government in 2026. However, as Congress continues to look for ways to pay for new initiatives or address health care spending, threats to the tax exclusion for employer-sponsored GHPs remain. Therefore, employers should continue to monitor any developments that would seek to reduce or eliminate this tax exclusion.

2. Transparency Regulations

In addition to transparency proposals in Congress, the Trump Administration is preparing to release two proposed regulations designed to provide greater insight into the costs of prescription drugs:

- **Prescription Drug Machine Readable File (MRF) Implementation.** The prescription drug MRF was one of three MRFs included in transparency-in-coverage regulations issued during the first Trump Administration. However, unlike the two medical MRFs, the requirement to post a prescription drug MRF has not yet been implemented. Earlier this year, the Administration issued a Request for Information (RFI) to understand what modifications to the disclosure requirements or additional technical implementation guidance may be necessary to provide accurate and timely information in the prescription drug MRF. The Administration has now signaled its intent to release proposed rules in response to the RFI later this year. Employers will need to analyze those new requirements and understand how the new requirements may impact or change compliance with the MRFs, whether their PBM will post MRFs on their behalf, and decide whether to provide comments to the agencies prior to the regulations being finalized, if needed.
- **PBM Compensation Disclosure.** The Trump Administration is also expected to release proposed regulations requiring additional disclosure of direct and indirect compensation received by PBMs related to services provided to GHPs. While these additional requirements may be helpful for providing plan sponsors with additional insight into compensation by PBMs, depending on how they are drafted, it may also require additional compliance obligations of plan sponsors, as well as impose additional costs, and increase the risk of fiduciary litigation against the GHP sponsor.

3. OBBB Act Guidance

Earlier in 2025, Congress passed the OBBB Act, which included a handful of provisions related to GHPs. These include a permanent extension of the ability to pay for telehealth services before the deductible in HSA-qualified high-deductible health plans (HDHPs), the use of direct primary care arrangements that meet certain criteria with HSA-qualified HDHPs, and an increase in the amount employees can contribute to a Dependent Care Flexible Spending Account. The Department of Treasury and Internal Revenue Service have indicated that they intend to issue guidance implementing these new provisions. Employers who plan to take advantage of these new provisions should be on the lookout for this guidance and then prepare to comply with the implementation requirements.

4. NSA Guidance

The NSA was passed in 2020 and prevents providers from balance-billing plan participants in certain situations where a participant sees an out-of-network provider, such as in an emergency situation where a participant goes to an in-network facility but is seen at that facility by an out-of-network provider, or for air ambulance services. In addition to protecting individuals from balance-billing, the NSA also sets up a process to arbitrate the amount a plan must pay an out-of-network provider in those circumstances covered by the NSA (known as the "independent dispute resolution" or "IDR" process). In practice, however, that arbitration process has not worked as intended, resulting in the number of claims going through the process far exceeding the number originally estimated. This has resulted in increased costs for plan sponsors.

The Trump Administration is expected to issue final rules to improve the current arbitration process sometime in 2026. There are also proposals in Congress that would implement penalties for parties who do not comply with payment deadlines. Given the concerns with the arbitration process as currently administered, employers should monitor any legislative proposals to increase penalties on GHPs for delinquent payments without reforms to that arbitration process.

5. Mental Health Parity and Addiction Equity Act (MHPAEA)

In 2024 the Biden Administration issued new regulations under MHPAEA detailing how health plans must complete a Nonquantitative Treatment Limitation (NQTL) comparative analysis, along with other new requirements. Those regulations were challenged in court, and earlier this year, the Trump Administration announced that it would not enforce the new provisions in the 2024 rules until the lawsuit is resolved (plus 18 months). The lawsuit remains paused, and the Trump Administration has indicated that it intends to reconsider the 2024 regulations, including whether to rescind all or part of the regulations, issue new regulations, and/or issue additional guidance. In the meantime, employers must continue to comply with the 2013 final regulations related to financial and quantitative testing, among other provisions, as well as continue to comply with the statutory obligation to conduct and document the NQTL comparative analysis. Under the statute, the Department of Labor is required to audit a certain number of GHPs for compliance each year.

6. Expansion of Fertility Benefits

In response to an Executive Order issued earlier in 2025, the Trump Administration issued Frequently Asked Questions (FAQs) outlining how employers may offer fertility benefits outside of a major medical plan to employees under existing guidance. As part of those FAQs, the Administration indicated that it

is considering additional guidance related to fertility benefits, including an option for plans to offer stand-alone, self-insured fertility benefits to employees outside of the GHP, which is not permissible under current rules. If such guidance is issued and implemented, then employers will have additional options for offering fertility coverage to their employees and will have to determine if they want to offer such coverage and the steps needed to provide that coverage in compliance with the rules.

7. Direct-to-Consumer Prescription Drug Programs

During the third quarter of 2025, President Trump announced agreements with certain drug manufacturers that will allow consumers to obtain prescription drugs at a discounted price when purchased directly from those drug manufacturers. The Administration has also announced that this direct-to-consumer purchasing will be facilitated by TrumpRx, a website that will link consumers with these drug manufacturing purchasing programs. However, there are limited details on how this program will work, and it is unclear if or how employer plans will have access to these discounted programs. More information is needed to understand the impact on prescription drug prices through this initiative, and we are likely to start getting such information early in 2026.

8. ERISA Preemption of State PBM Laws

Over the past several years, various states have passed laws regulating PBM practices. While the laws often purport to regulate the business of PBMs in those states, many of the provisions (e.g., bans on spread pricing, prohibiting incentives for using certain pharmacies) impact ERISA-covered GHP designs for employers providing health coverage to employees in those states. These state-specific laws are particularly problematic for employers who provide self-insured health coverage for employees in multiple states. Many of these state laws have been challenged as preempted by ERISA. For example, the Tenth Circuit Court of Appeals found that an Oklahoma law regulating pharmacy networks through restrictions on PBMs also restricted self-insured plan design and was preempted by ERISA, and earlier this year the United States Supreme Court declined considering the case, leaving the Tenth Circuit decision in effect. However, various states continue to pass laws restricting PBM practices and these laws continue to be challenged in court as preempted by ERISA, with current litigation in play in Tennessee and Iowa, among other states. How the courts decide whether ERISA preempts these states' laws will have an impact on uniform plan administration and the ability of ERISA GHP sponsors to claim ERISA preemption of certain state laws in the future.

9. Fiduciary Breach Litigation

Over the past two years, plan participants have filed lawsuits against self-insured GHPs alleging that plan fiduciaries breached their fiduciary duties under ERISA by failing to prudently select and monitor their PBMs and the prices of prescription drugs offered under their GHPs. This past year, another type of fiduciary lawsuit has been filed against self-insured GHPs alleging that plan fiduciaries breached their fiduciary duties by offering medical plan options that were of less value than other medical plan options offered by the GHP.

While courts have looked closely at whether the plaintiffs have been individually harmed by the actions alleged (i.e., whether the plaintiffs have legal "standing") and in some cases dismissed the lawsuits for lack of standing, the influx of lawsuits against plan fiduciaries for violations of ERISA continues and remains a risk for plan sponsors. Plan fiduciaries should make sure they have appropriate processes

and procedures in place and follow those processes and procedures to minimize the ongoing risk of breach of fiduciary duty claims.

10. HIPAA Wellness/Tobacco Surcharge Litigation

Numerous lawsuits have been filed over the past two years alleging violations of the HIPAA wellness rules, particularly with respect to tobacco surcharges. Claims include allegations that (i) plans did not make a reasonable alternative standard available to earn the wellness plan reward, (ii) plans did not make the full reward available once the reasonable alternative standard had been satisfied, and (iii) plans did not fully communicate the ability to complete a reasonable alternative standard in all plan materials (all of which are required under HIPAA). Litigation outcomes in these lawsuits have varied, with some employers opting to settle these cases. Some early court decisions allowed cases to proceed based on alleged failure to comply with the disclosure requirements or failure to provide retroactive reimbursement of surcharges. In a recent development, a district court dismissed the complaint concluding that retroactive reimbursement of the tobacco incentive was not required. However, litigation continues in this area so employers should make sure that they review their wellness programs, particularly those related to a tobacco use surcharge, for compliance with the wellness rules under HIPAA.

The Aon Health Solutions Compliance & Policy Consulting team will be monitoring and analyzing these developments to help employers understand their impact, risks, and opportunities, and help employers take appropriate action in response.

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