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EMPLOYEE BENEFITS COMPLIANCE RECAP



UBA EXPERT COMPLIANCE RESOURCES

Compliance Recap | October 2025

Nov. 5, 2025

In October, the IRS announced 2026 penalties for failure to file or furnish ACA reporting forms and published an FAQ clarifying certain infertility benefits and the 2026 Cost of Living Adjustments. California expanded its Paid Family Leave program to include “designated persons” and enacted a groundbreaking bill impacting pharmacy benefit managers.

2026 Penalties for Failure to File or Furnish ACA Reporting Forms 1095-C and 1094-C

The IRS has announced the 2026 penalties for failure by Applicable Large Employers (ALEs) to file or furnish Affordable Care Act (ACA) reporting Forms 1095-C and 1094-C for the 2025 tax year. Amounts can increase significantly depending on how late the filing is or if the failure is determined to be intentional disregard.

Filing is due by March 31, 2026, if filing electronically, or by Feb. 25, 2026, if filed on paper.

Penalty structure:

- Incorrect or late reporting: \$340 per form
- Failure to file with the IRS and failure to furnish a statement to an employee: \$340 per form
- If the IRS finds that the failure to file or furnish was due to intentional disregard: \$680 per return, with no annual maximum.
- If the failure is corrected within 30 days of the due date, the penalty is reduced to \$60 per return.
- If the failure is corrected more than 30 days after the deadline but by Aug. 1, 2026, the penalty is \$130 per return.



IRS Releases FAQ on Affordable Care Act Implementation

On Oct. 16, 2025, the Departments of Labor, Health and Human Services, and Treasury (the “Agencies”) released [FAQ 72: Affordable Care Act Implementation](#), clarifying that certain fertility benefits may qualify as “excepted benefits” under federal law. The guidance, issued with a [White House Fact Sheet](#) and in connection with the 2025 [Executive Order on Expanding Access to In Vitro Fertilization](#) (IVF), outlines new opportunities for employers to offer fertility coverage outside of traditional group health plans.

Expanding Access Through Excepted Benefits

Employer-sponsored health plans are subject to extensive federal requirements under the Affordable Care Act (ACA), Health Insurance Portability and Accountability Act (HIPAA), and the Employee Retirement Income Security Act (ERISA). “Excepted benefits” are exempt from many of these provisions.

Under the new guidance, fertility benefits may now qualify as excepted benefits, making them easier for employers to offer. The coverage could be offered through a standalone plan, similar to dental or vision benefits, rather than embedding such benefits within a major medical plan.

Independent, Non-Coordinated Excepted Benefits

One option for employers is to offer fertility coverage as an independent, non-coordinated excepted benefit. To qualify, the benefit must be:

1. Provided under a separate policy, certificate, or contract of insurance;
2. Independent from any exclusions under the employer’s primary health plan; and
3. Payable without regard to whether benefits are available under another group plan from the same sponsor.

Importantly, this benefit must be fully insured. Employees can enroll in a standalone fertility policy without enrolling in the employer’s group health plan, and participation will not disqualify them from contributing to a health savings account (HSA) if they are covered by a high-deductible health plan.

Limited Excepted Benefits

The FAQs also clarify that fertility coverage can be structured as a limited excepted benefit, the same category that applies to dental, vision, and employee assistance plans (EAPs).

Employers may offer an excepted benefit health reimbursement arrangement (HRA) to reimburse fertility-related out-of-pocket expenses, subject to specific conditions:

- The HRA must be entirely employer-funded, with no employee premiums or cost-sharing.
- A benefit cap of \$2,150 must apply for plan years beginning in 2025 and \$2,200 for 2026.
- Coverage must remain separate from the main group health plan.



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Employers may also provide fertility coaching or navigation services through an EAP that qualifies as a limited excepted benefit, as long as the EAP does not offer significant medical treatment. Fertility treatment itself must be provided under a separate group health plan to preserve the EAP's excepted benefit status.

Employer Considerations

The Agencies plan to issue proposed regulations expanding the ways fertility benefits can qualify as limited or supplemental excepted benefits. They are also considering updates to current limits (such as the 15% cap on the cost of supplemental coverage relative to primary health coverage) to allow more flexibility for employers.

IRS Releases 2026 COLAs

The IRS has issued 2026 cost-of-living adjustments for several provisions of the Internal Revenue Code that affect employer-sponsored benefit plans.

Health Flexible Spending Arrangements (FSAs)

	2026	2025
Employee contribution limit	\$3,400	\$3,300
Maximum carryover	\$680	\$660

Qualified Transportation Benefits

	2026	2025
Monthly limit for transit, vanpool, and parking benefits	\$340	\$325

Qualified Small Employer Health Reimbursement Arrangements (QSEHRAs)

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

Excepted Benefit HRAs

	2026	2025
Annual limit	\$2,200	\$2,150



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Health Savings Accounts (HSAs)

	Self-only		Family	
	2026	2025	2026	2025
Contribution limit	\$4,400	\$4,300	\$8,750	\$8,550
Minimum deductible	\$1,700	\$1,650	\$3,400	\$3,300
Out-of-pocket expense limit	\$8,500	\$8,300	\$17,000	\$16,600

Highly Compensated and Key Employee Thresholds for Nondiscrimination Testing

	Highly compensated	Key employee
Salary threshold	\$160,000	\$230,000

Group Health Plan Cost-Sharing Limits

	Self-only	Family
Maximum annual out-of-pocket limit (non-grandfathered plans)	\$10,600	\$21,200

Employer Considerations

Employers with plan years beginning on or after Jan. 1, 2026, should update plan documents, payroll systems, and employee communications to reflect these new limits. Reviewing nondiscrimination testing thresholds and benefit designs now will help ensure a smooth transition into the 2026 plan year.

California Expands Paid Family Leave Program

California has expanded its Paid Family Leave (PFL) program to better reflect the diverse relationships that shape modern caregiving. Governor Gavin Newsom recently signed Senate Bill (SB) 590, extending state-paid family leave benefits to employees who take time off to care for a “designated person,” defined as someone related by blood or whose relationship is equivalent to that of family.

This legislation builds on Assembly Bill (AB) 1041, passed in 2022, which first allowed employees to take job-protected leave under state law to care for a designated person. However, at that time, the state’s PFL program did not provide wage replacement benefits for such leave. SB 590 now aligns the benefit structure with the leave entitlement, ensuring that eligible employees can receive financial support when caring for those who are like family, even if not legally or biologically related.

Beginning July 1, 2028, California workers will be able to claim PFL benefits to care for a designated person. When applying, employees must identify their designated person and attest, under penalty of perjury, how that individual qualifies, whether through blood relation or an equivalent close bond.



SB 590 marks a significant step in recognizing the importance of caregiving relationships beyond traditional definitions of family, supporting a more inclusive and compassionate approach to employee leave.

Employer Considerations

Employers can mark their calendar to prepare appropriate documents prior to the start date of July 1, 2028.

California Enacts New PBM Law

California has enacted Senate Bill 41, a groundbreaking new law that redefines how pharmacy benefit managers (PBMs) operate in the state. Signed by Governor Gavin Newsom, the law strengthens oversight, transparency, and fairness in the prescription drug marketplace—changes that will have meaningful implications for employers, health plans, and pharmacies.

SB-41 gives employers and plan sponsors greater control and clarity over pharmacy benefit costs, ensuring that rebate savings flow directly to their plans and participants. By mandating fiduciary responsibility and transparency, California's new PBM framework empowers HR and benefits leaders to negotiate more effectively and align pharmacy benefits with organizational goals for affordability and fairness.

Key Points for Employers and Health Plans

- Fiduciary duty and licensing.
PBMs must now act in the best interests of their clients, including employers and health plans, and maintain state licensing through the Department of Managed Health Care (DMHC), which will conduct routine audits.
- Full rebate pass-through and ban on spread pricing.
PBMs must pass 100% of manufacturer rebates directly to the payer and accept as compensation only fees that are not tied to drug price metrics. They are prohibited from profiting through spread pricing.
- Transparency and reporting.
PBMs are required to share detailed quarterly reports on pricing, rebates, and pharmacy arrangements upon request, providing better visibility into how dollars are spent.
- Fair pharmacy practices.
The law prohibits steering patients to PBM-affiliated pharmacies, requires equal reimbursement terms, and eliminates extra transmission fees on pharmacy claims.
- Patient protections.
Health plans cannot charge members more than the actual cost of their prescriptions, and PBMs may only enter exclusive drug contracts that result in lower costs for both plans and patients.



Employer Considerations

- Determine whether your health plan offerings are fully insured or self-insured and whether they fall under California law for SB 41.
- Review your current PBM and pharmacy benefit contracts: look for spread pricing, rebate retention, exclusive arrangements, steering clauses, and non-affiliated pharmacy discrimination.
- During upcoming contract renewals or amendments (especially those effective Jan. 1, 2026, and later), ensure contract language aligns with SB 41 (or addresses whether your plan is exempt).
- Negotiate or confirm disclosure rights, including quarterly rebate/fee disclosures, de-identified utilization data, payment flows.
- Confirm that point-of-sale adjudication is set up to ensure member cost-sharing does not exceed the actual rate paid, if applicable under SB 41.
- Work with your PBM or insurance carrier to understand how their compliance plan for SB 41 will interface with your plan: Are they changing pricing models? Are they segregating California businesses? How will they handle mixed state operations?
- Update your vendor oversight and compliance monitoring process to include SB 41 compliance in your vendor risk assessment, contract management database, and audit program.
- Educate internal staff (benefits team, finance, and procurement) on the changes and be prepared to communicate any updates to employees regarding changes to networks, cost-sharing, or pharmacy options.
- Budget for potential impact. With changes in the PBM business model, pricing, and rebate flow, there may be shifts in premiums, cost-sharing, or overall drug costs. Review and update your projections accordingly.

Form 5500 Extension Filing

ERISA welfare plans with 100 or more plan participants as of the first day of the plan year were required to file [IRS Form 5500](#) by the last day of the seventh month following the end of the plan year. Employers that needed more time were able to request an extension of up to 2.5 months by filing Form 5558 by the original due date. This moved the deadline to October 15 for a calendar-year plan.

Medicare Part D Creditable Coverage Disclosure Notices

The annual coordinated election period for Medicare Part D begins on October 15 each year. It runs through December 7, with any coverage changes taking effect on January 1 of the following year.

During this period, also known as the Annual Enrollment Period (AEP) or Open Enrollment, beneficiaries can:

- Enroll in a Part D prescription drug plan for the first time.
- Switch from one Part D plan to another.
- Change from Original Medicare to a Medicare Advantage Plan.
- Switch from a Medicare Advantage plan back to Original Medicare.

Employer Considerations

Group health plans that provided prescription drug coverage to Medicare Part D eligible individuals were required to disclose whether that coverage was creditable or not creditable before the start of the annual coordinated election period for Medicare Part D. Model disclosure notices are available on the [Centers for Medicare & Medicaid \(CMS\) website](#).

Maryland Family and Medical Leave Insurance Program to Begin January 2027

On Oct. 17, 2025, the Maryland Department of Labor (DOL) released new guidance on the state's Family and Medical Leave Insurance (FAMLI) program, providing employers with important updates on timelines, compliance options, and next steps.

Background and Key Dates

FAMLI will provide eligible Maryland workers with up to 12 weeks of paid, job-protected leave to care for their own health or that of a family member. Originally slated to begin in 2026, implementation has been delayed:

- Employer contributions now begin Jan. 1, 2027. Employers may withhold up to 50% of the contribution from employee wages.
- Paid leave benefits will be available to employees starting Jan. 3, 2028.

Compliance Options

Employers can satisfy FAMLI requirements in one of three ways:

1. Participate in the state-administered plan.
2. Purchase a commercial plan through a private insurer.
3. Establish an Equivalent Private Insurance Plan (EPIP), subject to state approval, offering benefits equal to or better than the state plan.

Regulatory Developments

The Maryland DOL has issued proposed regulations (Chapters 1, 2, 3, and 5) covering key areas such as definitions, contributions, EPIP rules, and dispute resolution. Chapter 4, addressing claims administration, is expected to be released soon.

Updated FAQs

Newly released [FAQs](#) provide practical guidance on contributions, claims processing, and coordination with private plans—helping employers understand how the FMLI program will interact with existing leave benefits.

Employer Considerations

- Determine whether to use the state plan, a commercial plan, or an EPIP.
- Review and align existing leave and pay policies with FMLI requirements.
- Plan for payroll and benefits administration changes in 2027.
- Educate HR teams and employees about the upcoming program and timelines.

Question of the Month

Q. Is there any precedent that would allow a member to enroll in a group medical plan due to the government shutdown?

The employee is enrolled in a spouse's Tricare plan and was told by a Tricare physician that she may not be able to receive all of her maternity check-ups due to the government shutdown. Could this be considered a qualifying life event allowing enrollment in an employer's health plan outside of open enrollment?

A. On its face, the government shutdown, and potential ramifications to Tricare, is not a qualifying life event. That said, there is a qualifying life event for a "significant curtailment of coverage" under a plan. For example, if a PPO includes two hospital systems in one town, and one hospital system leaves the plan, that could be a significant curtailment of coverage triggering a qualifying life event. Arguably, if the government shutdown impacts Tricare so much as to create a significant curtailment of coverage, then I could see an employer saying it is a qualifying life event. The risk with that argument is that no one knows how long the government shutdown will last. If the shutdown lasts six months, the argument that it constitutes a significant curtailment of coverage is pretty strong. But if the shutdown ends tomorrow, the IRS would likely disagree that a two-week shutdown constituted a significant curtailment. And of course, no one can predict the future and know for sure when the shutdown will end.

So conservatively, the government shutdown is not a qualifying life event. But the longer it goes on, a more aggressive argument would be that the shutdown is causing a significant curtailment of coverage under Tricare and therefore is a qualifying life event.

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



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