

Employee Benefits Compliance Briefing

Winter 2025



Stay Compliant

Welcome to the UBA Partner Firm exclusive quarterly newsletter, delivering insights into employee benefits and labor law compliance.



UBA
PARTNER FIRM

Shared Wisdom.
Powerful Results.®



Acadia
BENEFITS
An Aetna Company

This Issue

1. What the Government Shutdown Means for Plan Sponsors
2. Key Changes Ahead for 2026 Form 1095-C Reporting
3. Annual Gag Clause Compliance Attestation Due Dec. 31
4. New ACA FAQ on Fertility Benefits
5. Vendor Fee Transparency under the CAA
6. IRS Releases 2026 Cost-of-Living Adjustments



About UBA

United Benefit Advisors® (UBA) is the nation's leading independent employee benefits advisory organization with more than 200 offices throughout the United States and Canada. UBA empowers 2,000+ advisors to maintain independence while capitalizing on each other's shared knowledge and market presence to provide best-in-class services and solutions.

This information has been prepared for UBA by Fisher & Phillips LLP. It is general information and provided for educational purposes only. It is not intended to provide legal advice. You should not act on this information without consulting legal counsel or other knowledgeable advisors.





What the Government Shutdown Means for Plan Sponsors

The federal government shutdown that began on September 30 has been the longest in U.S. history. While many agencies continue essential operations, the disruption has many employers questioning the impact on their employer-sponsored plans and related compliance requirements.

Operational Status of Key Agencies

Health policy issues have become a central element of negotiations to reopen the government. In particular, lawmakers are debating extensions or reforms of the enhanced advance premium tax credit (APTC) along with ancillary changes such as pharmacy benefit manager (PBM) transparency and expanded health savings account (HSA) uses.

Meanwhile, oversight and enforcement functions across federal agencies are impaired:

- The Internal Revenue Service (IRS) has furloughed more than 40% of its workforce, leaving many functions (especially non-statutory or administrative) paused.
- The Department of Labor (DOL) is operating at reduced capacity, with roughly 75% of the Employee Benefit Security Administration staff furloughed. As a result, many standard compliance examinations and rule-making efforts are delayed.
- The Centers for Medicare & Medicaid Services (CMS) has suspended most policy development efforts, although core programs such as Medicare and Medicaid continue.

Employer Action Items

While the government shutdown introduces operational uncertainty, the fundamental responsibilities of plan sponsors to act prudently, administer their plans in compliance with their governing documents and statutory and regulatory requirements, and maintain strong documentation are not altered by the shutdown and slower agency function and response.

- **Prepare for shifts in regulatory deadlines.**
Because enforcement agencies are operating with fewer resources, employers should monitor any official announcements about revised deadlines for filings, disclosures or audits. However, absence of enforcement does not relieve plan sponsors of fiduciary responsibilities.
- **Monitor plan design and vendor risk exposure.**
Potential legislation (such as changes to APTC or HSA rules) may necessitate updates to plan designs or vendor contracts. While there would likely be an implementation period following any changes, employers should

ensure that their plan documents, service agreements, and vendor disclosures remain aligned with emerging legal requirements.

- **Expect service interruptions or delays.**
With agencies operating under contingency plans, response times for IRS letter requests, DOL inquiries, or CMS system changes may be longer than usual. Plan sponsors relying on these functions for compliance support should build in buffers.
- **Keep proper audit trails and documentation.**
Even with limited enforcement activity, fiduciary duties remain unchanged. Maintaining clear documentation of decision-making, communications, and vendor oversight is essential to demonstrate prudence and compliance.



LOCAL SERVICE. NATIONAL PRESENCE.



Key Changes Ahead for 2026 Form 1095-C Reporting

Applicable large employers (ALEs) – those with 50 or more full-time equivalent employees - must file and furnish Forms 1094-C and 1095-C each year to report offers of health coverage under the Affordable Care Act (ACA). New legislative changes will alter how these forms are furnished to employees beginning with the 2026 reporting cycle, covering the 2025 calendar year.

Legislative Background

In December 2024, Congress enacted the Paperwork Burden Reduction Act and the Employer Reporting Improvement Act, aimed at streamlining ACA reporting requirements and reducing administrative costs. The legislation provides employers with more flexibility in distributing Form 1095-C to employees, while maintaining the same IRS filing and accuracy standards.

Reporting in 2026

Beginning with the 2026 reporting cycle, employers are no longer required to automatically furnish Form 1095-C to every full-time employee. Instead, they may post a notice to their employee website or benefits portal provided that the notice is clear and conspicuous and informs employees how to request their Form 1095-C.

The notice must include contact information (such as an email address, phone number, and mailing address) and remain available through October 15 of the year following the reported calendar year. When an employee requests a copy, the employer must furnish the form by the later of January 31 or 30 days after the request.

The alternative method applies only to the employee copy of Form 1095-C. Employers must still file Forms 1094-C and 1095-C with the IRS under the established deadlines and maintain compliance with all electronic filing requirements. Failure to furnish and file penalties can be as much as \$340 to \$680 per return.

Ongoing Compliance Considerations

Although these changes reduce mailing obligations, the employer's reporting accuracy and record-keeping responsibilities remain unchanged. Failure to provide timely responses to employee requests or to file accurate and complete information with the IRS may result in penalties. In addition, several states including California, Massachusetts, New Jersey, Rhode Island, and the District of Columbia have their own ACA-style reporting mandates that continue to require automatic furnishing or specific forms. The new federal updates do not change any state-specific requirements.

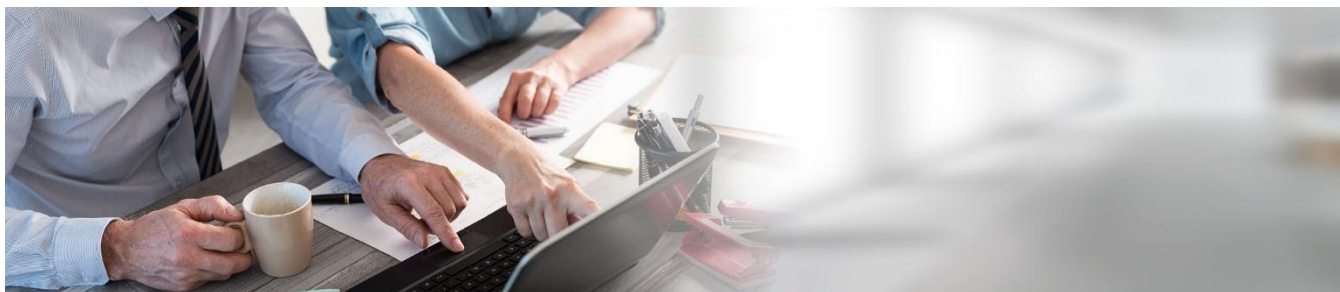
Employer Action Items

Employers should begin preparing now for the new rules to ensure smooth implementation ahead of the 2026 reporting cycle.

- Develop a compliant notice describing the process for requesting Form 1095-C and ensure it is posted in an accessible location, such as the company's intranet or benefits portal.
- Establish request-handling procedures to track and respond to employee requests within required timelines.
- Coordinate with reporting vendors to confirm their readiness for the alternative furnishing method and ongoing IRS electronic filing.
- Monitor state requirements that may impose separate or additional reporting obligations.



LOCAL SERVICE. NATIONAL PRESENCE.



Annual Gag Clause Compliance Attestation Due Dec. 31

As the end of the year approaches, plan sponsors should ensure they are prepared to meet the annual compliance deadline for the [Gag Clause Prohibition Compliance Attestation](#) (GCPCA), which must be submitted to the Centers for Medicare & Medicaid Services (CMS) by Dec. 31, 2025.

This attestation, required under the Consolidated Appropriations Act, 2021 (CAA), confirms that a group health plan complies with the federal prohibition on “gag clauses.” A gag clause is any term in an agreement between a plan and a service provider (such as a third-party administrator (TPA), network, or other vendor) that limits the plan’s ability to access or share information about provider cost, quality, or performance. The CAA requires plans to have unrestricted access to this information and to be able to share it with participants, referring providers, and regulators.

Who Must Comply

The gag clause prohibition and the annual attestation apply to nearly all group health plans, whether fully insured or self-insured. However, excepted benefits, such as stand-alone dental and vision coverage, accidental death and dismemberment coverage, and most employee assistance programs (EAPs), are generally not subject to the requirement.

For fully insured plans, the carrier typically completes the attestation on the plan’s behalf. Even so, employers should confirm in writing that the carrier will do so. For self-insured plans, the legal obligation to file rests with the plan sponsor, even if a TPA or other service provider agrees to assist.

How to Submit

CMS accepts gag clause attestations through its Health Insurance Oversight System (HIOS) portal. Employers can submit attestations directly or authorize a vendor, consultant, or carrier to submit on their behalf. CMS also provides [detailed instructions and FAQs](#), including guidance for plans that need to file for multiple entities under a single submission.

Why This Matters

The gag clause attestation is part of a larger transparency initiative under the CAA aimed at giving participants and employers better visibility into the cost and quality of health care. It complements other requirements, such the prescription drug data collection (RxDC) reporting and fee transparency provisions.

Failure to submit the attestation could expose the plan to civil penalties of \$100 per day per affected individual. For most employers, the attestation process is straightforward, but it requires coordination among internal benefits teams, carriers, and vendors to ensure compliance is properly documented.

Employer Action Items

To stay on track for the December 31 deadline, plan sponsors should:

- Review all vendor contracts (including TPAs, PBMs, behavioral health, and carve-out providers) for any provisions that limit the plan's access to cost or quality data.
- Work with legal counsel to identify and remove any contractual language with TPAs or other vendors that could be viewed as a gag clause.
- Confirm responsibility for filing and coordinate with your TPA or carrier to determine who will complete and submit the attestation.
- Document your compliance steps and keep copies of your review, correspondence with vendors, and the submitted attestation in your plan's compliance records.



LOCAL SERVICE. NATIONAL PRESENCE.



Vendor Fee Transparency under the CAA

The Consolidated Appropriations Act, 2021 (CAA) introduced a major shift in the way group health plan vendors must disclose their compensation and plan sponsors must oversee it. Plan fiduciaries have a continuing duty to ensure vendor fees are reasonable under the Employee Retirement Income Security Act (ERISA).

Vendor Disclosure Requirements

Under the CAA, certain “covered service providers” to group health plans – including brokers, consultants, third-party administrators (TPAs), pharmacy benefit managers (PBMs), and others – must disclose detailed information about their compensation and services. The rule applies when a provider reasonably expects to receive \$1,000 or more in direct or indirect compensation in connection with brokerage or consulting services.

These disclosure rules apply not only to brokers who assist in selecting an insurer or TPA, but also to consultants and other vendors who advise on the design or operation of a health plan, including areas such as compliance, pharmacy benefits, wellness programs, and similar services. Disclosures must be provided in writing before a contract or renewal takes effect.

Each covered vendor must disclose:

- A description of all services provided
- Whether the vendor will act as a fiduciary
- All direct compensation paid by the plan
- All indirect compensation (commissions, rebates, referral fees, revenue sharing, or other forms of payment)
- The method, manner, and timing of payment

This transparency requirement is designed to help plan fiduciaries understand exactly what vendors are paid and how those payments might influence plan costs or vendor recommendations.

Fiduciary Duties

While the obligation to disclose rests with vendors, the responsibility to evaluate those disclosures lies squarely with the plan sponsor and fiduciaries to act prudently with that information. Fiduciaries must review the information to determine whether total compensation is reasonable for the services provided and whether any conflicts of interest exist.

If a vendor fails to provide the required disclosure prior to entering into an agreement, fiduciaries must:

1. Request it in writing and give the vendor up to 90 days to respond.
2. Notify the Department of Labor (DOL) if the vendor fails to comply, and decide prudently whether to terminate or continue the contract.

The DOL has indicated it will apply a “good-faith, reasonable interpretation” enforcement approach to vendor disclosure requirements and fiduciary implementation, but vendors and plan sponsors should note that this is only a temporary enforcement policy and should stay abreast of DOL guidance on enforcement and requirements.

Employer Action Items

CAA disclosure rules reinforce long-standing ERISA fiduciary principles. Plan sponsors must be able to demonstrate that vendor arrangements are transparent, compensation is reasonable, and participants’ interests come first.

By gathering disclosures now, confirming fees, and documenting your review, plan sponsors can strengthen fiduciary oversight, meet CAA transparency obligations, and reduce future compliance risk.

- Identify all brokers, consultants, TPAs, PBMs, and other service providers that may meet the disclosure threshold.
- Request and review written documentation of all compensation (direct and indirect) before renewals.
- Benchmark fees and confirm that services and costs align with market standards.
- Conduct bids for service providers as needed based on the benchmark assessment or if it has been more than three to five years since the last bid or review.
- Keep copies of disclosures, benchmarking data, meeting notes, and communications in your files in the event of audit or ERISA litigation – especially considering the recent trend of excessive fee litigation.
- Update contracts to include clear rights to fee and data transparency, audit access, and termination for non-compliance in future vendor agreements.



LOCAL SERVICE. NATIONAL PRESENCE.



New ACA FAQ on Fertility Benefits

On Oct. 16, 2025, the Departments of Treasury, Labor (DOL), and Health and Human Services (HHS) (“the Agencies”) jointly issued [FAQs About Affordable Care Act Implementation Part 72](#) to clarify how fertility-related benefits may qualify as “excepted benefits” under existing federal regulations.

The FAQs address how employers may offer fertility coverage outside of a group health plan without triggering the Affordable Care Act (ACA) market-reform requirements (i.e., health status nondiscrimination requirements, preventative care coverage, etc.). Specifically, the agencies examined three regulatory pathways:

1. Independent, non-coordinated excepted benefits
2. Excepted benefit health reimbursement arrangements (HRAs)
3. Employee Assistance Programs (EAPs)

Each approach has different compliance implications and design constraints that employers should evaluate carefully.

Independent, Non-Coordinated Excepted Benefits

The Agencies confirmed that fertility coverage may qualify as an independent, non-coordinated excepted benefit when offered through a fully insured policy that meets the existing excepted benefit requirements. To qualify:

- The benefit must be provided under a separate policy, certificate, or contract of insurance.
- The policy must operate independently of the employer’s primary group health plan, with no coordination of benefits or eligibility.
- Coverage must be available regardless of enrollment or benefits under the employer-sponsored health plan or other individual coverage.
- The policy cannot be self-funded by the employer.

The Agencies indicated that further rulemaking is under consideration to expand the ways that fertility benefits may qualify as excepted benefits, potentially including self-funded arrangements.

Employers pursuing this option should coordinate with an insurer to ensure the policy is separately issued and administered and review plan communications to confirm there is no overlap or coordination with the employer’s group medical plan.

Excepted Benefit HRAs

The FAQs also clarify that an excepted benefit HRA can reimburse fertility-related expenses, subject to the usual limits and eligibility rules. Under current law:

- The employer must also offer a group health plan that is not limited to excepted benefits or that is not an account-based health plan (i.e., HRA) to the same employee population.
- Annual employer contributions cannot exceed \$2,150 for 2025 (adjusted annually for inflation).
- Reimbursable expenses must qualify as medical care under Internal Revenue Code § 213(d).
- The HRA is available to all similarly situated individuals under the same terms.

An employer may design the HRA either to reimburse all medical expenses up to the annual limit or to restrict reimbursement to fertility-related expenses only.

This approach allows targeted financial support within defined limits. Employers should ensure plan documents and administrative systems accurately reflect the reimbursement scope and that employees receive clear guidance on eligible expenses.

Employee Assistance Programs (EAPs)

Finally, the agencies confirmed that an EAP can continue to qualify as an excepted benefit even if it offers fertility-related coaching, navigation, or education as long as it does not provide significant medical benefits.

An EAP would lose excepted benefit status if it:

- Provides or pays for clinical fertility treatments or other medical care.
- Coordinates benefits with the employer's group health plan.

Employers that wish to support employees through informational or counseling services can safely include those services within an EAP, provided they are non-medical and clearly independent of other plan coverage.

Employer Action Items

- Assess current coverage to determine whether and how fertility services are currently provided under existing plans.
- Consider whether offering fertility benefits as an excepted benefit aligns with the organization's cost and benefits strategy.
- Confirm that any new design meets the applicable excepted benefit criteria and complies with state insurance and tax requirements.
- Engage insurers, TPAs, or HRA administrators early to confirm operational feasibility.
- Amend plan documents, summary plan descriptions, and employee communications as needed.



LOCAL SERVICE. NATIONAL PRESENCE.



IRS Releases 2026 Cost-of-Living Adjustments

Each year, the IRS provides cost-of-living adjustments (COLAs) to the contribution limits applicable to employee benefits.

Health Flexible Spending Arrangements (FSAs)

Employees can contribute pre-tax dollars to pay for qualified medical expenses. Unused balances are generally forfeited unless the employer allows a grace period or limited carryover.

	2025	2026
Maximum salary reduction contribution	\$3,300	\$3,400
Maximum carryover to next plan year	\$660	\$680

Transportation Fringe Benefits

Employers may offer employees tax-free transportation benefits.

	2025	2026
Monthly parking benefit exclusion	\$325	\$340
Monthly transit and vanpooling limit	\$325	\$340

Qualified Small Employer Health Reimbursement Arrangements (QSEHRAs)

Small employers (generally under 50 employees) may reimburse employees for individual health coverage.

	2025	2026
Maximum for self-only coverage	\$6,350	\$6,450
Maximum for family coverage	\$12,800	\$13,100

Adoption Assistance Exclusion and Adoption Credit

Employers can exclude qualified adoption reimbursements from employee income.

	2025	2026
Maximum exclusion from gross income	\$17,280	\$17,670
Maximum adoption credit	\$17,280	\$17,670
Phase-out begins at Modified Adjusted Gross Income (MAGI)	\$259,190	\$265,080
Phase-out ends at MAGI	\$299,190	\$305,080

Dependent Care Assistance Program (DCAP)

The increase in the DCAP amount is a notable change. Since 1986, the dependent care FSA limit has remained at \$5,000 for married individuals filing jointly, with no adjustments for inflation. The recently passed “One Big Beautiful Bill” raised the limit to \$7,500 (or \$3,750 for married couples filing separately) for plan years starting in 2026. The new cap is still not indexed for inflation.

Unfortunately, many employers struggle to provide dependent care FSAs with sufficient participation to pass the 55% Average Benefits Test, causing many highly paid employees to be excluded from the tax benefits. This increased limit may make it even harder to pass the test.

	2025	2026
Maximum DCAP benefits – single or married filing separately	\$2,500	\$3,750
Maximum DCAP benefits – married filing jointly	\$5,000	\$7,500

Health Savings Accounts (HSAs)

Employees with high deductible health plans can contribute to HSAs.:

	2025	2026
Self-only contribution limit	\$4,300	\$4,400
Family contribution limit	\$8,550	\$8,750
Catch-up contribution if age 55 or older	\$1,000	\$1,000

Qualified High Deductible Health Plan

	Self-only		Family	
	2025	2026	2025	2026
Minimum deductible	\$1,650	1,700	\$3,330	\$3,400
Out-of-pocket expense limit	\$8,300	\$8,500	\$16,600	\$17,000

Employer Action Items

- Revise cafeteria plan documents, payroll systems, and summary plan materials to reflect the 2026 limits for FSAs, transportation benefits, QSEHRAs, DCAPs, and HSAs.
- Coordinate with payroll vendors, FSA and HSA administrators, and benefits vendors to implement the updated limits and confirm system readiness before Jan. 1, 2026.
- Decide whether to adopt the higher DCAP limit, and coordinate with your administrator to update plan documents, conduct nondiscrimination testing, and communicate the change to employees.
- Educate employees and HR staff on the 2026 COLA updates, highlighting key impacts on contribution opportunities and compliance requirements during open enrollment.



LOCAL SERVICE. NATIONAL PRESENCE.