Sick of Healthcare? Healthcare Benefit Update for Employers – What to Watch in 2025

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(by **Jenn Malik** and **Anna Hosack**)

Regardless of party affiliation, the one issue that most Americans seem to be able to agree about in 2025 is that we all are sick of our healthcare system. Healthcare reform is no stranger to the American political discourse, but recent public sentiment at the expense, difficulty, and confusion inherent in navigating the American healthcare is at an all-time low. Americans' dissatisfaction with the current state of the healthcare industry is unsurprising when between 2008 and 2022, the per enrollee cost of private health insurance has grown by 61.6% according to a study by the Kaiser Family Foundation.[1] Despite rising costs, rates for denials of coverage have increased nationally with a current average of around 19%.[2] Add to these statistics the change of administration and corresponding anticipated changes in healthcare benefits policy, along with increased litigation against Plan Sponsors reminiscent of the retirement plan litigation in the late 2000s, and we are all left scratching our heads with how to provide healthcare coverage to employees at an affordable cost – especially when, according to a recent study by Forbes, two-thirds (2/3) of American employees name employer-covered healthcare as the most important benefit in considering whether to take a job.[3] Below are key issues for employers to watch in the healthcare benefits space this year to guide in planning your organization's healthcare benefits and to budget accordingly:

Challenge to Affordable Care Act's Preventive Care Coverage

Currently, the Patient Protection and Affordable Care Act (ACA), also known as Obamacare, mandates that most health insurance plans must cover certain preventive services at no cost share to patients.? These services include benefits such as an annual wellness visit, maternity care, STD testing, certain immunizations for adults and children, cancer screenings, and well-baby/well-child visits.? The United States Preventive Services Task Force (USPSTF)?, the Health Resources and Services Administration (HRSA), and the Advisory Committee on Immunization Practices (ACIP) are various agencies tasked with recommending what benefits must be covered at no cost share under the preventive care mandate.? Proponents of the mandate argue that covering these benefits at no cost-share leads to earlier detection of serious medical conditions, earlier medical intervention, and more positive patient outcomes which can decrease the number of high-cost claims in the population and deter costs, while critics oppose the increased costs to employers/plan sponsors and may also oppose certain preventive services on religious grounds, such as the requirement to cover pre-exposure prophylaxis for HIV (PrEP) or birth control.

This April, SCOTUS is set to hear a challenge brought by Braidwood Management, Inc., and other employers to the mandate on the basis that the USPSTF, in its role as an administrative body that recommends what services are covered at no cost share, are "principal officers" who must be nominated by the U.S. President and confirmed by the Senate in accordance with the Constitution's Appointment's Clause.? These employers also challenged the mandate on religious grounds, arguing that the ACA's requirement that plans cover medication for HIV prevention violated the Religious Freedom Restoration Act (RFRA). In 2022, a Texas District Court agreed with the employers, holding that the USPSTF's recommendations are unconstitutional because its members are officers of the United States that were not appointed in accordance with the Appointments Clause.? The District Court held that because the members were unconstitutionally appointed, all recommendations implemented by the USPSTF after March 23, 2010 (the effective date of the ACA) must be vacated and issued a nationwide injunction blocking enforcement of the ACA's preventive care mandate. The District Court also held that the USPSTF's recommendation to cover PrEP at no cost share violated the RFRA.

On appeal, the Fifth Circuit Court of Appeals affirmed the District Court decision that the USPSTF members were unconstitutionally appointed; however, the Fifth Circuit held that the District Court had erred in vacating all agency actions to implement and enforce the USPSTF's preventive care requirements and erred by enjoining enforcement

nationally.[1]? The Fifth Circuit limited the remedy of enjoining enforcement to the particular plaintiffs and those similarly situated in lieu of a national injunction. The Fifth Circuit also declined to issue similar decisions against ACIP and the HRSA and issued a remand to address whether the Secretary of Health and Human Services properly ratified the recommendations of those agencies.

SCOTUS granted certiorari and will specifically review whether USPSTF members are "inferior officers" of the United States, meaning their appointment was constitutional, and whether the District Court failed to sever the allegedly unconstitutional provision. SCOTUS denied certiorari on the Plaintiff's cross-petition for review of whether all ACA preventive care requirements violated the non-delegation canon; consequently, all ACA preventive care requirements recommended prior to March 23, 2010 are preserved.

What employers should consider for 2025:

Until SCOTUS renders an opinion, employers subject to the ACA should continue to cover the preventive services recommended by the USPSTF at no cost-share to their employees. If the challenge is successful, employers may be able to impose cost sharing for certain preventive services and/or benefits which may initially reduce healthcare costs. However, it is important to remember that federal law sets the floor, and not the ceiling for required covered benefits – and that while imposing cost-sharing on employees may have an immediate financial gain in the short-term, shifting costs to employees can cause delays in care, which can lead to later medical interventions, higher cost claims, and ultimately, a sicker workforce.

Financial Impact of Prescription Drug Developments

Prescription drug costs are skyrocketing with prescription drug cost trends outpacing medical cost trends in 2025: according to a Segel Health Plan Cost Survey, prescription drug costs grew by 11.4% and medical costs increased by 8%. This trend is heavily influenced by the emergence of glucagon-like peptide-1 receptor agonists (commonly known as GLP-1s) used to treat type 2 diabetes and obesity. While the monthly cost of these drugs is low compared to some other medications, typically ranging from $900 – $1300 per month per patient, their widespread utilization by the public has left employers and health insurers scrambling with how to maintain costs. The financial impact of GLP-1s has been so staggering that many insurers have begun to offer buy-up options to employers if they choose to include GLP-1s on their covered medications list (i.e. Formulary) for weight loss. Proponents of GLP-1s argue that inclusion of the medications on Formulary greatly reduces other costly medical interventions such as gastric bypass surgery, and likewise reduces cardiovascular conditions such as heart attack, and stroke. Those against coverage of GLP-1s argue that there is a lack of independent studies on the impact of long-term usage of GLP-1s, that the costs have significant negative fiscal impacts to the healthcare system, and that the side effects cause even more high-cost claims. Big Pharma continues to seek approvals from the FDA for expanded indications of GLP-1s including for the treatment of sleep apnea, kidney disease, and liver disease.

Additionally, the financial savings that were anticipated when biosimilars, or biologic drugs that are highly similar to an already FDA-approved biologic product, hit the market as many brand medications began to lose their patent protection has been underwhelming. Biosimilar adoption has been slow due to concerns about safety and efficacy among healthcare providers and patients, complex Formulary and reimbursement structures that favor brand drugs over biosimilars, and lack of patient and provider education despite the significantly decreased price tag.

Specialty medications, which on average account for 50% of prescription drug spend, continue to be developed and while these medications offer life altering treatments for patients living with severe illnesses – they also come with a hefty price tag. For example, a new treatment to cure Hemophilia B, a lifelong debilitating bleeding disorder, comes at a price tag of $3.5 Million per treatment. While many balk at the cost, consider on average that an individual with Hemophilia averages $700,000-$800,000 in medical costs per year – so in theory the treatment would pay for itself in 4-5 years. However, for employer-sponsored plans, a single claim of $3.5 million would have an extreme impact on renewals.

Finally, the Trump Administration announced on April 8, 2025 that his administration would soon announce tariffs on pharmaceutical imports. While it is uncertain how Big Pharma will respond to such tariffs, it is certain that if such tariffs come into effect, they will very likely cause significant increases to how much consumers – and specifically plan sponsors/employers will spend on prescription medications. For reference, the U.S. imported over $210 Billion in pharmaceuticals in 2024.

What employers should consider for 2025:

Employers should anticipate prescription drug costs to continue increasing and budget accordingly as GLP-1s are here to stay and increased indications for GLP-1 drugs continue to be considered by the FDA. Employers looking to reduce costs should consider whether to cover GLP-1s for weight loss only. Likewise, employers should speak to their carriers and pharmacy benefits managers (PBMs) about their biosimilar strategy as a means to reduce cost. Employers should investigate copay accumulator programs as a means to leverage drug manufacturer coupon dollars to lower costs of specialty medications and consider plan design changes to their prescription benefits. Finally, employers should prepare for the impact of tariffs on their plans' prescription drug spends.

Challenge to Mental Health Parity and Addiction Equity Act

The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) generally requires health plans to cover mental health and substance use disorder benefits similarly to medical and surgical benefits. Since MHPAEA's enactment, complex federal regulations have been published to determine whether a health plan treats these benefits in parity which has led to significant difficulty for issuers and plan sponsors in determining whether a health plan is in compliance. In late 2020, Congress enacted the Consolidated Appropriates Act (CAA) which requires group health plans and health insurers to conduct comparative analyses to demonstrate that both quantitative treatment limitations (QTLs), or treatment limitations that are numerical in nature such as visit limits and copays, and non-quantitative treatment limitations (NQTLs), i.e. non-numerical limitations such as network access to providers, are no more stringently applied to mental health/substance abuse benefits than medical/surgical benefits. Since 2021, plans and insurers have been required to make these comparative analyses available to the Department of Labor, HHS, and Department of Treasury (Departments), upon request – but due to the complexity of the rules, enforcement has been challenging and many plans have been found to be out of compliance.

This led to the Departments eventually publishing final rules amending the longstanding 2013 rules on September 23, 2024 (2024 Final Rules). The 2024 Final Rules establish new NQTL standards, bolster the comparative analysis requirements that were added by the CAA, and prohibit plans and issuers from using discriminatory information, evidence, sources, or standards that systematically disfavor or are specifically designed to disfavor access to mental health/substance use disorder benefits as compared to medical/surgical benefits when designing NQTLs.[11] Some of these regulations are already in force while others begin on or after January 1, 2026.

Earlier this year, the ERISA Industry Committee (ERIC) filed suit against the Departments in the U.S. Court of Appeals for the D.C. Circuit seeking to invalidate the 2024 Final Rules, or at a minimum, invalidate key provisions and prohibit the Departments from implementing or enforcing the new rules, asserting that the 2024 Final Rules violate the U.S. Constitution and the Administrative Procedure Act and impose vague and burdensome requirements on health plans.[12] That same day, the Departments released a report to Congress indicating that employers had made progress on complying with MHPAEA but still fell short. The executive director of the ERIC Legal Center asserted that the new regulations "threaten the ability of employers to offer high quality, affordable coverage for the mental health and substance use disorder needs of employees and their families."[13]

Prior to the establishment of the 2024 Final Rules, compliance with the MHPAEA caused significant financial strain on health plans and health insurers alike, and by extension drive up compliance costs associated with healthcare benefits coverage. If the additional requirements under the 2024 Final Rules pass constitutional muster, health insurers and plans will incur additional monitoring and reporting costs. Additionally, though MHPAEA enforcement was a top priority for the Biden administration, it is unclear what the Trump administration's position will be – or what impact the recent workforce cuts at the DOL and HHS will have on the enforcement of MHPAEA going forward.

What employers should consider for 2025:

The 2024 Final Rules may not be here to stay between budget constraints, federal staffing constraints, and the ERIC lawsuit targeting the 2024 Final Rule. In the meantime, employers should monitor updates and budget accordingly for the additional requirements in the 2024 Final Rules to ensure continued compliance with MHPAEA as applicable.

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[1] Amin, K., Cox, C., Ortaliza, J. & Wager, E., Health Care Costs and Affordability, Kaiser Family Foundation, (May 28, 2024) https://www.kff.org/health-policy-101-health-care-costs-and-affordability/.

[2] Lo, J., Long, M., *et al,* Claims Denials and Appeals in ACA Marketplace Plans in 2023, Kaiser Family Foundation, (Jan. 27, 2025) https://www.kff.org/private-insurance/issue-brief/claims-denials-and-appeals-in-aca-marketplace-plans-in-2023/#:~:text=Key%20Takeaways,by%20insurer%20and%20by%20state.

[3] O'Reilly, Dennis, Best Employee Benefits, Forbes (October 30, 2024) https://www.forbes.com/advisor/business/best-employee-benefits/#:~:text=More%20than%20half%20of%20American,as%20the%20most%20important%20benefit.

[4] 42 U.S.C. § 300gg-13(a)(1).

[5] Preventive Services Covered by Private Health Plans Under the Affordable Care Act, Kaiser Family Foundation (Feb. 28, 2024) https://www.kff.org/womens-health-policy/fact-sheet/preventive-services-covered-by-private-health-plans/#:~:text=The%20services%20required%20to%20be,is%20published%20or%20otherwise%20released.

[6] The USPSTF determines what preventive services must be covered at no cost share by reviewing scientific evidence related to the effectiveness, appropriateness, and cost-effectiveness of clinical preventive services for the purpose of developing recommendations for the health care community, and updating previous clinical preventive recommendations. 42 U.S.C. § 299b-4(a)(1).

[7] The USPSTF recommends what services must be provided at no cost-share, while ACIP recommends which immunizations must be covered, and the HRSA determines what contraceptives require coverage.

[8] Petition for a Writ of Certiorari, *Becerra et al. v. Braidwood Management, Inc. et al.,* No. 24-316 (Sept. 19, 2024).

[9] Memorandum Opinion & Order, *Braidwood Mgmt. v. Becerra*, 627 F. Supp. 3d 624 (N.D. Tex. 2022)

[10] *Braidwood Management, Inc. v. Becerra et al.,* No. 23-0326 (5th Cir. 2024).

[11] Fact Sheet: Final Rules Under the Mental Health Parity and Addiction Equity Act (MHPAEA), U.S. Department of Labor (last visited Apr. 1, 2025) https://www.dol.gov/agencies/ebsa/about-ebsa/our-activities/resource-center/fact-sheets/final-rules-under-the-mental-health-parity-and-addiction-equity-act-mhpaea.

[12] *See* Complaint, *Erisa Industry Committee v. Department of Health and Human Services et al.*, No. 1:25-cv-00136 (D.D.C. 2025).

[13] Kellie Mejdrich, Trade Group Sues to Stop Federal Mental Health Parity Regs, LAW360 (Jan. 17, 2025) https://www.law360.com/articles/2286079.