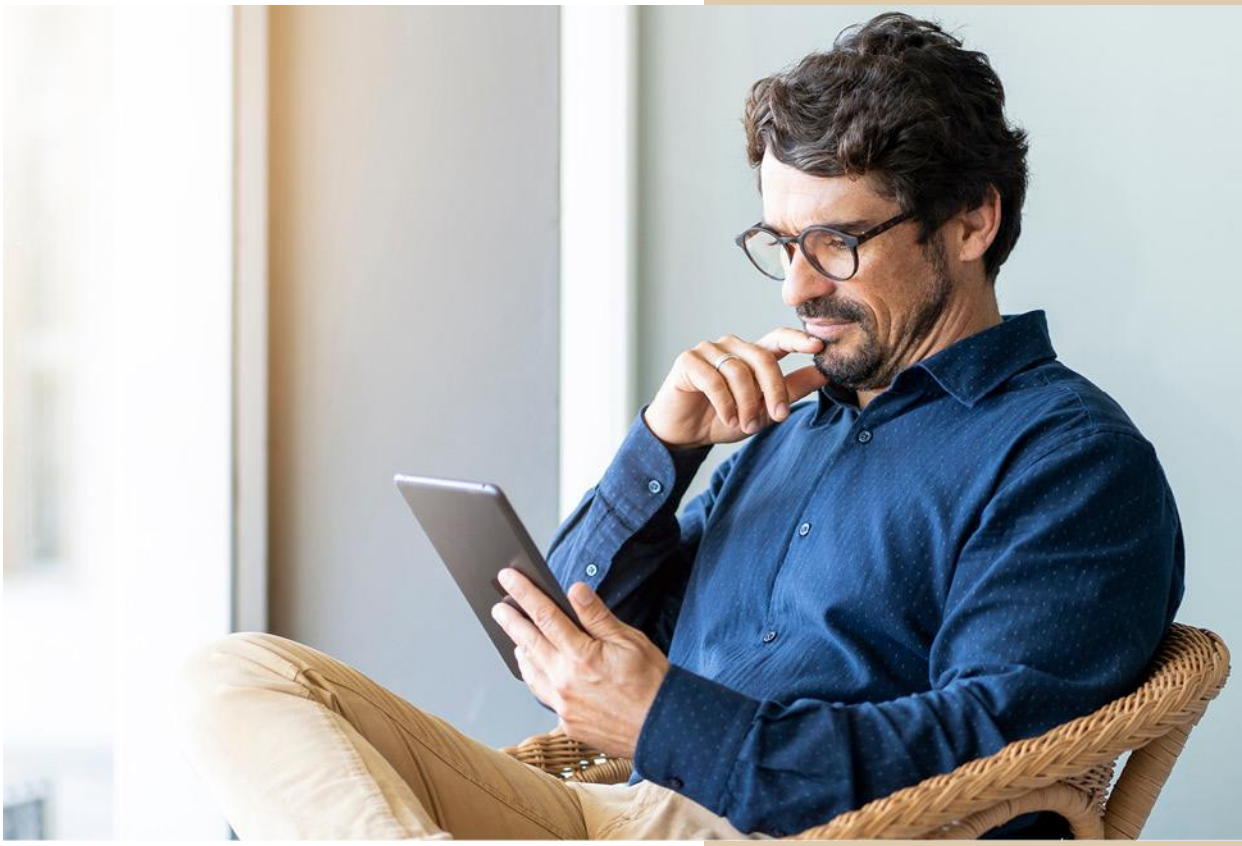
Employee Benefits Compliance Briefing

Summer 2025



Stay Compliant

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

Acadia BENEFITS

UBA PARTNER FIRM | Shared Wisdom. Powerful Results.

This Issue

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.

UBA | Shared Wisdom. Powerful Results.®

Fisher Phillips

New Federal Data Sharing Deals Heighten Compliance Risks for Plan Sponsors

Recent federal changes are reshaping the way immigration enforcement intersects employment issues, posing new compliance risks for employers and plan sponsors. Two recent developments ramped up coordination among government agencies, including the Internal Revenue Service, to detect and deter unauthorized work and benefits, and shed light on what employers need to know.

IRS-ICE Information-Sharing Agreement

On April 7, the Internal Revenue Service (IRS) signed an agreement with Immigration and Customs Enforcement (ICE) to share select tax records for non-tax criminal investigations. This includes access to Individual Taxpayer Identification Numbers (ITINs), W-2 and 1099 forms, and employer tax filings. Although this data cannot be used for civil immigration or deportation proceedings, it may be used to investigate identity fraud, document falsification, or unauthorized employment. This agreement between the agencies marks a shift in IRS policy where as recently as 2023, the IRS took the position that it did not have the legal authority to share this type of data with the Department of Labor (DOL) for the purpose of finding missing retirement plan participants.

SSA "Ineligible Master File" Initiative

Just a day later, the Social Security Administration (SSA) announced that it will now use its "death master file" to flag noncitizens whose work authorization has lapsed or been revoked – rendering their Social Security numbers (SSNs) unusable for employment or financial purposes. This could affect employers who rely on Social Security numbers to verify benefit eligibility or process payroll-linked benefit contributions.

Together, these moves underscore a growing strategy of using once-siloed government databases to crack down on unauthorized employment – raising the compliance stakes for all employers.

What This Means for Plan Sponsors and Employers

Employers could face significant liability and operational disruption as these interagency efforts evolve.

- Increased SSA "No-Match" Letters: As SSA tightens data integrity efforts, employers may receive more letters flagging discrepancies between names and SSNs on wage reports. The notices do not imply wrongdoing but can create operational and legal complexity.

- Increased Scrutiny of ACA Filings: Discrepancies between Form 1095-C submissions and IRS/SSA data could draw audits or enforcement inquiries. Multiple ITIN-linked submissions or mismatched SSNs may flag a plan sponsor for review and introduce a greater risk for a worksite audit.
- ICE Raids and Warrants: Cross-referenced IRS and SSA data may be used to plan worksite raids or issue judicial warrants targeting high-risk locations. These actions may disrupt operations and draw media attention.
- Potential Criminal Charges: Employers found to have knowingly hired or facilitated unauthorized work may face prosecution for violations such as unlawful employment of unauthorized workers or filing false or fraudulent tax documents. While criminal charges against employers have historically been less common, this new IRS and SSA data-sharing initiative – along with the increased threat of prosecution under the new administration – adds pressure for employers to act cautiously and document compliance efforts.

Employer Action Items

- Audit employee eligibility and benefits systems.
  Conduct a comprehensive review of employment eligibility documentation, enrollment data, ACA reporting, and payroll records. Ensure that SSNs used to determine benefit eligibility match SSA records and that no one is enrolled based on ITINs or questionable documentation.
- Coordinate with HR, legal, and plan administrators.
  Ensure that HR and benefits staff understand how to properly handle SSN mismatches and other eligibility red flags. Collaborate with outside counsel, especially if your systems show employees who have incomplete I-9 records.
- Develop a response strategy for SSA "no-match" and IRS letters.
  Establish protocols for addressing government notices. Mishandling a "no-match" letter or failing to act on a discrepancy flagged in ACA reports could result in investigation or penalties.
- Review the use of independent contractors and 1099 workers.
  If your organization issues 1099s, especially those tied to ITINs, review the nature of the relationship and determine whether the individual is properly classified as an independent contractor. While your company may not verify the ITIN or SSN of a 1099 worker, there may be penalties if an employer is found to be using 1099 workers to avoid immigration compliance activities.
- Establish a crisis response plan.
  In the event of an ICE audit or enforcement action, have a rapid-response plan that includes legal counsel, compliance leads, and benefits administrators. Ensure you're prepared to manage operational disruptions, employee communications, and benefit access issues in real time.

ERISA Requirementes for Plan Document Translation

Many employers today have a diverse workforce that includes individuals who speak little or no English. Employers commonly ask whether they are required to translate Summary Plan Descriptions (SPDs) or Summaries of Material Modifications (SMMs) into other languages.

ERISA does not mandate full translations of SPDs or SMMs, but certain employers may be required to offer language assistance and notify participants of its availability if a significant portion of their workforce is literate only in the same non-English language.

When Is Language Assistance Required?

ERISA outlines specific thresholds for providing language assistance based on the size of the benefit plan.

- Large Plans (100 or more participants): Language assistance must be provided if the lesser of:
  - 10% of participants, or
  - 500 participants are literate only in the *same* non-English language.
- Small Plans (fewer than 100 participants): Language assistance is required if 25% or more of the participants are literate only in the *same* non-English language.

Example

A company plan has 8,000 participants and 530 of those participants are literate only in Spanish. For this example, "participants" include only employees or former employees (such as retirees) who are covered by the plan. Dependents like spouses or children are not included in this calculation. Ten percent of the plan's participants is equal to 800 participants.

Spanish language assistance must be provided because there are at least 500 participants that are literate only in the same non-English language, even though it is less than 10% of the total number of plan participants.

What Must Be Included in the SPD or SMM?

If your plan meets the thresholds above, the SPD or SMM must contain a prominent statement in the applicable non-English language, offering assistance and explaining how to obtain it. This notice should appear either at the beginning of the SPD or SMM or on its cover to ensure visibility.

Here is a sample statement, adapted from Department of Labor regulations:

> This Summary Plan Description [or Summary of Material Modifications] contains a summary in English of your plan rights and benefits under the [Plan Name] Plan. If you have difficulty understanding any part of this Summary Plan Description [or Summary of Material Modifications], contact the plan administrator, [insert name or title], at [insert office location]. Office hours are from ___ to ___ Monday through Friday. You may also call [insert telephone number] for assistance.

Including an email address is recommended, although not required under the original DOL guidance.

What Kind of Language Assistance Must Be Offered?

The assistance does not need to be in writing. However, it must be "calculated to provide participants with a reasonable opportunity to become informed as to their rights and obligations under the plan."

This generally means having a designated contact person who is fluent in the applicable non-English language and capable of explaining plan benefits and obligations clearly and accurately. Some plan sponsors may choose to translate documents as an added measure, but this is not required by law.

Additional Considerations

It's important to remember that these ERISA language assistance rules apply only to SPDs and SMMs. Other plan-related material (such as the Summary of Benefits and Coverage (SBC) or COBRA notices) are governed by different rules and standards when it comes to language accessibility. For instance, SBCs must be "presented in a culturally and linguistically appropriate manner." An SBC must be offered in a non-English language to individuals in any county where at least 10% of the population in the county is literate only in the same non-English language based on U.S. Census data.

Employer Action Items

- Review participant demographics.
  Determine whether your plan meets the thresholds requiring language assistance by analyzing participant data annually.
- Add required notices.
  If applicable, ensure your SPD and SMM include the prominently placed language assistance statement in the relevant non-English language.
- Designate a bilingual contact.
  Assign a fluent contact person (or service) to assist non-English-speaking participants with understanding their benefits.

- Document language services.
  Keep internal records of who is available to assist, what languages they speak, and how assistance is provided.
- Consider written translations.
  While not required, written translations of key documents can reduce errors and support better understanding.
- Train HR and benefits staff. Ensure relevant personnel are aware of the language assistance requirements and know how to handle participant inquiries.

CMS and Medicare Updates for 2026

The Centers for Medicare & Medicaid Services (CMS) has released its annual guidance on Medicare payment policies for Medicare Advantage and Part D prescription drug plans. This guidance directly impacts group health plan sponsors that must annually assess whether their prescription drug coverage qualifies as "creditable" for Medicare Part D purposes.

Background

Many Medicare-eligible individuals remain enrolled in employer-sponsored group health plans, often as active employees, and every year group health plans are required to notify its Medicare-eligible policy holders whether their prescription drug coverage is "creditable coverage." Drug coverage is creditable if it is as good or better than the Medicare drug benefit. If a Medicare-eligible individual is not enrolled in creditable coverage, they may incur permanent late enrollment fees for every month they are not enrolled in Medicare part D.

There are two primary notice requirements for entities that offer prescription drug coverage:

1. Annual disclosure to Medicare-eligible individuals covered by the plan by no later than October 15 of each year.
2. Annual reporting to CMS of its creditable coverage status of their prescription drug plan by:
    - 60 days prior to the beginning of the plan year (March 1 for calendar year plans),
    - Within 30 days of the termination of a prescription drug plan, or
    - Within 30 days after any change in creditable coverage status.

2026 Creditable Coverage Testing Options

CMS's final guidance, issued April 7, 2025, gives plan sponsors flexibility to continue using existing creditable coverage calculation methods (60% threshold) or opt for a newly revised simplified determination methodology.

The Revised Simplified Determination requires:

- The plan to pay, on average, at least 72% of participants' prescription drug expenses.
- Reasonable coverage for both brand-name and generic drugs,
- Reasonable access to retail pharmacies.

CMS has not yet defined "reasonable" for coverage or pharmacy access purposes.

CMS has indicated that, beginning in 2027, the existing simplified methodology will no longer be available. Plan sponsors will need to prepare to:

- Use the revised simplified method, or
- Complete a full actuarial equivalence evaluation.

Sponsors should consider this upcoming change when planning future benefit designs.

Other Medicare Updates Relevant to Plan Sponsors

Medicare Advantage Payment Update. CMS announced a 5.06% payment increase for Medicare Advantage plans in 2026, based on a final effective growth rate of 9.04% – substantially higher than earlier projections. This higher rate means that Medicare Advantage plans will receive a 5.06% percent payment increase in 2026.

Technical Rules Update. CMS finalized certain regulatory technical corrections but withdrew its proposal to require Medicare Advantage plans to cover GLP-1 medications for obesity treatment.

Employer Action Items

- Decide which creditable coverage testing methodology to apply for 2026.
- Review prescription drug benefit designs in light of the new 72% standard under the revised simplified method.
- Monitor CMS guidance for developments regarding the mandatory shift for 2027 determinations.
- Consult advisors regarding the impact of the Medicare Advantage payment changes and technical updates to understand how the increased rates could affect premiums, plan designs, and funding strategies.

IRS Releases 2026 Cost-of-Living Adjustments for HSAs and HDHPs

The IRS recently issued Revenue Procedure 2025-19, announcing the 2026 inflation-adjusted amounts that apply to health savings accounts (HSAs), excepted benefit health reimbursement arrangements (EBHRAs), and high-deductible health plans (HDHPs). Each of the newly announced figures is an increase in the applicable limits for 2026. These limits will differ depending on whether an individual is covered by a self-only or family coverage tier under an HDHP. The maximum permitted catch-up HSA contribution for eligible individuals who are 55 or older during 2026 is not inflation-adjusted and remains unchanged for 2026.

	2025		2026	
Applicable Limits	Self-Only	Family	Self-Only	Family
HSA maximum contribution	$4,300	$8,550	$4,400	$8,750
HSA maximum catch-up contribution	$1,000	$1,000	$1,000	$1,000
HDHP minimum deductible	$1,650	$3,300	$1,700	$3,400
HDHP maximum out-of-pocket expense (in-network)	$8,300	$16,600	$8,500	$17,000
EBHRA maximum employer contribution	$2,150		$2,200	

The higher HSA contribution limit and HDHP out-of-pocket maximum will take effect January 1, 2026. The higher HDHP deductible limits will increase for plan years that begin on or after January 1, 2026.

Employer Action Items

- Review and update plan designs for HDHPs and EBHRAs in preparation for 2026.
- Ensure all plan communications, open enrollment materials, and other plan documentation are updated to reflect the new limits, so participants and beneficiaries are adequately informed.
- Communicate the new limits to benefits and HR staff so they are prepared to answer employee questions and properly administer benefits under the new guidelines.

COBRA Compliance: Why "Good Faith" Isn't Good Enough

Recent litigation emphasizes a vital reminder for employers that with COBRA notices, a good faith effort to comply is not a legal defense. The case *Marrow v. Carpenter Company* centers on an employee who claimed she lost coverage due to a deficient COBRA notice. The court ruled that a "good faith effort" to comply with COBRA notice requirements is insufficient to survive a motion to dismiss – but the broader takeaway for employers is clear: technical compliance with COBRA requirements is essential. Even well-intentioned missteps can expose an organization to litigation and liability.

The Importance of COBRA Notices

The Consolidated Omnibus Budget Reconciliation Act (COBRA) requires group health plans to offer continuation coverage to employees and their covered spouse after qualifying events such as termination of employment. Critical to this process is the COBRA election notice, which must:

- Be clear and understandable,
- Include all required information about election deadlines and procedures, payment terms, and plan details, and
- Be provided within the legally mandated timeframe.

This notice often serves as the sole source of information for former employees navigating their health coverage options during a time of stress or transition. Any ambiguity or inaccuracy can lead to significant financial consequences—for both the employee and the employer.

Common COBRA Notice Mistakes

Even employers with the best intentions can fall short of compliance and the liability for non-compliance can be steep – up to $110 per day per participant. Some of the most frequent COBRA notice errors include:

- Failing to provide notices on time after a qualifying event
- Not using the Department of Labor (DOL) Model Election Notice or modifying it to the point of noncompliance
- Providing inconsistent or confusing information about deadlines and payment amounts

These issues can undermine an employee's ability to make an informed decision and may lead courts to find that the employer failed in its legal obligations.

Employer Action Items

To mitigate risk and support compliance, employers should adopt the following action steps.

- Use the DOL Model COBRA Election Notice. Customize only where necessary and ensure no essential information is omitted.
- Review all language for accuracy and readability. Confirm that election timelines, payment instructions, and contact information are current and clearly presented.
- Periodically review your organization's COBRA notices and administrative processes.
- Train HR and Benefits Teams. Ensure all team members involved in COBRA administration understand the legal requirements and how to properly and timely issue notices.
- Maintain records of when, how, and to whom COBRA notices were sent. Use delivery methods that allow tracking and confirmation.
- Involve Legal or Benefits Counsel. If there's any uncertainty about your notice content or process, consult with qualified legal or compliance professionals.

Navigating State PBM Laws: Undertanding ERISA Preemption and Compliance

Pharmacy benefit managers (PBMs) play a pivotal role in the U.S. healthcare system, managing prescription drug benefits on behalf of insurers and employer-sponsored health plans. However, rising concerns over PBM transparency, pricing practices, and reimbursement rates have led to an expanding patchwork of state-level legislation. For employers – especially those offering self-insured health plans – these developments introduce complex compliance challenges, particularly in the context of federal ERISA preemption.

ERISA Preemption: A Primer for Employers

The Employee Retirement Income Security Act of 1974 (ERISA) establishes uniform national standards for employer-sponsored health plans. One of its most important provisions is preemption—ERISA overrides state laws that directly regulate these plans. However, the scope of ERISA preemption is nuanced.

- Fully Insured Plans: Generally subject to state insurance regulations. PBM-related laws at the state level typically apply.
- Self-Insured Plans: Typically shielded from state insurance laws under ERISA preemption. But if a state law regulates PBMs (rather than health plans directly), ERISA may not preempt it.

The issue of ERISA preemption over state PBM laws reached the U.S. Supreme Court in 2020. This 2020 case, *Rutledge v. Pharmaceutical Care Management Association,* clarified the distinction between laws regulating plans *versus* those regulating PBMs. In this case, the Court upheld an Arkansas law that required PBMs to reimburse pharmacies at or above acquisition cost. The Court stated that this law targeted PBMs directly and did not regulate employer health plans, and therefore the law was not preempted by ERISA. This decision has had significant implications for the regulation of PBMs nationwide because it allowed states to pass laws that regulate PBMs without risking violations of ERISA.

The Evolving Patchwork of State PBM Laws

Since *Rutledge*, most states have introduced or enacted bills targeting PBM practices. These laws are generally aimed at lowering drug costs, increasing transparency, and protecting pharmacies. Common statutory themes include:

- Prohibiting spread pricing (charging the client (the insurer) a higher amount than is reimbursed to the pharmacy)
- Mandating disclosure of manufacturer rebates
- Limiting patient cost-sharing

- Imposing network access requirements
- Requiring detailed reporting and compliance attestations

As these laws expand in number and scope, the burden on plan sponsors (especially those operating across multiple states) increases.

Employer Action Items

To manage risk and maintain compliance in a shifting regulatory environment, employers should take proactive steps based on the type of plan they offer.

All Employers

- Monitor legal developments. Assign internal or external legal resources to track PBM-related legislation and litigation in states where employees reside.
- Engage with PBMs. Regularly review PBM contracts to understand how regulatory compliance is addressed and whether reporting obligations are covered.

Employers with Fully Insured Plans

- Coordinate with carriers. Work closely with insurance carriers to ensure compliance with new state laws, especially regarding reporting and cost-sharing requirements.
- Understand cost impact. Analyze how PBM practices shaped by state law may influence premiums or pharmacy benefit costs.

Employers with Self-Insured Plans

- Consult ERISA counsel. Legal guidance is essential to determine whether specific state PBM laws may impact your plan, particularly if those laws regulate PBMs rather than plans directly.
- Assess PBM support for compliance. Confirm that your PBM partner is capable of handling multi-state compliance, including reporting and transparency mandates. If operating in multiple states, evaluate whether regional variations in law necessitate operational changes or different PBM arrangements.

The legal landscape governing PBMs is in flux. As state legislatures continue to pass new laws and courts assess the reach of ERISA preemption, plan sponsors must stay up to date on legal developments. Compliance is not guaranteed by satisfying ERISA alone. Maintaining strong relationships with PBMs, working closely with legal counsel and other advisors, and remaining informed about legislative trends will be key to navigating this complex and rapidly evolving area of law.