



Stay Compliant with Employee Benefits Compliance Brief

An exclusive UBA Partner Firm monthly newsletter, focusing on one of your most important responsibilities — employer compliance.

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2026 Transparency in Coverage (TiC) Posting Requirements

Employers sponsoring non-grandfathered, self-funded group health plans and health insurance issuers remain responsible for the ongoing Transparency in Coverage (TiC) public posting requirements. Plans must publicly post machine-readable files (MRFs) that disclose in-network negotiated rates, out-of-network allowed amounts, and billed charges for covered items and services.

For fully insured coverage, the group health plan satisfies the TiC MRF posting requirement if the plan requires the health insurance issuer to provide the required MRF information.

These MRFs must be updated monthly. While updates are not required on a specific day of the month, they must be made at 30-day intervals. The TiC rules do not require retention of prior months' files, but the

Departments of Labor and Health and Human Services, and the Internal Revenue Service (the “Departments”) recommend maintaining prior months’ MRFs to help demonstrate compliance.

The Departments released [schema version 2.0](#) on Oct. 1, 2025, and beginning Feb. 2, 2026, will assess compliance for the in-network and out-of-network MRFs using schema v2.0.

The TiC rule also contemplates a prescription drug MRF (negotiated rates and historical net prices), and the Departments have indicated they intend to develop technical requirements and an implementation timeline. In 2025, the Departments issued a formal Request for Information (RFI) on the prescription drug MRF requirement, signaling continued activity in this area.

Employer Action Items

- Confirm whether the group health plan is non-grandfathered.
- Self-funded plans can contract with a third-party administrator (TPA) or other vendor to generate and host the MRFs, but if the vendor fails to post compliant files, the plan sponsor remains responsible.
- Fully insured plans should confirm that a written agreement is in place requiring the health insurance issuer to post the MRFs. If the issuer fails under that agreement, the issuer (not the plan) violates the TiC MRF posting requirement.
- Ensure the MRFs are publicly accessible, free of charge, and not gated (no account creation, password, credentials, or personally identifiable information required).
- If a TPA or vendor hosts the files on a third-party site, confirm that the employer’s or plan’s public website includes a link to the file location.
- Confirm that the posting clearly shows the “most recently updated” date and that the files are updated monthly (at approximately 30-day intervals).

IRS Issues Guidance on HSA-Related OBBBA Changes

On Dec. 9, 2025, the IRS released [Notice 2026-05](#) to explain how the One Big Beautiful Bill Act (OBBBA) expands health savings account (HSA) eligibility and clarifies common questions.

For employers, the biggest takeaway is practical: employees may have more paths to HSA eligibility, and certain benefit designs such as telehealth coverage, individual coverage health reimbursement arrangements (ICHRAs), and direct primary care arrangements need a closer compliance review.

The IRS addressed three HSA-related changes.

1. The telehealth safe harbor is now permanent (and applies retroactively for 2025 plan years).

The OBBBA permanently allows an otherwise HSA-eligible individual to keep HSA eligibility even if their high deductible health plan (HDHP) provides telehealth/remote care before the deductible is met, for plan years beginning on or after Jan. 1, 2025.

Notice 2026-05 also confirms that an otherwise eligible person may contribute to an HSA for 2025 even if their plan offered pre-deductible telehealth earlier in 2025 (before the OBBBA was enacted on July 4, 2025), as long as the plan otherwise satisfied HDHP requirements.

2. Certain bronze and catastrophic individual plans are treated as HDHPs starting in 2026.

Beginning Jan. 1, 2026, bronze and catastrophic plans available as individual coverage through an ACA Exchange are treated as HSA-compatible HDHPs even if they don't meet the usual HDHP deductible or out-of-pocket limits.

Key clarifications in Notice 2026-05 include:

- Off-Exchange coverage purchase can still qualify if the same plan is available on-Exchange.
 - The IRS provides a practical “good faith” rule when an individual cannot reasonably determine whether a plan is available on an Exchange.
 - SHOP (small group Exchange) coverage generally does not automatically qualify under this special rule because it is not individual coverage (though it could still qualify under the normal HDHP rules if it meets them).
3. Direct primary care service arrangements can coexist with HSA eligibility starting in 2026 if fee limits are met.

Starting Jan. 1, 2026, an otherwise eligible person enrolled in a qualifying direct primary care service arrangement (DPCSA) may remain HSA-eligible and can use HSA funds tax-free to pay DPC fees. However, the IRS specifically states that an HDHP generally may not pay DPC membership fees pre-deductible as an HDHP benefit.

To preserve HSA contribution eligibility, DPC fees generally must not exceed \$150/month (self-only) or \$300/month (covers more than one individual) in the aggregate, with inflation adjustments after 2026.

The arrangement must provide solely primary care services by primary care practitioners and be paid via a fixed periodic fee; certain services are excluded from “primary care services” (e.g., procedures requiring general anesthesia, most prescription drugs other than vaccines, and certain lab services).

Important: HSA distributions for DPC fees may still be permitted as qualified medical expenses even when the monthly fee limit is exceeded, but exceeding the limit can disqualify HSA contribution eligibility while enrolled.

Employer Action Items

- Confirm that your HDHP telehealth design aligns with the IRS Notice. If your HDHP covers telehealth pre-deductible, confirm that the services fit within the IRS framework (including the Medicare telehealth list approach described in the Notice).
- Coordinate with your insurance carrier, TPA, and HSA vendor to ensure the plan is still administered as an HDHP (e.g., claims adjudication rules for telehealth vs. in-person services).

- Update messaging in 2026 open enrollment and midyear communications to ensure employees understand that telehealth no longer breaks HSA eligibility. However, in-person services, equipment, or drugs connected to telehealth generally do not automatically become “telehealth” for HDHP purposes.
- Prepare for a potential increase in the number of employees who can contribute to HSAs, even if there are no changes to the group medical plan.
- If employees are allowed to make pre-tax payroll contributions to an HSA, confirm your processes can handle increased participation and eligibility questions.
- Confirm whether your HRA is structured to avoid disqualifying coverage for HSA purposes.
- Ensure your benefits team and vendors have a clear explanation ready to respond to employees who want to use an HRA and contribute to an HSA.
- Decide whether to subsidize or simply facilitate DPCSA.
- If you pay or reimburse DPC fees, evaluate whether the arrangement inadvertently becomes disqualifying coverage or creates ERISA/plan administration obligations (separate from the tax rules discussed here).
- Communicate the monthly fee limits for HSA contribution eligibility.
- For 2026, the Notice references \$150/\$300 monthly thresholds for maintaining HSA contribution eligibility while enrolled in a DPCSA.

Senate Vote on ACA Subsidies Fails

In a pair of closely watched votes on Dec. 11, 2025, the U.S. Senate failed to approve legislation to extend or replace expiring Affordable Care Act (ACA) premium tax credits that help millions of Americans afford marketplace health coverage. Neither the Democratic plan to maintain enhanced subsidies nor the Republican alternative that would shift funds into health savings accounts (HSAs) garnered the 60 votes required to advance under Senate rules. As a result, the enhanced premium tax credits expired Dec. 31, 2025, setting the stage for significant premium increases for many Americans beginning Jan. 1, 2026.

This legislative outcome adds urgency to broader national concerns about health care affordability, marketplace stability, and access to coverage — issues that, although focused on the individual market, can materially affect employers and their group health plans.

According to health policy research, enhanced premium tax credits, first expanded during the COVID-19 pandemic, have helped more than 20 million Americans reduce costs for individual market coverage. Without these subsidies:

- Average marketplace premiums are expected to rise sharply in 2026, with some estimates suggesting double-digit or higher percentage increases.
- Some individuals may drop marketplace coverage entirely if costs rise beyond their means, increasing the number of uninsured.

State legislators in some states are moving to cushion the impact. For example, Connecticut’s governor authorized \$70 million in state funds to offset federal subsidy cuts for low- and moderate-income residents in 2026.

Employer Considerations

Although the failed Senate vote focused on the individual, marketplace segment of health insurance, employers — particularly those offering group health plans — should be prepared for downstream effects that may influence workforce dynamics, benefits strategy, and compliance planning.

The expiration of enhanced ACA subsidies may heighten employees’ reliance on employer coverage and increase scrutiny of plan affordability, dependent coverage costs, and overall benefit value. Higher marketplace premiums may reinforce the value of employer-provided coverage, appearing to be more stable and cost-effective.

Without subsidies, marketplace coverage becomes more expensive, which could increase COBRA elections among terminating employees who need continuity of care.

Rising individual premiums may increase demand for employer-sponsored benefits, particularly comprehensive plans with predictable cost-sharing. For small businesses (under 50 employees not subject to ACA employer mandate), the affordability and attractiveness of employer plans versus marketplace coverage could shift. As a result, employer-sponsored benefits could have a greater effect on employee recruitment and retention.

CMS Releases ICHRA Employer Lowest Cost Silver Plan Premium Look-up Table

The [ICHRA Employer Lowest Cost Silver Plan Premium Look-Up Table](#) is published by the Centers for Medicare & Medicaid Services (CMS) to help employers determine whether an Individual Coverage Health Reimbursement Arrangement (ICHRA) they offer is considered “affordable” under ACA rules.

The Lookup Table contains the lowest cost silver plan premiums for individual Marketplace plans (qualified health plans) available in specific geographic areas. Silver plans are used because they are the benchmark for the ACA to ensure affordability and are the basis for calculating premium tax credits.

The table is intended for use with plans offered through Federally-facilitated Exchanges (FFE) and State-based Exchanges on the Federal platform (SBE-FPs).

This is important because:

- Applicable large employers (employers with 50 or more full-time equivalent employees) must offer affordable coverage or potentially face a penalty under the ACA’s employer mandate. The affordability test uses the cost of the Lowest-Cost Silver Plan (LCSP) in an employee’s area as a benchmark.
- Employers can use the Look-Up Table to compare their ICHRA allowances against LCSP premium data by geographic location (including differences by age or rating area).
- If the employer’s contribution via the ICHRA, when subtracted from the LCSP cost, results in an employee contribution that does not exceed the affordability threshold (a percentage of income set by IRS rules for that plan year), the coverage is considered affordable.

Employer Considerations

There are several important employer considerations when using the Look-Up Table for the 2026 plan year, especially for ALEs trying to stay compliant with the ACA employer mandate.

- CMS's Lowest Cost Silver Plan (LCSP) Look-Up Table is an approved safe harbor for determining the applicable benchmark premium for ICHRA affordability. Using the table correctly helps avoid penalties.
- If the employee's required contribution exceeds the applicable IRS affordability threshold (as measured against household income or an employer affordability safe harbor), the ICHRA is unaffordable for that employee and may trigger §4980H(b) penalty exposure if the employee receives a premium tax credit.
- Employees must be informed whether the ICHRA is considered affordable as affordability affects eligibility for premium tax credits.
- To be ready for possible IRS audits, employers should retain the LCSP table version used, the ZIP code or rating area logic data, employee age assumptions, affordability calculations, and contribution schedules.

Guidance on Alternative Manner for ACA Health Coverage Reporting

Early in 2025, the IRS issued [Notice 2025-15](#), providing guidance on an optional alternative method employers may use to satisfy ACA reporting requirements under Internal Revenue Code Sections 6055 and 6056 to furnish health coverage statements to individuals, including full-time employees of applicable large employers (ALEs).

Background

Under the ACA, certain entities must annually report health coverage information.

- Section 6055 applies to providers of minimum essential coverage (MEC), such as health insurers and self-insured employers. These entities file Form 1094-B and 1095-B with the IRS and furnish Form 1095-B to covered individuals.
- Section 6056 applies to ALEs (employers with more than 50 full-time and full-time equivalent employees). ALEs file Form 1094-C and 1095-C with the IRS and furnish Form 1095-C to their full-time employees about the coverage offered.

Historically, employers were required to furnish paper statements to all employees. Notice 2025-15 clarifies when they may instead use a streamlined method based on online posting and requests.

The Alternative Manner of Furnishing Statements

The Paperwork Burden Reduction Act amended IRC Sections 6055(c) and 6056(c) to allow a reporting entity to comply if it:

1. Provides clear and conspicuous notice, in a location on its website that is reasonably accessible to all responsible individuals, that the individual may receive their statement upon request.
2. Furnishes the statement upon request in a timely manner.

The alternative method is available to ALEs, self-insured employers and other MEC providers, and health insurers.

This method does not alter IRS filing requirements; it only affects how statements are furnished to individuals.

The notice must be posted by the due date for furnishing statements (including the automatic 30-day extension) and retained in the same location at least through October 15 following the applicable plan year. It must include the email address, telephone number, and physical mailing address for statement requests.

If an individual requests a copy of their 1095 form, the employer must furnish it within 30 days of the request or by January 31 of the year following the calendar year to which the form relates, whichever is later. Employers may furnish statements electronically if permitted under applicable electronic consent rules.

For the 2025 calendar year reporting, Forms 1095 must be furnished to employees by March 2, 2026, whether in paper or using the alternative notice method.

Employer Action Items

- Evaluate the cost and administrative savings from reducing mass distribution of 1095 forms.
- Consider employee population and communication channels to ensure effective notice access.
- Ensure the notice is prominently displayed on your public website or an employee portal.
- Maintain an archive of annual notices and retention through October 15.
- Assign responsibility for processing requests within the 30-day window.
- Create clear internal tracking and documentation for requests and responses.
- Confirm that electronic delivery meets regulatory requirements (including employee consent where required).
- Remember that some states or localities may have separate health coverage reporting requirements that are unaffected by federal changes.
- Align ACA reporting processes with payroll and HR systems to ensure timely filing and furnishing.

IRS Guidance on ACA Reporting and Submissions

The IRS has published two guides to assist in Affordable Care Act (ACA) reporting in 2026 for the 2025 plan year.

[IRS Publication 5258](#) is the Affordable Care Act (ACA) Information Returns (AIR) Submission Composition and Reference Guide and provides technical guidance to employers and third-party administrators that are required to electronically file ACA information returns with the IRS.

The publication contains detailed technical information and specifications on how to compose and successfully transmit compliant electronic submissions to the IRS, including secure communication protocols, file structures, and data requirements for forms like 1094 and 1095 series.

[IRS Publication 5223](#), General Rules and Specifications for ACA Substitute Forms 1095-A, 1094-B, 1095-B, 1094-C, and 1095-C, provides information on using official IRS forms, preparing acceptable substitute forms for filing information returns, and using either official or substitute forms to provide information to recipients for the 2025 tax year.

The guide also details technical and design specifications for substitute forms to ensure they are complete, scannable, and easily processed by the IRS, along with guidance on electronic delivery of statements to recipients and using a website notice as an alternative method for certain forms.

Texas Passes the Woman and Child Protection Act

Texas House Bill 7, the Woman and Child Protection Act (the “Act”), took effect on Dec. 4, 2025, allowing private citizens to sue people who import abortion-inducing drugs into Texas, with statutory damages of at least \$100,000 per violation.

Background

After the 2022 U.S. Supreme Court’s decision that overturned *Roe v. Wade*, Texas implemented a broad criminal ban on elective abortion through the Human Life Protection Act. As a result, abortion-inducing medications are increasingly being purchased online from out-of-state sources. This new Act is intended to deter that activity by using a civil enforcement model similar to the Texas Heartbeat Act, which relies on lawsuits brought by private individuals rather than direct government enforcement.

The Act

The Act allows any private citizen to file a civil lawsuit against a wide range of parties connected to abortion-inducing drugs in Texas. Potential defendants include anyone who manufactures, distributes, mails, transports, delivers, prescribes, or otherwise provides abortion-inducing drugs in Texas. The scope is deliberately broad and can reach out-of-state parties, not just individuals physically located in Texas.

If the plaintiff succeeds, defendants could be subject to damages of at least \$100,000 per violation, injunctive relief (a court order to stop the activity), attorneys’ fees and costs. A prevailing private citizen who is not related to the pregnant individual would be entitled to 10% of the awarded amount, with the remainder directed to a charity chosen by the plaintiff.

Key Exemptions and Carve-Outs

- No lawsuits are permitted against a pregnant person who seeks or obtains abortion-inducing drugs for their own use.
- No lawsuits are permitted against hospitals, healthcare facilities, and physician groups.
- Coverage for use of abortion-inducing drugs in certain circumstances such as medical emergencies, ectopic pregnancies, or removal of a deceased unborn child is permitted.
- Conditional protections exist for certain intermediaries and infrastructure providers, including internet service providers, search engines, cloud providers, transportation companies, delivery networks, and pharmaceutical manufacturers.
- Speech or conduct protected by the First Amendment is exempted.

Why This Matters to Health Plans and Employers

Plan sponsors are not expressly exempt from the Act. That means an employer whose drug benefit program is viewed as covering abortion-inducing drugs in a way the Act treats as unlawful could become a target for litigation.

Two practical challenges increase uncertainty and risk:

1. The Act does not clearly define what it means to “distribute” or “provide” these drugs, leaving ambiguity about when benefit-related activity could be alleged to cross the line.
2. Because enforcement is driven by private citizens, employers could face lawsuits from individuals motivated by ideology or potential financial gain—even where the underlying claim is weak—creating meaningful defense costs regardless of outcome.

Under ERISA, state laws are generally preempted when they “relate to” employee benefit plans, which may provide protection for many private-sector employers (excluding governmental and church plans). In addition, abortion shield laws in some states (designed to protect patients and providers from cross-border enforcement efforts) have made similar lawsuits difficult to pursue in some circumstances, though how these dynamics will play out under this Texas law remains unclear.

Employer Action Items

- Employers with self-funded plans that cover abortion-inducing medications in Texas should proactively evaluate whether to continue that coverage, understanding that the Act increases the risk of being pulled into civil litigation.
- Coordinate with ERISA counsel to assess preemption arguments and litigation posture.
- Review plan design and pharmacy benefit administration to understand how and where abortion-inducing drugs may be covered, accessed, or shipped.
- Clarify vendor roles and contractual protections (e.g., indemnification, claims handling, and where clinical decisions are made).

- Prepare for employee communications that are accurate and supportive, while staying within legal guardrails.
- Monitor ongoing developments, since the law is expected to face legal challenges and the enforcement landscape could shift quickly.

Important Reminders

Make price comparison information available online

Most non-grandfathered group health plans are required to provide cost-sharing information for all covered items and services (including prescription drugs) through an internet-based self-service tool (and in paper form upon request).

Employers with fully insured plans should confirm their insurance carrier will comply with the requirement.

Self-insured plans should confirm with their third-party administrators (TPAs) or other service providers that they will comply with this requirement on behalf of the plan.

Plans should get the issuer or administrator's agreement to provide the self-service tool in writing.

Submit Gag Clause Attestation

Employers and carriers must have submitted an attestation of compliance with the gag clause prohibition contained in the Consolidated Appropriations Act (CAA) by Dec. 31, 2025.

Group health plans that have been granted a Form 5500 extension must have furnished the Summary Annual Report within two months after the close of the extension period, by Dec. 15, 2025.

W-2 deadline for 2025 wages

Furnish Form W-2 to employees by Monday, Feb. 2, 2026. The standard deadline is Jan. 31, 2026, but since that date falls on a weekend, the due date shifts to the next business day, Feb. 2.

Question of the Month

Q. A California company has Kaiser and UHC policies and subject to COBRA. Separately, they opened a Kaiser Hawaii policy for their sole employee in Hawaii who has since left the company. There are no plans to hire another employee in Hawaii. Is the company required to keep the Hawaii policy active to accommodate the employee who needs to be offered COBRA?

A. The employer is not required to keep the Hawaii Kaiser policy in effect if the employer no longer has any active Hawaii employees. The employee would be entitled to COBRA under the Kaiser CA and UHC policies.

Answers to the Question of the Week are provided by Kutak Rock.

This information 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.

