



## EMPLOYEE BENEFITS COMPLIANCE BRIEF



### UBA EXPERT COMPLIANCE RESOURCES

## Stay Compliant with the Employee Benefits Compliance Brief

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

April 2026

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## DOL Extends Comment Period on Proposed PBM Fee Disclosure Rule

The Department of Labor (DOL) has [announced](#) a short extension to the comment period for its proposed rule on pharmacy benefit manager (PBM) compensation transparency. The rule is intended to strengthen disclosure requirements for PBMs and related service providers working with self-insured group health plans subject to ERISA.

Employers and other stakeholders now have until April 15, 2026, to submit comments, an additional 15 days beyond the original March 31 deadline.

The extension follows the passage of the [Consolidated Appropriations Act, 2026](#) (CAA, 2026), which includes new statutory requirements affecting PBMs and plan transparency. The DOL asks stakeholders to [comment](#) on whether the rule should be revised to align with new statutory requirements, whether additional provisions are needed and how to minimize administrative complexity while maintaining transparency goals.

For sponsors of self-insured health plans, this rule represents a continued shift toward greater fiduciary responsibility and visibility into vendor compensation.

## Why This Rule Matters

PBMs play a central role in managing prescription drug benefits for employer-sponsored health plans. In recent years, they have gained increased influence over drug pricing, rebate arrangements, and formulary decisions.

The proposed rule stems from a presidential directive aimed at:

- Increasing visibility into PBM compensation structures
- Reducing prescription drug costs
- Promoting accountability in the healthcare supply chain

Employers have much to gain, including improved insight into how PBMs are paid, better tools to evaluate contract terms and increased leverage in negotiating pharmacy benefit arrangements

At the same time, the changes may introduce additional administrative oversight responsibilities and greater scrutiny of plan fiduciary decisions.

## Key Provisions of the Proposed Rule

If finalized, the rule would impose new disclosure obligations on PBMs and the brokers and consultants that use PBM services.

Service providers would need to disclose:

- Direct compensation received from the plan
- Indirect compensation, including payments from third parties
- Expected future compensation (advanced estimates)

These disclosures are intended to help plan fiduciaries evaluate whether service arrangements and associated fees are reasonable under ERISA's prohibited transaction rules.

The proposal also includes audit provisions, allowing plan fiduciaries to verify the accuracy of disclosed compensation and whether compensation aligns with contractual terms. The aim is to give employers more practical oversight of PBM arrangements.

The CAA, 2026 introduces several statutory changes that directly affect PBM transparency and oversight:

- The law amends ERISA Section 408(b)(2) to require additional reporting on fees, rebates, discounts, and other compensation.
- PBMs may be required to pass through certain rebates and price concessions to the group health plan.
- A new ERISA provision requires PBMs to provide regular reports to group health plans, including drug cost data, utilization information and reporting at least every six months and quarterly, if requested by the plan.

## Employer Action Items

- Review current PBM contracts for transparency provisions. Inadequate documentation of fee reasonableness may increase exposure during audits.
- Identify what compensation disclosures are currently available (and what is missing). Failure to properly assess PBM compensation could raise ERISA fiduciary concerns.
- Consider submitting comments to the DOL by April 15, 2026.

## April 15 Deadline for 2025 HSA Contributions and Corrections

As the tax filing deadline approaches, employers and employees have a final opportunity to act on health savings account (HSA) contributions for the prior year. April 15, 2026, marks the last day to make 2025 HSA contributions or correct contribution errors, making this an important compliance and planning checkpoint for employer-sponsored health plans.

HSA rules allow contributions to be made for a given calendar year until the individual's tax filing deadline, which is generally April 15 of the following year. For the 2025 tax year, contributions may be made between January 1, 2025, and April 15, 2026. Contributions made in early 2026 can still be applied toward the 2025 annual limit, provided they are properly designated.

This same deadline also applies to correcting contribution errors, including excess contributions or missed funding opportunities. While this extended window offers flexibility, it can also create confusion for employees and additional coordination considerations for employers.

### 2025 HSA Contribution Limits

Contribution limits for 2025 are \$4,300 for individuals or \$8,550 for families, with an additional catch-up contribution of \$1,000 allowed for individuals over age 55.

Employers should remind employees that the limits apply to the total of employer and employee contributions.

### Contributions and Corrections: What's Still Allowed

Employees who did not fully fund their HSA during 2025 still have time to make additional contributions before April 15, 2026. These contributions can be made directly through the HSA custodian and designated for the prior year. In some cases, employers may also choose to make contributions during this extended period, depending on plan design and administrative capabilities.

This deadline is also critical for employees who may have contributed more than the allowable IRS limit. Excess contributions can generally be corrected by withdrawing the excess amount, along with any associated earnings, before the deadline. Taking corrective action in time helps employees avoid the 6% excise tax that applies to uncorrected excess contributions.

In addition, the extended window provides an opportunity for employees to "true up" their contributions. For example, individuals who became HSA-eligible mid-year or who under-contributed due to cash flow constraints can use this period to reach the maximum allowable contribution for 2025.

## Eligibility Rules Still Govern Contributions

Even though contributions can be made after year end, eligibility is still determined based on the individual's status during 2025. To contribute to an HSA, an individual must have been enrolled in a qualified high-deductible health plan (HDHP), have no disqualifying coverage, and not be enrolled in Medicare or claimed as a dependent.

Employers should take care to reinforce that eligibility rules still apply when communicating about this deadline. Employees may mistakenly assume that anyone can contribute during the extended period, which can lead to compliance issues and tax consequences.

## Employer Role and Administrative Considerations

Although HSAs are individually owned accounts, employers often play an important role in supporting employee understanding and facilitating contributions through payroll. However, contributions made after the close of the calendar year are typically handled outside of payroll and made directly with the HSA custodian.

This distinction can create administrative challenges. Employers may have limited visibility into post-year-end contributions, which can complicate reconciliation efforts and employee questions. It also underscores the importance of accurate W-2 reporting for employer contributions made during the calendar year.

## Common Compliance Pitfalls

Several common issues arise around the HSA contribution deadline. Employees may inadvertently exceed contribution limits when combining employer and employee funding. Others may misunderstand eligibility rules, particularly if they enrolled in Medicare or had other disqualifying coverage during the year.

There is also potential confusion around properly designating contributions made in early 2026 for the 2025 tax year. If contributions are not coded correctly by the HSA custodian, they may be applied to the wrong year. Additionally, failure to correct excess contributions before the deadline can result in avoidable tax penalties.

## Employer Action Items

- Consider sending a clear and timely reminder to employees about the April 15, 2026, deadline to encourage employees to review their total 2025 contributions, confirm their eligibility status, and take any necessary action before the cutoff. Direct employees to the HSA custodian for specific instructions on making contributions or corrections.
- Confirm that employer contributions for 2025 were accurately tracked and reported. Coordination between payroll, finance, and HSA vendors can help identify and resolve any discrepancies before they become larger issues.
- Ensure accurate reporting of employer contributions on Form W-2. While employers are not responsible for monitoring all sources of employee HSA contributions, they are responsible for accurately reporting employer contributions. Incorporate HSA education into broader year-end and tax-season communication strategies. Evaluate whether current vendors provide sufficient tools and support for employee education and contribution tracking, to improve the overall effectiveness of the HSA program.

## RxDC Reporting for 2026: What Employers Need to Know About Prescription Drug Data Collection

[Prescription Drug Data Collection](#) (RxDC) reporting remains a key federal compliance requirement for employer-sponsored health plans. As part of broader transparency efforts under the [Consolidated Appropriations Act, 2021](#) (CAA), employers must ensure that detailed information about prescription drug costs and overall healthcare spending is submitted annually to federal regulators.

For the 2025 reference year, reports are due no later than June 1, 2026, and no extensions are available. Many carriers and TPAs require employer input well before the federal deadline to allow vendors time to compile and submit the full report.

### What Is RxDC Reporting?

RxDC reporting is a federal data submission requirement designed to improve transparency in prescription drug pricing and healthcare costs. It requires group health plans and insurers to report a wide range of financial and utilization data to the Centers for Medicare & Medicaid Services (CMS). Federal agencies use this information to better understand cost drivers, trends in drug pricing, and the impact of rebates and fees on employer plans and participant costs.

RxDC reporting can also offer employers insight into plan spending trends, particularly for prescription drugs, to help guide future plan design, cost management strategies, and vendor negotiations.

RxDC reporting continues to be a significant annual compliance requirement with operational and strategic implications. Employers that take a proactive and coordinated approach will be better positioned to meet deadlines, reduce risk, and gain value from the data being reported.

### Who Must Comply

RxDC reporting applies broadly across employer-sponsored health coverage and includes fully insured, self-funded, and level-funded group health plans of all sizes.

Certain excepted benefits (like standalone dental or vision, and most EAPs or HSAs) are not subject to RxDC reporting.

Even when reporting responsibilities are delegated to vendors, the legal obligation ultimately remains with the plan sponsor, particularly for self-insured arrangements.

### What Data Must Be Reported

Plans, issuers, and carriers must submit plan (P) and drug (D) data, along with a narrative response. Together, these provide a comprehensive view of plan costs and prescription drug utilization.

Plan-level information includes:

- Plan name and identifying information
- Enrollment and participant counts
- Average monthly premiums paid by employers and employees

Drug and cost data includes:

- Total healthcare and prescription drug spending
- The most frequently used prescription drugs
- The most costly drugs
- Drugs with the greatest increase in spending
- Manufacturer rebates and fee arrangements

The narrative response describes the impact of prescription drug rebates on premium and cost sharing.

These data elements allow regulators to analyze how prescription drugs contribute to overall healthcare costs and premium increases.

Completing the RxDC report requires coordination across multiple parties:

- Insurance carriers or TPAs provide claims and spending data.
- Pharmacy Benefit Managers (PBMs) supply drug pricing, rebate, and utilization information.
- Employers contribute plan-level details such as premium contributions and enrollment data.

Because no single entity holds all required data, successful reporting depends on collaboration and timely information sharing.

## Employer Responsibilities: More Than a “Hands-Off” Requirement

Although many employers rely on carriers, TPAs, or PBMs to submit RxDC reports, employers still play an active role in the process.

For fully insured plans, the insurance carrier typically handles the filing. However, employers are often required to:

- Review and confirm plan information
- Provide contribution and enrollment data
- Respond to carrier-issued surveys or questionnaires

For self-insured plans, the employer is technically responsible for the filing but may delegate the task to a vendor through a written agreement. Even in these cases, the employer retains compliance liability if reporting is incomplete or inaccurate.

## Penalties and Compliance Risk

Failure to comply with RxDC reporting requirements may trigger penalties under the Internal Revenue Code §4980D of \$100 per day per affected individual.

Beyond financial penalties, incomplete or inaccurate reporting may also raise fiduciary concerns, particularly for self-insured plan sponsors.

## Employer Action Items

- Confirm early in the year who is responsible for submitting the RxDc report. This includes reviewing agreements with carriers, TPAs, and PBMs to ensure responsibilities are clearly defined.
- Watch for data requests in advance of the June 1 deadline and respond promptly to avoid delays or incomplete filings.
- Confirm what data each vendor will provide and what information the employer must supply. Written confirmation of filing responsibility is the best practice.
- Understand that delegating reporting does not eliminate liability. Inaccurate or incomplete filings can result in penalties and potential fiduciary exposure.

## Question of the Month

### Employee HSA Contributions with Spouse on Medicare

**Q.** An employee is under age 65 and has employee plus spouse coverage but the spouse is over age 65 and enrolled in Medicare. Is the employee limited to the individual maximum for HSA contributions?

**A.** The family HSA limit is available to this employee regardless of whether the spouse has other coverage, like Medicare. As long as the employee has employee + 1 or family HDHP coverage, the employee can contribute the family limit to their HSA.

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