UBA PARTNER FIRM | Shared Wisdom. Powerful Results.®

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.

May 2026

- A New Era of Health and Welfare Fiduciary Litigation
- CMS Revises Medicare Part D Creditable Coverage Rules for 2027
- IRS Releases 2027 Employer Shared Responsibility Payment Amounts
- Question of the Month

A New Era of Health and Welfare Fiduciary Litigation

Health and welfare plan fiduciaries are entering a period of increased legal scrutiny. For many years, fiduciary litigation under the Employee Retirement Income Security Act of 1974 (ERISA) focused primarily on retirement plans, and particularly on allegations of excessive fees involving 401(k) plans. More recently, however, plaintiffs and regulators have shifted attention toward employer-sponsored health and welfare plans.

This growing wave of litigation is being driven by rising healthcare costs, expanded transparency requirements, increased access to plan pricing data, and evolving expectations surrounding fiduciary oversight. In particular, employers sponsoring self-funded health plans are now facing questions about whether they are adequately monitoring plan expenses, vendor compensation, pharmacy benefit arrangements, and participant costs.

As a result, health and welfare plan fiduciaries should expect heightened scrutiny of the way they select and oversee vendors, negotiate service agreements, and document fiduciary decision-making.

©2026 United Benefit Advisors, LLC. All rights reserved.

Why Litigation Is Increasing

Historically, health plan fiduciary claims were relatively uncommon compared to retirement plan litigation. That trend has changed significantly in recent years. Several developments have contributed to the increase.

Healthcare transparency requirements.

Federal transparency rules have expanded access to health plan pricing information, making health plan cost structures more visible than ever before. These include:

- Transparency in Coverage (TiC) machine-readable files
- Prescription drug reporting under the Consolidated Appropriations Act (CAA)
- Hospital price transparency rules
- Gag clause attestation requirements

Plaintiffs' attorneys are now using publicly available pricing data and plan disclosures to compare employer health plans and identify potential claims involving excessive costs or imprudent vendor arrangements.

Rising healthcare and prescription drug costs.

Escalating healthcare expenses continue to place pressure on employers and employees. Plaintiffs increasingly argue that fiduciaries failed to:

- Prudently manage and monitor plan costs, administration fees, and plan expenses
- Evaluate pharmacy benefit manager (PBM) compensation structures
- Negotiate favorable provider contracts

Many lawsuits focus on allegations that plans paid substantially higher prices than comparable plans for the same services or medications.

Increased focus on pharmacy benefit managers (PBMs).

PBM arrangements have become a central target in fiduciary litigation. Common allegations include:

- Lack of oversight over spread pricing
- Failure to monitor rebate arrangements
- Conflicts of interest
- Excessive prescription drug costs
- Opaque compensation structures

Because prescription drug spending represents a significant portion of many employer health plans' costs, PBM oversight has become a major fiduciary concern.

Expansion of ERISA fiduciary theories.

Plaintiffs are increasingly applying traditional retirement plan fiduciary theories to health plans. Failure to act prudently in monitoring service providers, ensure reasonable compensation, and failure to act solely in participants' interests all expose health plans to claims of fiduciary duty.

©2026 United Benefit Advisors, LLC. All rights reserved.

Common Allegations in Recent Health Plan Fiduciary Lawsuits

- Excessive administrative fees: Plaintiffs may allege that employers failed to monitor or negotiate TPA fees, network access fees, or consulting expenses. Claims often assert that plans paid unreasonable amounts compared to similarly situated employers.
- Imprudent prescription drug spending: Lawsuits allege overpaying for medications and failure to adequately evaluate rebate pass-through arrangements that resulted in higher participant cost-sharing.
- Failure to monitor vendors: ERISA fiduciaries generally retain responsibility for monitoring service providers, even when operational functions are delegated. Litigation increasingly focuses on vendor performance, vendor selection, fee reasonableness, and documentation oversight.
- Inadequate fiduciary governance: Plaintiffs may scrutinize whether employers maintained formal fiduciary procedures, such as fiduciary committee structures, meeting documentation, and plan governance policies. Poor documentation can make it difficult to demonstrate prudent decision-making.

Self-Funded Plans Face Greater Exposure

Although all ERISA-covered group health plans may face fiduciary risks, self-funded plans generally face the greatest litigation exposure. As transparency data becomes more accessible, plaintiffs can more easily compare plan costs and identify perceived pricing disparities among self-funded plans. This is largely because self-funded employers directly bear plan costs and exercise greater control over:

- Vendor selection
- Claims administration
- PBM arrangements
- Stop-loss and plan design
- Network contracting strategies

Fully insured plans may still face fiduciary scrutiny, but insurers typically assume more responsibility for claims payment and network pricing.

Fiduciary Duties Under ERISA

ERISA imposes several core fiduciary duties on plan fiduciaries including acting:

- Solely in participants' interests. Fiduciaries must act exclusively for the benefit of plan participants and beneficiaries
- Prudently. Decisions must reflect a careful, informed, and reasoned process.
- In accordance with plan documents. Fiduciaries must follow governing plan documents unless they are inconsistent with ERISA.
- With reasonable plan expenses. Plan costs and vendor compensation should be reasonable relative to services provided.

ERISA focuses heavily on process. Courts often evaluate whether fiduciaries followed a prudent decision-making process rather than whether every outcome produced the lowest possible cost.

©2026 United Benefit Advisors, LLC. All rights reserved.

The Growing Importance of Documentation

One of the most important risk management tools for fiduciaries is documentation. Without documentation, even well-intentioned fiduciary actions may be difficult to defend.

Best practices often include maintaining:

- Committee meeting minutes
- Vendor evaluation summaries
- Fee benchmarking materials
- Consultant reports
- Request For Proposal documentation
- Fiduciary training records

Emerging Areas of Concern

Several additional areas may receive increased scrutiny in future litigation.

Mental Health Parity Compliance

The Mental Health Parity and Addiction Equity Act (MHPAEA) continues to be a significant enforcement priority. Fiduciaries may face questions regarding network adequacy and access, nonquantitative treatment limitations (NQTLs), comparative analyses, and claims administration protocols.

Artificial Intelligence and Claims Administration

As insurers and TPAs increasingly use artificial intelligence and automated tools in claims processing and utilization management, fiduciaries may face additional oversight obligations regarding claims accuracy and appeal processes.

Data Privacy and Cybersecurity

Health plans maintain large volumes of sensitive participant data. Fiduciaries may face increasing expectations surrounding HIPAA compliance coordination, breach response planning, and vendor data protection practices.

Employer Action Items

- Periodically review agreements with TPAs, PBMs, brokers and consultants, stop-loss carriers, and wellness vendors.
- Review fiduciary governance structures.
- Evaluate vendor compensation arrangements.
- Monitor PBM and TPA performance.
- Benchmark plan expenses against similar plans in your industry and state.
- Conduct periodic requests for proposals.
- Enhance documentation of fiduciary practices and decision-making.
- Provide fiduciary training where appropriate.

Although no fiduciary process can eliminate litigation risk entirely, organizations that establish prudent governance procedures and maintain clear documentation may be better positioned to demonstrate compliance with ERISA fiduciary obligations.

©2026 United Benefit Advisors, LLC. All rights reserved.

CMS Revises Medicare Part D Creditable Coverage Rules for 2027

The Centers for Medicare & Medicaid Services (CMS) has finalized important changes affecting Medicare Part D creditable coverage determinations beginning with plan years starting on or after January 1, 2027. The updates will impact the way employer-sponsored health plans evaluate prescription drug coverage and comply with Medicare Part D disclosure requirements.

The final rules arrive after significant Medicare Part D redesign changes that took effect in 2025 and increased the actuarial value of standard Medicare prescription drug coverage. As a result, many employer-sponsored prescription drug plans needed to reassess whether they still qualified as "creditable" under CMS standards.

In addition to revising the methodology used to determine creditable coverage, CMS also finalized relief for certain account-based plans, eliminating the requirement for some employers to provide Medicare Part D creditable coverage notices for those arrangements.

Understanding Creditable Coverage

Medicare Part D imposes a late enrollment penalty on individuals who fail to maintain creditable prescription drug coverage for 63 consecutive days or longer after becoming eligible for Part D. Creditable coverage generally means prescription drug coverage that is expected to pay at least as much, on average, as standard Medicare Part D coverage.

Employers offering prescription drug coverage must notify Medicare-eligible individuals each year whether the coverage is considered creditable or non-creditable. These notices are typically distributed before October 15 so participants can make informed Medicare enrollment decisions and avoid potential penalties.

CMS Retires the Older Simplified Testing Method

Since 2009, employers relied on a simplified safe harbor methodology to determine whether prescription drug coverage was creditable. Under that approach, plans generally qualified if they:

- Covered brand and generic drugs
- Provided reasonable pharmacy access
- Paid at least 60% of prescription drug costs on average
- Met certain deductible or benefit limit requirements

CMS determined that this older standard no longer accurately reflected the richer Medicare Part D benefit structure created by the 2025 redesign. As a result, CMS introduced a revised simplified methodology for 2026 and has now eliminated the older 2009 methodology beginning in 2027.

Starting in 2027, employers generally can determine creditable coverage through actuarial equivalence testing or the revised simplified determination methodology.

Under the revised methodology, prescription drug coverage generally will be considered creditable if the plan:

- Covers brand-name drugs, generic drugs, and biological products.
- Provides reasonable access to retail pharmacies.
- Pays, on average, at least 73% of participants' prescription drug expenses for 2027.

©2026 United Benefit Advisors, LLC. All rights reserved.

This represents an increase from the 72% threshold permitted during 2026. CMS also indicated that the required actuarial value percentage is expected to continue increasing in future years and could reach 75% by 2030.

Because of these higher standards, some employer-sponsored prescription drug plans that previously qualified as creditable may no longer automatically satisfy CMS requirements.

High-Deductible Health Plans May Face Additional Challenges

CMS acknowledged that high-deductible health plans (HDHPs) may face more difficulty meeting creditable coverage standards because these plans shift more up-front costs to participants. However, CMS clarified that HDHPs are not automatically considered non-creditable.

The agency identified several plan design features that may help HDHPs meet the actuarial value requirements, including

- Carving out preventive or maintenance medications from the deductible.
- Allocating a reasonable portion of the deductible toward prescription drug expenses during actuarial testing.
- Offering lower participant cost-sharing after the deductible is satisfied.

Employers sponsoring HDHPs may want to review current plan designs carefully to determine whether adjustments may be necessary.

CMS Provides Relief for Account-Based Plans

CMS removed the requirement that employers determine creditable coverage status and distribute Medicare Part D notices for certain account-based plans, including health reimbursement arrangements (HRAS), individual coverage HRAs (ICHRAs), and similar account-based arrangements.

CMS explained that these arrangements function differently from traditional prescription drug plans and therefore are not appropriate for direct comparison to Medicare Part D coverage. According to CMS, evaluating an account-based arrangement against a prescription drug plan is not an “apples to apples” comparison because the arrangements primarily provide financial reimbursement rather than direct prescription drug coverage.

Employer Action Items

As employers prepare for the 2027 changes, reviewing prescription drug plan structures and compliance procedures may become increasingly important.

- Coordinate with carriers, pharmacy benefit managers, third-party administrators, actuaries, and benefits consultants to confirm whether current prescription drug coverage satisfies the revised actuarial thresholds. Special attention may be needed for integrated medical and prescription drug plans as well as HDHP arrangements.

- Ensure that Medicare Part D notices accurately reflect the plan’s creditable coverage status and maintain documentation supporting the determination methodology, including actuarial analyses or records demonstrating compliance with the revised simplified methodology.

©2026 United Benefit Advisors, LLC. All rights reserved.

As Medicare Part D standards continue evolving, proactive planning and periodic plan reviews may help reduce compliance risks and avoid participant confusion regarding Medicare enrollment obligations.

IRS Releases 2027 Employer Shared Responsibility Payment Amounts

The Internal Revenue Service has released the adjusted Employer Shared Responsibility Payment amounts for calendar year 2027 under the Affordable Care Act (ACA). These annual adjustments affect applicable large employers that do not meet the ACA's employer mandate requirements.

As penalty amounts continue to rise with inflation, employers should review their ACA compliance practices carefully. Even relatively small coverage, affordability, or reporting errors can create significant financial exposure, especially for organizations with larger full-time workforces.

Overview of the ACA Employer Mandate

The ACA's employer shared responsibility provisions apply to applicable large employers, generally defined as employers that averaged at least 50 full-time employees, including full-time equivalent employees, during the prior calendar year.

Under these rules, applicable large employers may face penalties if they:

- Fail to offer minimum essential coverage to substantially all full-time employees and their dependent children.
- Offer coverage that is unaffordable or does not provide minimum value.

2027 Penalty Amounts

Penalties are commonly referred to as the Section 4980H(a) penalty, or the "A penalty," and the Section 4980H(b) penalty, or the "B penalty." For calendar year 2027, the IRS increased both employer shared responsibility payment amounts.

Section 4980H(a) Penalty

The Section 4980H(a) penalty may apply when an applicable large employer fails to offer minimum essential coverage to substantially all full-time employees and at least one full-time employee receives a premium tax credit through a Health Insurance Marketplace.

For 2027, the annualized Section 4980H(a) penalty is $3,780 per full-time employee, minus the first 30 full-time employees. This amount is assessed on a monthly basis.

Because the penalty applies across the entire full-time workforce, potential liability can increase quickly for larger employers.

Section 4980H(b) Penalty

The Section 4980H(b) penalty generally applies when an employer offers coverage to substantially all full-time employees, but the coverage is either unaffordable or does not provide minimum value.

©2026 United Benefit Advisors, LLC. All rights reserved.

This penalty may also apply if a specific full-time employee is not offered coverage and receives subsidized Marketplace coverage.

For 2027, the annualized Section 4980H(b) penalty is $5,670 per affected full-time employee. Unlike the Section 4980H(a) penalty, the Section 4980H(b) penalty is assessed only for employees who receive premium tax credits.

Why These Adjustments Matter

Although annual inflation adjustments are expected, the financial impact of ACA penalties can still be substantial. Employers may face increased risk because of:

- Rising penalty amounts
- Complex affordability calculations
- Workforce classification issues
- Variable-hour employee tracking
- Payroll and reporting errors
- Remote and hybrid workforce arrangements

Even employers that offer health coverage may still face ACA exposure if administrative processes are inconsistent or reporting obligations are not handled correctly.

Affordability Remains a Key Compliance Issue

One of the most common ACA compliance challenges is determining whether employee contributions satisfy affordability standards.

The ACA affordability calculation is adjusted annually and generally compares the employee’s required contribution for self-only coverage against a specified percentage of household income.

Because employers typically do not know employees’ household income, the IRS permits the use of affordability safe harbors, including:

- W-2 wages
- Rate of pay
- Federal poverty level

Employers should continue reviewing contribution strategies each year to make sure affordability thresholds remain satisfied.

ACA Reporting Obligations Continue

In addition to potential penalties for coverage failures, applicable large employers must continue complying with ACA reporting requirements using Forms 1094-C and 1095-C.

©2026 United Benefit Advisors, LLC. All rights reserved.

Common reporting issues include:

- Incorrect employee coding
- Inaccurate affordability reporting
- Failure to track full-time status properly
- Late filings
- Incomplete employee data

IRS penalty notices often begin with reporting discrepancies, even when coverage was properly offered.

Remote Work Creates Complexity

Hybrid and remote work arrangements continue to create ACA administration challenges for many employers. Organizations may need to carefully monitor:

- Employee hours of service
- Measurement periods
- Workforce classifications
- Staffing agency relationships
- Controlled group structures
- Rehired employee rules

Rapid workforce growth, mergers, acquisitions, or restructuring activity may also affect applicable large employer status determinations and compliance obligations.

Employer Action Items

Employers that regularly review their ACA administration practices and address compliance issues proactively may be better positioned to reduce penalty exposure and administrative disruptions.

- Confirm that systems accurately identify and track full-time employees under ACA standards, particularly for variable-hour and seasonal employees.
- Reassess employee contribution levels and affordability safe harbor strategies for the upcoming plan year.
- Periodically review Forms 1094-C and 1095-C preparation procedures to identify coding or data issues before filings are submitted.
- When relying on third-party administrators, payroll providers, or ACA reporting vendors, confirm responsibilities and data accuracy well in advance of reporting deadlines.
- Retain records supporting coverage offers, employee elections, affordability calculations, measurement period determinations, and ACA reporting submissions.
- Monitor workforce changes that could affect applicable large employer status.

©2026 United Benefit Advisors, LLC. All rights reserved.

Question of the Month | Standalone EAP Subject to COBRA

Q. When a group purchases an EAP outside of their ancillary carrier's free program, is this standalone EAP product a COBRA benefit to employees?

A. Whether an EAP is subject to COBRA depends on the structure of the EAP and whether it provides "medical care." If the EAP provides medical care, which can include mental health counseling, it is subject to COBRA. But if the EAP does not provide medical care, for example it does not provide counseling but simply provides referrals to a counselor, the EAP is not subject to COBRA. Most EAPs tend to provide some form of medical care and therefore are subject to COBRA.

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.

©2026 United Benefit Advisors, LLC. All rights reserved.