TRUE NETWORK OF ADVISORS

EEOC Releases New National Enforcement Plan

By: Abby Blankenship

On June 4, 2026, the U.S. Equal Employment Opportunity Commission (the "EEOC") approved a new National Enforcement Plan ("NEP") for fiscal years 2025–2029, replacing the prior Biden-era Strategic Enforcement Plan, which the EEOC approved in 2023.

Key Enforcement Priorities

The NEP marks a notable shift in how the EEOC approaches enforcement. Most significantly, the NEP expressly prioritizes disparate-treatment (intentional discrimination) theories over disparate-impact claims. Consistent with Executive Order 14281, signed by President Trump on April 23, 2025, the EEOC will seek to "eliminate" the use of disparate-impact theories in its investigations "to the maximum degree possible" and "will not commence, develop, or continue litigation advancing disparate-impact claims."

Additionally, a central focus of the NEP is enforcement activity directed at diversity, equity, and inclusion ("DEI") programs that the EEOC views as constituting intentional discrimination. Specifically, the NEP targets race- and sex-based quotas, diverse slate and diverse hiring panel policies, mandatory diversity statements for candidates, compensation structures tied to diversity goals, and the sharing of demographic data with managers or the public.

Beyond DEI, the NEP identifies additional priority categories: cases with a substantial likelihood of broader impact (including repeated or facially discriminatory policies); protections for vulnerable workers (including teenagers and workers with developmental or intellectual disabilities); and cases involving the integrity of the EEOC's enforcement process, particularly "the investigation and conciliation of charges."

Topics the EEOC Has Flagged for Potential Expansion of Legal Precedent

In addition to its enforcement priorities, the NEP highlights cases that may advance the EEOC's development of the law. These topics signal where the EEOC intends to bring cases designed to push legal boundaries or resolve open questions through litigation.

Among the cases the EEOC has singled out include:

1. Certain DEI programs in light of the Supreme Court's decisions in *Ames v. Ohio Department of Youth Services, Muldrow v. City of St. Louis*, and *Students for Fair Admissions, Inc. v. President & Fellows of Harvard College*;
2. The continued viability of voluntary affirmative action plans under United Steelworkers of *America v. Weber*, and *Johnson v. Transportation Agency, Santa Clara County, California*, particularly given the implications of *Ames, Muldrow,* and *Students for Fair Admissions*;
3. Application of the "some harm" threshold recognized in *Muldrow*;
4. The obligations employers face when asked to provide religious accommodations following the Supreme Court's framework in *Groff v. DeJoy*;
5. The scope of *Bostock v. Clayton County*, particularly in disputes over sex-based workplace policies and classifications; and
6. The reach of employer obligations created by the Pregnant Workers Fairness Act.

Key Takeaways for Employers

In light of the NEP, employers should consider several practical steps:

1. Audit DEI-related compensation and benefits programs for provisions that could be characterized as conferring preferences based on protected characteristics;
2. Examine benefits eligibility criteria and plan design to avoid inadvertent preferencing or exclusion;
3. Strengthen religious accommodation protocols and maintain thorough documentation of decision-making processes to demonstrate legitimate, non-discriminatory rationales.

Additionally, employers should continue to stay current on further EEOC developments, as these priorities can shift with changes in EEOC leadership.

Inside this issue:

GLP-1 Coverage in Employer Group Health Plans; Navigating Cost, Compliance, and Nondiscrimination Risk

By Kate Belyayeva

Employer-sponsored health plans are facing increasing pressure to address coverage for glucagon-like peptide-1 receptor agonists, such as semaglutide (i.e., Ozempic and Wegovy) and tirzepatide (i.e., Mounjaro and Zepbound), which are collectively referred to as GLP-1s. Although GLP-1s were initially associated primarily with treatment of Type 2 diabetes, certain drugs in this class are now widely used for chronic weight management and other obesity-related indications. For many employers, the issue is not simply whether to cover GLP-1s. The more difficult question is how to design, administer, and communicate coverage in a way that balances cost, access, fiduciary oversight, and potential nondiscrimination risk. Several employers and insurers have already eliminated or narrowed weight-loss GLP-1 coverage for 2026, citing unsustainable utilization and cost increases.

Against this backdrop, employers face a developing legal and regulatory landscape. Although no federal law broadly mandates that employer-sponsored health plans cover GLP-1 drugs for obesity treatment, plan sponsors must navigate potential nondiscrimination concerns under multiple federal statutes, including the Americans with Disabilities Act ("ADA"), Section 1557 of the Patient Protection and Affordable Care Act ("ACA"), the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), emerging state-law coverage mandates, and the fiduciary duties imposed by the Employee Retirement Income Security Act of 1974 ("ERISA"). This article provides a brief overview of key considerations for employer-sponsored health plans evaluating GLP-1 coverage.

No Federal Mandate

As mentioned above, there is currently no broad federal mandate requiring coverage of GLP-1s for weight loss. Self-insured plans retain substantial discretion to define covered benefits; however, that discretion does not mean employers should approach exclusions casually. GLP-1 coverage can be complicated because the same class of drugs may be prescribed for different reasons. A plan may cover a GLP-1 for Type 2 diabetes, exclude the same or similar drug when prescribed primarily for weight loss, and separately cover a drug when prescribed for another covered medical indication. Those distinctions may be permissible, but they should be drafted clearly and administered consistently.

ADA Considerations

The ADA analysis is not settled in every respect. Many federal courts have held that obesity alone is not necessarily a protected disability, but the analysis may differ for severe obesity, obesity caused by an underlying physiological condition, or obesity-related conditions that independently qualify as disabilities. In addition, the Equal Employment Opportunity Commission has historically taken a broader view than some courts regarding when weight-related conditions may constitute an impairment.

The ADA does not, by itself, require an employer health plan to cover a particular drug, treatment, or medical condition. However, health benefits are generally treated as part of the terms, conditions, and privileges of employment, so plan design and administration should not discriminate because of disability. Accordingly, indication-based GLP-1 rules should be framed around covered diagnoses, FDA-approved, or otherwise medically supported indications, medical necessity, and uniformly applied clinical criteria, rather than language that appears to exclude coverage because a participant has obesity or another disability.

ACA Section 1557

Section 1557 of the ACA prohibits discrimination on certain protected bases, including disability, in covered health programs or activities. Section 1557 does not automatically apply to every employer plan sponsor in the same way, but it may be relevant for insurers, third-party administrators, and certain health programs or activities that receive federal financial assistance. In March 2026, the First Circuit affirmed dismissal of a proposed class action in *Holland v. Elevance Health, Inc.*, holding that the plaintiff failed to plausibly allege disability discrimination from a weight-loss medication exclusion. The decision is helpful for plan sponsors and insurers defending weight-loss drug exclusions, but employers should not read it as resolving all risk. The decision arose at the pleading stage, under the facts alleged, and within the First Circuit. Different plan language, different facts, or a different jurisdiction could produce a different result.

HIPAA Considerations

HIPAA's nondiscrimination rules prohibit discrimination based on health factors but generally permit uniform benefit limitations applied to similarly situated individuals. An exclusion for weight-loss drugs is not automatically prohibited—the key is whether it is written and administered as a generally applicable plan design rule, rather than being applied selectively based on an individual's health status, claims experience, or disability.

Employers commonly manage utilization through prior authorization, BMI thresholds, step therapy, and lifestyle program requirements. These tools may be useful, but they should be implemented carefully. Prior authorization criteria should be consistent with the plan document, summary plan description, formulary, and claims procedures. Claims administrators and PBMs should also apply the criteria consistently across similarly situated participants, and exceptions and appeals should be handled through the plan's ordinary claims procedures.

Tax-Advantaged Account Alternatives

Employers that do not cover GLP-1s for weight loss under the medical or prescription drug plan may consider whether employees can access tax-advantaged account reimbursement. Health FSAs, HRAs, and HSAs may reimburse expenses that qualify as medical care under Code Section 213(d). However, if employers point employees to the aforementioned accounts as an alternative way to defray cost, communications should be precise as tax-advantaged account availability does not convert every weight-loss expense into a reimbursable medical expense. Employees may need a prescription, physician diagnosis, or other documentation showing that the expense is for treatment of a specific disease or medical condition. Employers sponsoring HSA-compatible high deductible health plans should also consider the HDHP rules before providing first-dollar coverage for GLP-1s or related services. Unless the coverage fits within permitted preventive care or another exception, pre-deductible coverage may jeopardize HSA eligibility.

Employer Impact

Employers should take a deliberate, well-documented approach to GLP-1 coverage decisions and should avoid treating "GLP-1 coverage" as a single yes-or-no decision. GLP-1 coverage can raise different considerations depending on the diagnosis, drug, plan design, utilization management criteria, and population affected. Because these decisions may have varying implications, plan sponsors should consider documenting the rationale for any coverage approach, particularly where the plan excludes, narrows, or imposes additional requirements on coverage for obesity or weight-

management indications. This is especially important where a plan covers GLP-1s for some indications but not others.

Employers should also treat participant communications as a compliance issue, not merely an employee-relations issue. GLP-1 coverage changes can be highly visible and sensitive, particularly for participants who are already using a medication and may experience a disruption in treatment if coverage is narrowed or terminated. Communications should clearly explain whether any prior authorization or other clinical requirements will apply and what steps participants may need to take to maintain or seek coverage.

Conclusion

GLP-1 coverage is likely to remain a significant issue for employer-sponsored group health plans. Employers currently retain broad discretion in plan design, but that discretion should be exercised through a careful and documented process. As litigation, agency enforcement priorities, state insurance laws, and market practices continue to develop, employers should revisit GLP-1 coverage as part of a broader prescription drug and chronic condition strategy.

CMS Requests Input on PBM Compensation and Data Reporting Requirements

By Kate Belyayeva

On June 18, 2026, the Centers for Medicare & Medicaid Services ("CMS"), a division of the Department of Health and Human Services ("HHS"), published a Request for Information ("RFI") in an effort to solicit input on the services, compensation arrangements, affiliate relationships, pharmacy payment practices, and data reporting practices of pharmacy benefit managers ("PBMs") and their affiliates. The RFI is intended to inform CMS's implementation of Section 6224 of the Consolidated Appropriations Act, 2026 ("CAA 2026"), which added new PBM accountability requirements under Medicare Part D. Comments are due by 5:00 p.m. on July 20, 2026.

Background

Section 6224 establishes a new regulatory framework for PBMs operating within Medicare Part D. Beginning in calendar year 2028, the statute restricts the remuneration that PBMs and PBM affiliates may receive for services connected with the utilization of covered Part D drugs and establishes annual data reporting requirements. In general, PBMs and their affiliates may receive only "bona fide service fees" in connection with covered Part D drugs. These fees must reflect fair market value for bona fide, itemized services actually performed and must be flat dollar amounts. Section 6224 also requires PBMs and their affiliates to pass through to Part D plan sponsors rebates, discounts, and other price concessions received from manufacturers, and requires PBMs to provide annual reports to Part D plan sponsors and the Secretary of HHS containing detailed drug utilization, pricing, reimbursement, and retained-revenue information.

The RFI does not propose specific regulatory text. Instead, it organizes CMS's questions into six broad categories, as further detailed below: (i) the definition of "pharmacy benefit manager"; (ii) the definition of "affiliate"; (iii) the definition of "bona fide service fee"; (iv) the determination of fair market value; (v) pharmacy payment arrangements; and (vi) data collection requirements.

Key Issues in the RFI

PBM Definition

Section 1860D-12(h)(7)(C) of the Social Security Act ("SSA") defines a PBM broadly to include any person or entity that, directly or through an intermediary, acts as a price negotiator or group purchaser on behalf of a prescription drug plan or plan sponsor, or manages prescription drug benefits provided by such plan or sponsor. The definition expressly includes entities that perform functions such as claims processing, utilization review, prior authorization, appeals adjudication, pharmacy network contracting, and cost control, regardless of whether the entity calls itself a PBM. This portion of the RFI suggests that CMS may focus on substance over form by looking to the functions performed and the economics of the arrangement, rather than the labels used by the parties. CMS also asks whether additional functions commonly performed by PBMs should be addressed and how intermediaries operate between PBMs and Part D sponsors.

Affiliate Definition

Section 1860D-12(h)(7)(A) of the SSA defines affiliate broadly to include entities with direct or indirect ownership, control, or contractual relationships with the PBM or Part D plan sponsor, to the extent those entities perform pharmacy benefit management functions. CMS asks whether entities such as data vendors, group purchasing organizations, rebate aggregators, mail-order pharmacies, specialty pharmacies, retail pharmacies, wholesalers, payment facilitators, and pharmacy benefit consultants should be treated as PBM affiliates. This definition is significant because it may determine which entities are subject to the new compensation restrictions and reporting requirements. Given the vertical integration of the PBM market, CMS's approach to the affiliate definition may affect not only which entities are regulated, but also how compensation and retained revenue must be disclosed and evaluated.

Bona Fide Service Fees

The RFI also focuses heavily on the statutory concept of a "bona fide service fee." CMS seeks input on current remuneration arrangements with PBMs or their affiliates. A flat fee will not necessarily qualify as a bona fide service fee merely because it is expressed as a fixed dollar amount. The fee must also reflect fair market value for a bona fide service actually performed. CMS asks how fair market value should be determined for PBM and affiliate services, including whether valuation practices should account for PBM market concentration and vertical integration.

Pharmacy Payments

Section 6224 does not prohibit Part D sponsors from paying pharmacies through flat dispensing fees or reimbursement based on ingredient costs. CMS seeks input on arrangements that meet these descriptions, as well as arrangements that fall outside either category. Pharmacy reimbursement is a major component of PBM contracting and may involve multiple payment streams, including payments to PBM-affiliated pharmacies.

Data Reporting

Beginning in 2028, PBMs will be required to submit annual reports to Part D plan sponsors and the Secretary of HHS by July 1st of each year, covering the prior plan year. Among other things, the required reports must include detailed information regarding drug utilization, dispensing activity, drug costs and pricing, pharmacy reimbursement, overall plan spending, and revenue retained by the PBM or its affiliates. CMS asks whether additional data elements would help inform implementation and monitoring.

Employer Impact

The RFI does not directly impose new obligations on employers or employer-sponsored group health plans because its immediate focus is Medicare Part D. However, employers should monitor the rulemaking process because the broader CAA 2026 includes PBM transparency and

compensation provisions that apply directly to employer-sponsored group health plans.

In addition, CMS's interpretive positions on key definitions such as "PBM," "affiliate," "bona fide service fee," and "fair market value" may influence the employer plan market, even if the RFI itself remains limited to Medicare Part D. PBMs that operate across Medicare, commercial, and employer-sponsored markets may update contract terms, compensation structures, reporting processes, data systems, and affiliate arrangements across multiple lines of business in response to the Part D requirements.

Finally, employers should consider whether current rebate pass-through, compensation, reporting, disclosure, audit, and termination provisions may need to be revised before the CAA 2026 employer-plan provisions become effective. Plan sponsors should continue monitoring CMS and Department of Labor guidance, particularly regarding definitions, reporting format, compensation disclosures, and the interaction between Part D reforms and employer-plan PBM arrangements.

Conclusion

The RFI is an early step in CMS's rulemaking process to implement the Medicare Part D PBM provisions of the CAA 2026, but it should not be viewed in isolation. For employer-sponsored group health plans, the RFI is another reminder that PBM oversight is no longer simply a procurement issue. It is a core plan governance and fiduciary oversight issue.

Compliance Corner: A Primer on Compliance Considerations for Self-Insured Health Plans

By: Abby Blankenship

As more employers turn to self-insured (also called self-funded) health plans for greater flexibility and control over their benefits, it is important to understand the distinct compliance obligations that come with this arrangement. This month's Compliance Corner provides a primer on the key compliance considerations for self-insured health plans, including requirements under the Employee Retirement Income Security Act of 1974 ("ERISA"), the Patient Protection and Affordable Care Act ("ACA"), the Health Insurance Portability and Accountability Act ("HIPAA"), stop-loss insurance, plan documentation, and additional regulatory items that employers should have on their radar.

Overview of Self-Insured Plans

In a self-insured arrangement, the employer assumes the financial risk of providing health care benefits directly to its employees, rather than purchasing a fully insured policy from an insurance carrier. The employer pays claims out of its own assets (or a trust), typically engaging a third-party administrator ("TPA") to process claims and provide administrative services.

Importantly, level-funded plans are not fully insured and are treated as self-insured for compliance purposes. Under Internal Revenue Code ("Code") Section 105(h)(6), a self-insured plan is any plan that reimburses employees for medical expenses where reimbursement is not provided under a policy of accident and health insurance. Accordingly, employers with level-funded arrangements must comply with all of the same regulatory requirements as traditional self-insured plans.

ERISA Considerations

1. The Deemer Clause and State Law Preemption: ERISA's express preemption clause generally preempts state laws that "relate to" employee benefit plans. The Deemer Clause further provides that self-insured plans cannot be "deemed" to be insurance companies subject to state insurance regulations. This gives self-insured employers complete flexibility in plan design, free from state-mandated benefit requirements that apply to fully insured plans.
2. Fiduciary Duties: Employers sponsoring self-insured plans have fiduciary obligations, including the duty of loyalty (acting solely in the interest of plan participants), the duty of prudence (exercising care in plan administration and vendor selection), and the duty to follow plan terms.
3. TPA as Named Appeals Fiduciary: For self-insured major medical plans, employers should ensure that the TPA is designated in writing as the named appeals fiduciary. Because claims appeals for major medical plans often require medical necessity determinations, compliance with strict regulatory timeframes, and the ability to address urgent care claims within as little as 24 hours, these responsibilities are typically beyond the employer's expertise.

ACA Considerations

All employers sponsoring a self-insured medical plan must comply with ACA reporting requirements, regardless of employer size:

1. Applicable Large Employers ("ALEs"): ALEs (those with 50 or more full-time employees, including full-time equivalents) must report under both Code Section 6055 and Code Section 6056, using Forms 1094-C and 1095-C. ALEs with self-insured plans must also complete Part III of Form 1095-C, which requires the names of all covered individuals, their Social Security numbers, and months of coverage.
2. Non-ALEs (under 50 full-time equivalent employees): Small employers with self-insured plans must report under Code Section 6055 using Forms 1094-B and 1095-B.
3. State Individual Mandate Reporting: Several states (including California, New Jersey, Massachusetts, Rhode Island, and the District of Columbia) impose their own individual mandate reporting requirements. Self-insured employers must provide Forms 1095-C (or equivalent state forms) to the applicable state agencies, with varying deadlines.

HIPAA Considerations

Self-insured employers must directly address HIPAA's privacy and security requirements, including:

1. Establishing and maintaining written HIPAA privacy policies and procedures;
2. Appointing a HIPAA Privacy Official;
3. Conducting HIPAA training for employees; and
4. Executing Business Associate Agreements ("BAAs") with all third-

party vendors that create, receive, maintain, or transmit Protected Health Information ("PHI") on behalf of the plan.

Stop-Loss Insurance Considerations

While self-insured employers assume the financial risk for plan claims, stop-loss insurance can provide a safety net against catastrophic or unexpectedly high costs. There are two primary types:

1. Individual (Specific) Stop-Loss: Reimburses the employer when an individual's claims exceed a specified threshold; and
2. Aggregate Stop-Loss: Limits the employer's total claims liability across the entire covered group.

Stop-loss coverage does not eliminate risk entirely, but it helps make self-funding more predictable and manageable. Employers should carefully confirm that their stop-loss provider has approved any policies that extend coverage during non-protected leaves of absence (most stop-loss providers permit up to six months) and any domestic partner coverage. Going beyond the stop-loss provider's approved parameters could result in the employer self-funding claims with no stop-loss protection.

Plan Document Considerations

Self-insured plans must be established and maintained pursuant to proper plan documentation:

1. Plan Document and SPD: Employers must maintain a plan document and Summary Plan Description ("SPD") that includes standard HIPAA provisions, plan terms, and participant rights.
2. Code Section 105(h) Nondiscrimination Rules: Self-insured plans are subject to nondiscrimination testing under Code Section 105(h). This includes an Eligibility Test (the classification of eligible employees must be "reasonable and nondiscriminatory"), a Benefits Test (all benefits provided to Highly Compensated Individuals ("HCIs") must be available to all eligible participants), and a prohibition on operational discrimination (employers cannot selectively establish, amend, or terminate the plan to benefit HCIs). Violations result in taxation of "excess reimbursements" to all HCIs.

Key Takeaways for Employers

While self-insured plans offer significant advantages in flexibility and cost control, they carry substantial compliance responsibilities. Employers should keep the following in mind:

1. Maintain Proper Plan Documentation: Employers should ensure that a comprehensive plan document, SPD, and HIPAA policies are in place and kept current. Designate the TPA as the named appeals fiduciary in writing for major medical plans.
2. Stay Current on ACA and State Reporting: Employers should develop reliable processes for collecting participant SSNs, tracking coverage months, and timely filing both federal and applicable state individual mandate reports.
3. Prioritize HIPAA Compliance: Employers should appoint a Privacy Official, train relevant personnel, and execute BAAs with all vendors handling PHI.
4. Coordinate with Stop-Loss Carriers: Employers should confirm that all plan design features – including leave policies and domestic partner coverage – are approved by the stop-loss provider to avoid gaps in coverage.

STAY IN THE KNOW...

- On June 17, 2026, the U.S. Department of Labor (DOL) issued a technical release confirming that employer contributions to a child's Trump Account will not be subject to Title I of the Employee Retirement Income Security Act (ERISA), meaning employers can contribute to these accounts without triggering certain requirements under ERISA. As background, for each baby born between January 1, 2025, and December 31, 2028, the U.S. government will deposit $1,000 into a Trump Account. The federal deposits are expected to begin in July 2026.

- The U.S. Supreme Court issued its long-awaited rulings in Trump v. Slaughter, in which the Court ruled that the president has the constitutional authority to fire, at will, the leadership personnel at most federal agencies, and Trump v. Cook, in which the Court declined to include the Federal Reserve's Board of Governors within that constitutional authority. The decisions overrule Humphrey's Executor v. United States, a 1935 precedent that previously held Congress could use legislation to insulate federal agency leaders from the president's termination authority. The Court's rulings may result in a much greater propensity for turnover within the federal bureaucracy, while the president may now demand greater adherence by those agency leaders to the president's policy priorities.

- The U.S. Occupational Health and Safety Administration ("OSHA") announced last month that beginning August 19, 2026, it would begin holding a series of informal public hearings to discuss its deregulation initiative, including efforts to roll back employee respiratory protection requirements for 16 different chemicals or chemical-like substances.

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