HUB

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2026 Compliance & Benefits Update

February 2026

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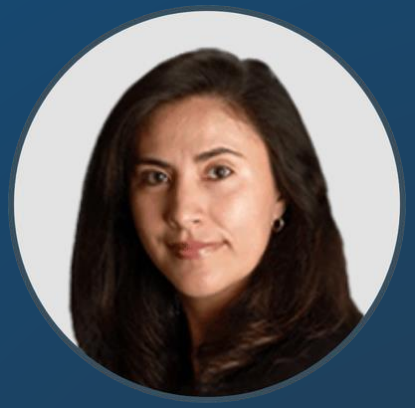

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Agenda

1. Industry Trends
2. Fiduciary Litigation & SCOTUS Update
3. Prescription Drug Landscape
4. One Big, Beautiful Bill Act (OBBBA)
5. Foundational Compliance Items (with updates for 2026)
6. Key Takeaways

Industry Trends

Employer Benefit Challenges in 2026

- **Increase in Health Care Costs and Premiums**
  - Significant increases in both the cost of care and group health plan premiums
- **Increase in Pharmacy Spending**
  - Cellular / Gene Therapies and GLP-1s
- **Competing Priorities**
  - Employers need to control costs but also need to support talent attraction, retention and keep their population happy and healthy
- **Leveraging AI and Vendor Management**

Cost Drivers

- **Unit Cost Increases**
  - The same service / treatment is likely to cost more in 2026 than 2025
- **ACA Subsidies and Medicaid**
  - Significant drop in premium tax credit eligibility on the exchange
  - Medicaid funding reductions coming in 2026
  - **Result:** Providers must offset the costs
- **Pharmacy Costs**
  - GLP-1s
  - Cell and gene therapies
- **Market Consolidation**
  - Fewer providers / options leads to increased pricing power
- **New Benefit Mandates** (federal and/or state)

Employer Strategies – Cost Management

- Captives
- PEOs
- Association Health Plans
- ICHRAs
- Narrow Networks / Reference-based Pricing
- Benefit Carve-outs
- Spousal Incentive Programs

Evolving Pharmacy Landscape

- **The current administration has taken several steps directed at prescription drug coverage costs**
  - Proposed additional regulatory scrutiny
  - Emphasis on reducing prescription drug costs
- **TrumpRx and manufacturer-specific direct-to-consumer programs offer easy access and cost transparency**
  - These new programs may lead many consumers to bypass traditional group pharmacy coverage and purchase certain drugs as cash patients
  - Possible impact on the traditional group pharmacy coverage model

Rising Use of Artificial Intelligence (AI)

Many companies are starting to roll out AI platforms and embedded tools for general HR support

AI use-cases related to HR Administration are abundant

- Benefits administration and enrollment platforms
- Chatbots for employee Q&A
- Automated systems employee communications
- AI-assisted recruiting and onboarding processes

Insurers and TPAs leverage AI to automate policy reviews, streamline claims processing, detect fraud and potentially auto-adjudicate claims

Healthcare providers are using AI to identify opportunities to increase billing charges and reduce physician time in charting and other administrative functions

Risks Associated with AI Use

AI use risks

- Risk of potential discrimination
- Participant data privacy concerns
- AI decision-making and logic/algorithm errors
- Evolving regulatory landscape
- Growing legal scrutiny and class-action litigation tied to AI-assisted claim denials

What Employers need to do:

- Implement AI policies related to data governance and general AI use in the workplace
- Ensure human oversight over AI workplace functions
- Conduct thorough due diligence before engaging with AI vendors and adopting embedded tools

Fiduciary Litigation

Plan Fiduciary Updates

Lewandowski & Gregory v. J&J

- January 24, 2025, NJ Court dismissed complaint due to the plaintiff's lack of standing (participant met OOPM).
- Amended complaint was filed in March 2025
  - Conflict of interest in placing PBM coverage as consultants receive compensation from PBM while recommending a PBM vendor to employer.
  - Breach of fiduciary duties as the prices paid for generic medications that have been reclassified as specialty medications is significantly higher that the price paid in retail stores (in some cases 2,000% more expensive through Accredo and ESI than retail stores).
- Court dismissed the case on November 28, 2025 due to lack of standing, reaffirming the Court's decision on the first complaint.

Navarro et al v. Wells Fargo Co.

WFC employees and retirees brought a lawsuit arguing that WFC was in breach of its fiduciary duties and engaged in self-dealing (prohibited transaction under ERISA) because the plan paid excessive fees for prescription drugs and PBM fees purchased through Express Scripts and its pharmacy Acreedo.

- The first complaint was dismissed due to lack of standing, the Court concluded that the plaintiffs would not benefit from potential equitable relief as the members were former employees and did not identify a concrete injury as WFC had the right to set contributions and plan design.
- An amended complaint was filed on May 8, 2025.
- WFC filed a motion to dismiss on August 7, 2025, claiming the plaintiff lacks standing and failed to show breach of plan fiduciary duties.

The case is ongoing as of this date.

Plan Fiduciary Updates

Stern v. JPMorgan Chase Co.

Lawsuit brought in NY by employees and retirees of JP Morgan Chase on 3/13/25 for JP Morgan Chase's breach of fiduciary duties and engaging in self-dealing *(prohibited transaction under ERISA)* as the plan paid excessive fees for prescription drugs and PBM fees purchased through CVS Caremark.

- Selection of a PBM and administration of prescription drug plan was contrary to plan fiduciary duties.
  - No open RFP in vendor selection
  - Relied on CVS integrated model which lacked transparency in cost
- JPMorgan Chase filed motion to dismiss on 8/22/25 claiming lack of standing, and failure to prove harm or existence of ERISA violations.

Voluntary Benefits Cases

- Law firm Schlichter Bogard filed a series of lawsuits against large employers and their insurance brokers and consultants alleging breach of fiduciary duties for failure to properly manage the plan by not monitoring, negotiating or ensuring reasonable carrier selection, broker commissions and loss ratios, causing plan participants to pay excessive premiums.
- Plaintiffs were allegedly harmed by paying higher rates for voluntary benefits.
- Key consideration is whether plans in question are truly subject to ERISA.

Fiduciary Best Practices – Benefits Committees – Next Steps

- Implement a benefits committee for vendor selection
  - Members of different departments (benefits, HR, finance, procurement, etc.)
  - Develop guidelines for the benefits committee to follow and conduct fiduciary training
- Committees can monitor due diligence, act as the record keeper for processes and decision making, and help avoid potential conflicts of interest
- HR / Benefits team must educate and train committee members on programs and services sought
- Purchase fiduciary liability coverage to protect fiduciaries – common for retirement plans
- Document meetings with minutes (a summary, not a transcript)
- Retain legal counsel to review contractual terms of service agreements (PBMs rebates and cost of Rx)
- Monitor outcome of court decisions regarding breach of plan fiduciary duties in appointing PBMs and the terms of PBM agreements

The Prescription Drug Landscape

Federal Regulation of Prescription Drugs

Executive Orders issued on April 15, 2025 and May 12, 2025 – Most Favored Nation (MFN) status with focus on:

- Improving Transparency in Pharmacy Benefit Manager (PBM) Fee Disclosures.
- Reevaluating the Role of PBMs.
- Importation of foreign drugs
- Accelerating Competition for High-Cost Prescription Drugs.

Developments

- **July 2025 -** 17 pharmaceutical manufacturers received formal notices from the White House mandating a 60-day compliance timeline and requesting a new pricing framework.
- U.S. prices now follow the Organisation for Economic Co-operation and Development (OECD) guidelines and are based on countries that have a per capita gross domestic product (GDP) of at least 60% of the U.S. (38 member countries).
- President Trump announced agreements with drug manufacturers to lower costs for Medicaid recipients and allow individuals purchasing medications directly from drug manufacturers through the TrumpRx government website that was launched earlier this year.

PBM Transparency Rules

H.R. 7148 (Consolidated Appropriations Act of 2026) New PBMs Disclosure Requirements

- **Effective Date:** Plan years beginning on or after January 1, 2029 (30 months after enactment)
- **Covered Employers:** All employers, regardless of size, insured, self-insured, and level-funded. Including non-ERISA subject employers. For insured plans, the disclosure is made to the insurance carrier contracting with the PBM, but the large employer can access it by opting in.
- **Frequency of Disclosure:** Every 6 months or no more frequently than quarterly, if requested by the plan sponsor.
- **PBM Mandatory Disclosure** Requirements**:**

Large employers: **100 or more employees** based on the number of business days in the prior calendar year, if the plan is self-insured or level funded; large insured employers have the option to opt-in to receive PBM reports. Detailed analysis of PBM costs and compensation received by PBM and third parties.

Small employers: Employers with one employee **up to 99 employees** based on the business days in the prior calendar year, must receive a summary report of PBM fees and claims paid.

Sample of PBM Reporting

Provision	Employer Size
Summary Document - estimated net price, cost per claim, fee structure, cost per participant	Small & Large Employers
Total net drug spending and rebates/remuneration received or expected	Small & Large Employers
Benefit design parameters steering to affiliated pharmacies	Small & Large Employers
Total gross drug spending	Small & Large Employers
Drug-level data: contracted compensation paid by the plan to the PBM, compensation paid by the PBM to pharmacy, and the spread for each claim by National Drug Code	Large Employers Only
High-cost drug ($10,000+ or top 50) formulary rationale and year-over-year changes	Large Employers Only

PBM Transparency Rules

- **Plan Participant Disclosure Requirements:** A summary document will be made available by the PBM or the insurance carrier to plan sponsors. Plan sponsors will distribute the summary document to plan participants upon participants' request. Participants will have the right to request claim-level information from PBMs regarding total pharmacy spend, including rebates paid, and fees paid to brokers and consultants.
  - Employers will also have to issue a notice to plan participants on an annual basis informing participants of the PBM disclosure requirements.
- **Prohibition against spreading and expands plan sponsor's audit rights**
- **Penalties:** Failure to comply with notification requirements could result in the imposition of a $10,000 per day penalty. For PBMs or carriers disclosing false information, the penalty is $100,000 per false item reported.

Proposed DOL PBM Transparency Rules

Proposed rules issued by DOL on January 29, 2026

- DOL **proposed** regulations (amending ERISA Section 408(b)(2)) create new disclosure requirements applicable to PBMs, certain TPAs, and brokers/consultants. May become effective in 2026.
- **Covered Employers:** ERISA subject level-funded and self-insured plans, regardless of the employer's size, working with a PBM or consultant in the placement of PBM services. Excludes fully-insured plans.

Entities subject to the new disclosure requirements:

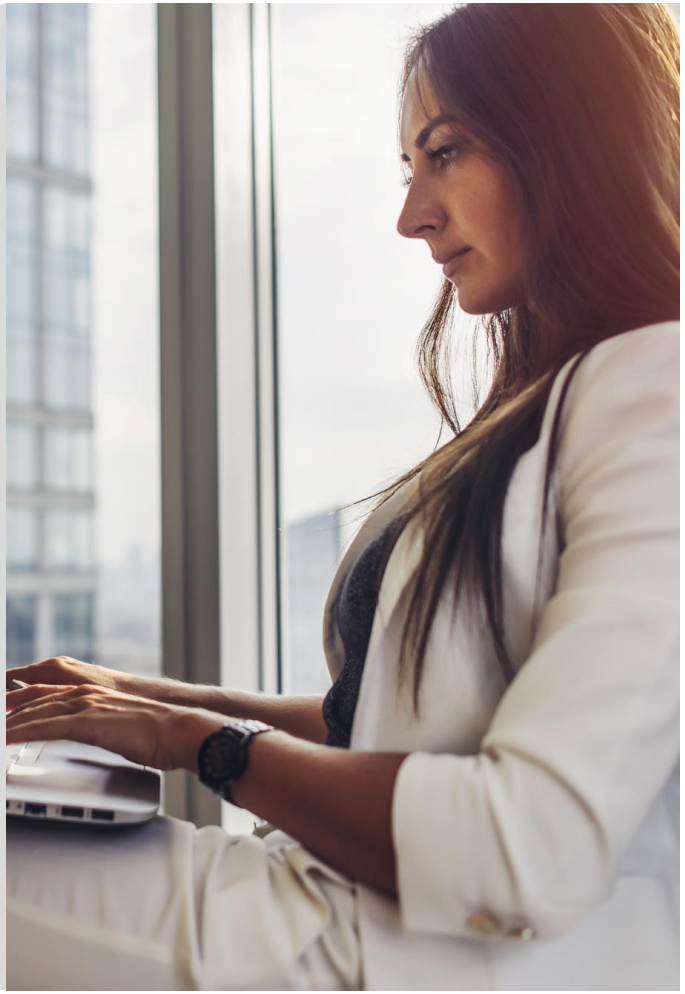
- Stand-alone Pharmacy Benefits Managers
- TPAs if procuring PBM services (TPA in a level-funded plan, or if TPA procures the PBM as a bundled service)
- Brokers and consultants must disclose if they receive $1000 or more in compensation, if they act as a negotiator or aggregator of rebates, fees, discounts, and other price concessions for prescription drugs

When is disclosure required: At the time of entering into, renewing or extending a contract or arrangement (30-day advance notice). Including semi-annual disclosures or upon request by plan sponsor.

New Transparency Rules – Next Steps

CAA 2026 & DOL PBM Regulations

- Regulations will be issued ***within the next 18 months*** – Summary document templates and reporting guidelines, sample notices plans will have to use to comply with the new notification requirements, reporting guidelines applicable to PBMs, large insured plans opt-out process, etc.
- PBMs and insurance carriers will be issuing notices of their intent to comply with the new mandates, noting that regulations will further explain what plan sponsors, PBMs, and carriers will be required to do.
- PBM agreements will have to be amended to capture the new reporting and disclosure requirements by 2029.
- Discuss with PBMs and insurance carriers the regulations' possible impact on Rx rebates (self-funded/level-funded plans) and on insurance premiums for insured medical plans.
- Await release of final DOL regulations regarding disclosure requirements for PBMs and consultants.



State Regulation of PBMs

AR – Rule 128 and Act 624 reporting in addition to banning PBMs that own pharmacies from operating in the state **(1/1/26)** – Court issued injunction.

WA – Effective **1/1/26**, allows self-insured plans to opt in to state protections. WA Insurance Commissioner will address disputes between pharmacies and PBMs. Prohibits spreading and reimbursing pharmacies less than cost paid for Rx.

MT – New $15 fee for prescriptions to be filled, no additional reporting requirements.

FL – Imposes network adequacy requirements, prohibits mail order for prescription drugs and narrow pharmacy networks. Reporting applies to self-insured plans, however many claim ERISA preemption and may constitute a violation of HIPAA to share PHI with the state.

TN – Prohibits spreading, requires 100% rebate pass-through, requires PBM to allow participation of other non-network pharmacies, includes reporting requirements for self-insured plans.

CA – Effective 1/1/26-1/1/29. Prohibits spread pricing, use of a narrow network pharmacy, imposes plan fiduciary duties on PBMs when contracting with self-insured plans.

IN – Considers PBMs and TPAs to be fiduciaries of self-insured plan **(7/1/25).**

IL – Effective **1/1/26,** IL will require every PBM to pay a $15 fee per covered participant.

One Big, Beautiful Bill Act (OBBBA)

One Big, Beautiful Bill Act (OBBBA)

- Enacted into law on July 4, 2025
- The most important provisions that affect employer benefits:
  - **Telehealth Services:** Pre-deductible telehealth coverage allowed while maintaining HSA eligibility
  - **Direct Primary Care Service Arrangements (DPCs):** Individuals in a qualifying DPC can contribute to an HSA
  - **Dependent Care Flexible Spending Accounts (DCFSAs):** Limit for 2026 increases to $7,500 or $3,750 for married filing separately

Telehealth Changes

Pre-deductible telehealth coverage allowed without affecting HSA eligibility

Employer may:

- Charge fair market value
- Reduce or eliminate cost-sharing

Applies retroactively to plan years starting after December 31, 2024

- 2024 plan year relief still applies

Mid-year changes may be complex – consider forward implementation

HSAs and Direct Primary Care

Effective beginning January 1, 2026

Individuals in a qualifying Direct Primary Care Arrangement (“DPC”) individually or through their employer can contribute to an HSA

HSA eligibility rules still apply – enrollment in qualified HDHP coverage and no other disqualifying non-HDHP medical coverage

Fixed periodic fee for DPCA services cannot exceed **$150/month for individuals** or **$300/month for more than one individual**

HSAs and Direct Primary Care Cont'd

Direct Primary Care ("DPC") fees can now be paid with HSA funds – starting January 1, 2026

Change only amends §223 of the IRC, which governs HSAs

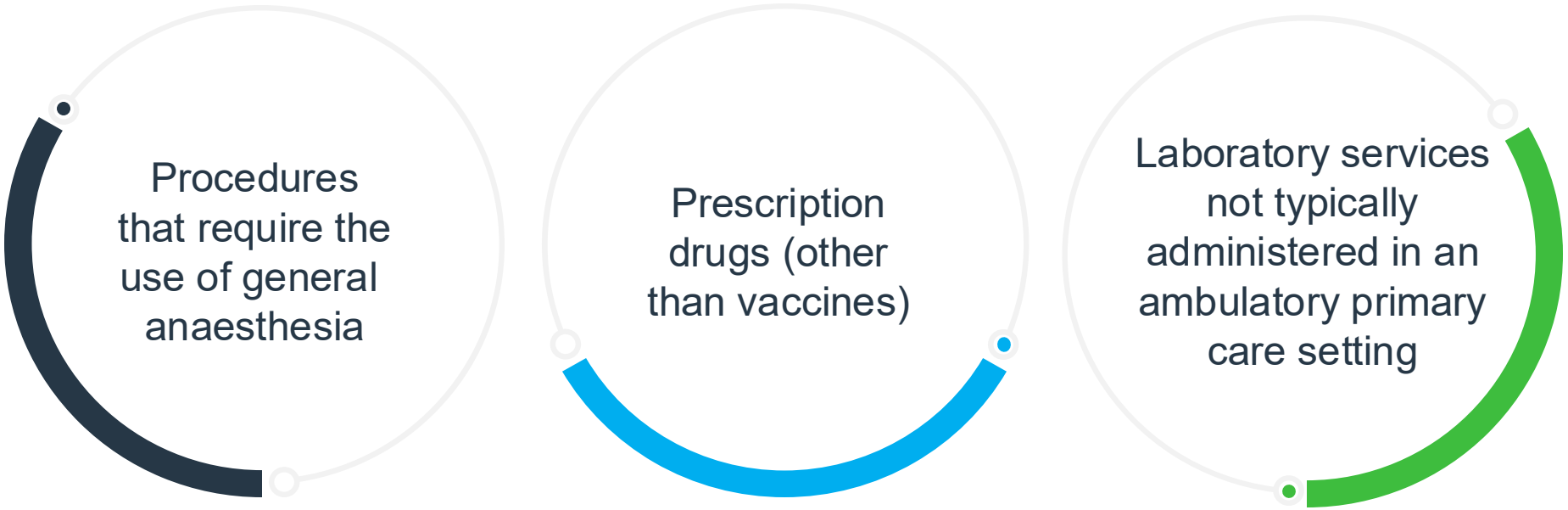
Does not amend §213(d), which is the general definition of medical expenses for virtually all tax purposes

Result – DPC fees are a "medical expense" for HSA funds only, does not apply to FSAs, HRAs or out of pocket medical expenses

Likely beneficial for individuals who have HSA balances but no health coverage

Direct Primary Care – Definition

Direct Primary Care Service Arrangement means, with respect to any individual, an arrangement under which such individual is provided medical care consisting solely of primary care services provided by primary care practitioners if **the sole compensation for such care is a fixed periodic fee**. For purposes of this definition, “primary care services” shall **not** include:



Look to DPC providers to confirm if their offerings meet these requirements

2026 Dependent Care FSA Contribution Limit

Limit increases to **$7,500** ($3,750 if MFS) starting January 1, 2026

Helps families with high childcare costs

Adjustment doesn't match inflation ($5,000 in 1986 is equal to **$14,665** in 2025)

May increase discrimination testing failures for employers

Non-discrimination rules remain unchanged

Foundational Compliance Requirements

2026 ACA Affordability

Affordability of Employee-only Coverage

Lowest cost plan that is **minimum value. Safe harbor for 2025** is **9.02%**, for **2026 it is 9.96%**
Affordability is based on one of the three safe harbors:

1 Rate of Pay

(Hourly rate of pay x 130)
9.96% Maximum amount to charge for employee-only coverage will increase from 2025 to 2026.

- ***Example:*** An employee earning $16.50 an hour in 2025 cannot pay more than $193.47 *per month. However, in 2026, that employee who is still earning $16.50 per hour can be asked to pay $213.64 .*

2 Federal Poverty Level *(FPL)*

Calendar year plans and plans renewing before 7/1/26 must use **2025 FPL* x 9.96% / 12** to assess affordability for 2025
($15,650 x 9.96% / 12) = ***$129.89***

- Non-calendar year plans renewing after 7/1 use 2026 FPL of 15,960 x 9.96% / 12 to assess affordability for 2026 (15,960 X 9.96%/12) = **$132.46** (100% of FPL) **IRS directs employers to use the FPL from within six months before the plan year begins*

3 W-2 Safe Harbor

Use Box 1 of employee's W-2 earnings.
Must use projected 2025 income; amount cannot change throughout the year.

- Box 1 = gross earnings minus pre-tax deductions under a cafeteria plan and a 401(k) plan

ACA Penalties Through the Years

		2021	2022	2023	2024	2025	2026
4980H(a) Penalty	Annual Amount	$2,700.00	$2,750.00	$2,880.00	$2,970.00	$2,900.00	$3,340
	Monthly Amount	$225.00	$229.17	$240.00	$247.50	$241.66	$278.33
	MEC Offer % of FT	95%	95%	95%	95%	95%	95%
	FT Headcount Reduction	30	30	30	30	30	30
4980H(b) Penalty	Annual Amount	$4,060.00	$4,120.00	$4,320.00	$4,460.00	$4,350.00	$5,010
	Monthly Amount	$338.33	$343.33	$360.00	$371.67	$362.50	$417.50
	Affordability Safe Harbor %	9.83%	9.61%	9.12%	8.39%	9.02%	9.96%
	100% FPL Annual Amount*(individual)*	$12,880.00	$13,590.00	$14,580.00	$15,060	$15,650	$15,960
		2021	**2022**	**2023**	**2024**	**2025**	**2026**

ACA Reporting – Reminders for Calendar Year 2025 (reported in 2026)

Remember: Self-insured medical plans, including MEC and ICHRA plans sponsored by employers of any size are required to comply with ACA reporting requirements. Self-insured and level-funded medical plans must comply with federal and state individual mandate reporting requirements.

Who is required to report?

- **Issuer of MEC:** Medical insurance carriers, self-insured medical plans including MEC, ICHRAs, SIHRAs and level-funded plans sponsored by **employers of any size**.
- **Applicable Large Employer (ALE)**: Employer who employed on average 50 FT and FTE employees in the prior calendar year *(2024)*. Must report the offer of coverage made to FT employees for one or more months in a calendar year, the cost of coverage, and if the FT employee elected or waived enrollment in coverage.
- **ACA Reporting Deadlines:**
  - **March 2, 2026** - Distribute Forms 1095-B/C to covered participants and employees.
  - **March 31, 2026** - E-file Forms 1094/1095-B/C with the IRS

What forms are Covered Employers Required to use?

- **Self-insured *(including MEC and ICHRAs)* or level-funded employer with less than 50 FT and FTE employees (non-ALE):** Must use Form 1094 and 1095-B to report the months employees and dependents were covered by a self-insured/level-funded group health plan.
- **Self-insured *(including MEC and ICHRAs)* or level-funded employer who is an ALE:** Must use Forms 1094/1095-C must complete Parts I, II and III of the Form 1095-C. Part III reports the months the employee and dependents, COBRA QB and retirees were enrolled in the group health plan.
- **Fully-insured employer who is an ALE:** Must use Forms 1094/1095-C, must complete only Parts I and II of Form 1095-C.

ACA: New Distribution Options

Employers may notify plan participants that the Form 1095 is available upon request (rather than automatic mailing), if the IRS conditions are met:

For full-time and part-time employees covered under the group health plan:

- Electronic consent will be required to distribute Form 1095 in electronic format
- Notice of consent must be posted on the system where Forms 1095-B/C can be retrieved

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For non-employees (COBRA, partners, retirees and others), the employer may post notice on its public website:

- The notice is clear, conspicuous, and accessible to all full-time employees
- It uses plain language and prominent formatting to highlight relevance
  - "Tax Information" link is on the main webpage
  - Secondary page includes a statement, in capital letters, "IMPORTANT HEALTH COVERAGE TAX DOCUMENTS"
- It explains how to request a copy of Form 1095-C, including contact details for requests
- The notice must be posted by March 2, 2026, and remain accessible through October 15, 2026
- Furnish a copy to the requesting individual within 30 days of the date the request is received

ACA Reporting – Penalties

For filings due in 2026 for the 2025 calendar year, a penalty of $340 could apply for each return or statement to which a failure relates, per calendar year. This applies separately to:

- **Each failure to send the statement to the employee; *and***
- **Each failure to send the statement to the IRS**

Note: Lower penalty caps apply to organizations with less than $5 million in gross receipts

Penalty amounts are reduced if failures are corrected by the following dates:

Thirty-Day Rule

If a failure is corrected within **30 days** after the required filing date *(or the deadline for furnishing individual statements)*, the penalty is reduced to **$60 per return or statement,** and the calendar-year **maximum penalty is capped at $664,500**.

August 1 Rule

If a failure is corrected after the 30-day rule described above but **on or before August 1**, the **penalty is reduced to $130** per return or statement, and the calendar-year **maximum penalty is capped at $1,933,500.**

August 1st or later

If the returns are corrected **after August 1, the penalty is $340** per return capped at **$4,098,500**.

Intentional disregard of ACA filing requirements

Employer is subject to a penalty of at least **$680 per form**—with no maximum.

State Individual Reporting Mandated Deadlines | Updates

Insurance carriers, self-funded *and* level-funded medical plans *(ICHRAs, level-funded and MEC plans)* and insured medical plans if carrier is not filing on the employer's behalf.

California

- Distribute Forms 1095-C/B to covered participants by **February 2, 2026**
- File 2025 1095 C/B forms with state Franchise Tax Board (FTB) by **March 31, 2026**
- ***Entities have an automatic extension until May 31 to file, after which the FTB may assess a penalty of $50 per individual who was provided health coverage.***
- File the state Healthcare MEC on paper if under 250 files; otherwise, the form must file electronically
- The CA distribution deadline does not automatically extend to mirror the federal deadline.
- Report health insurance information | FTB.ca.gov

Massachusetts

- Distribute Form MA 1099-HC to covered participants no later than **February 2, 2026**
- Complete HIRD Form groups with six (6) or more employees and submit to the MTC portal each year on December 15th of the reporting year
- Will be required to file on MassTaxConnect (MTC) portal by **February 2, 2026.**

New Jersey

- Distribute Forms 1095-C/B to covered participants by **March 2, 2026**
- File Form 1095-C/B or NJ Form 1095-C by **March 31, 2026** with the New Jersey Division of Taxation Payroll Taxes and Wage Withholding Login (state.nj.us)
- ** Fully insured plans should not file Forms 1095-C as Part III is blank. Confirm that the medical insurance carrier will file on their behalf. If the carrier will not file, the employer must file NJ-1095.

Rhode Island

- Distribute Forms 1095-C/B to covered participants by **March 2, 2026**
- Forms 1095 C/B must be filed with the Rhode Island Division on Taxation by **March 31, 2026**.

Washington D.C.

- Employers that have a Washington D.C. residence and have 50 or more employees
- Forms 1095-C/B must be distributed to covered participants as outlined by the IRS, including any extensions
- 1095 C/B forms must be filed with the Office of Tax and Revenue no later than 30 days after the form filing deadline established by the IRS, including extensions.
- Forms must be electronically-submitted only to the D.C Office of Tax and Revenue (OTR) at MyTax DC.

HIPAA Updates

HIPAA rules finalized in 2024 regarding reproductive rights have been vacated

- On June 18th, 2025, a Texas federal judge in *Purl v. U.S. Dept. of Health and Human Services* vacated the HIPAA reproductive health rules finalized on April 26, 2024.
- Confidentiality of substance use disorder patient records and updates to Notice of Privacy Practices **still apply** (to a minority of plans) and go into effect February 16, 2026.

What this means for Employers:

- Reproductive health records are no longer afforded the special additional protections (requiring an attestation) before disclosing HIPAA-protected reproductive health information in connection with an investigation. Standard HIPAA protections still apply.
- Updates related to the confidentiality of substance use disorder patient records are still applicable and Part 2 Program providers must update and distribute the Notice of Privacy Practices by **February 16, 2026**.

Mental Health Parity

ERISA Industry Committee (ERIC) filed a complaint against HHS

- **Final MHPAEA Rules released (September 9, 2024)**
- **Effective Date:** Plans renewing on or after January 1, 2025. For some provisions, the effective date will be the first plan year beginning on or after January 1, 2026, the provisions effective in 2026 are:
  - Implementing the meaningful benefits standard,
  - Prohibition on discriminatory factors and evidentiary standards,
  - Required use of outcomes data, and
  - Comparative analysis requirements.
- **ERISA Industry Committee (ERIC) filed a complaint against HHS in January 2025**
  - **Trump Administration announced a non-enforcement policy in May 2025**
  - Statutory obligations under MHPAEA remain in effect
  - Self-funded plans must consider whether to conduct a comparative analysis
  - Retain copies of audit results of MHPAEA tests and determine if there are areas for improvement if the testing identifies any deficiencies
  - Fully insured plans should request carriers provide them with copies of their MHPAEA tests. Retain copy in files due to future DOL audits.

Medicare Part D – New Simplified Determination

Medicare Part D

- CMS released final rules on April 7, 2025, on Medicare Part D simplified **creditable coverage determination** for CY 2026.
- New simplified determination would require a plan to satisfy the following requirements:
  - Provide reasonable coverage for brand name and generic prescription drugs and biological products;
  - Provide reasonable access to retail pharmacies; and
  - Be designed to pay on average at least 72 percent of participants' prescription drug expenses.
- Plans can also use the actuarial determination to assess if their plans are creditable coverage or not.
- Plans filing for the retiree drug subsidy are required to follow the new Part D Simplified Determination criteria, 2026 OOPM for Medicare Part D will be $2,100.
- **Only for CY 2026,** plans can choose to use the old simplified determination to assess if their pharmacy plan is creditable Part D coverage or not.

Transparency

Requirement	Machine-Readable Files	RxDC Reporting	Gag Clause Attestations
What	Post machine-readable files containing costs of INN and OON claims on external website	Report certain data related to prescription drug spend and overall plan expenses	Attest that provider / network agreements do not contain gag clauses prohibiting sharing of certain information
Who	Can be completed by carrier / TPA / PBM on behalf of plan sponsor, or may require plan sponsor to directly complete		
When	Ongoing	June 1, 2026 and thereafter	December 31, 2026 and thereafter
How	Posted on employer's website or website of carrier / TPA	CMS HIOS site: CMS Enterprise Portal	HIOS website: Gag Clause Attestation | Welcome!

Key Takeaways

Key Takeaways

- **Cost pressure is real –** though the impact will vary by employer, region, provider and individuals
- **Strategies available** to mitigate costs while providing value to plan participants carry their own **possible risks** (either from a compliance perspective or otherwise)
- **Fiduciary duties remain applicable and relevant concerns,** even if recent cases haven't been successful to date
- It's new and exciting to develop and implement these modern benefit strategies but it's important to **ensure that the compliance foundation is strong** (ACA compliance, MHPAEA, HIPAA, etc.)
- Be thoughtful in benefits design and **take a compliance-driven approach** to avoid potential pitfalls

UPCOMING EVENTS

hubinternational.com/events/

IN PERSON EVENTS – Employee Benefits

2026 Compliance & Benefits Summits

Regional Events (dates vary by location)

VIRTUAL EVENT – MOXIE Women's Network

Give to Gain:

The Power of Generous Networks, Mentorship & Collective Success

Tuesday, March 10 | 1PM CT

WEBINAR – Retirement & Private Wealth

Medicare Mastery:

Future Planning to Protect Your Health & Wealth

Tuesday, March 24 | 12PM CT

Thank you

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Appendix

Glossary of Terms

- **ACA** – Affordable Care Act
- **ALE** – Applicable Large Employer
- **AV** – Actuarial Value
- **CARES Act** – Coronavirus Aid, Relief and Economic Security Act
- **CMS** – Centers for Medicare & Medicaid Services
- **COBRA QB** – COBRA Qualified Beneficiary
- **Dependent Care FSA/DCAP** – Dependent Care Flexible Spending Account/Dependent Care Assistance Program
- **DOL** – U.S. Department of Labor
- **EOC** – Evidence of Coverage
- **ERISA** – Employee Retirement Income Security Act
- **FSA** – Flexible Spending Account
- **HCE** – Highly Compensated Employee
- **HDHP** – High-Deductible Health Plan
- **HIOS** – Health Insurance Oversight System
- **HIPAA** – Health Insurance Portability and Accountability Act
- **HRA** – Health Reimbursement Arrangement
- **HSA** – Health Savings Account
- **ICHRA** – Individual Coverage Health Reimbursement Arrangement
- **INN** – In-Network

Glossary of Terms

- **MEC** – Minimum Essential Coverage
- **MH/SUD** – Mental Health/Substance Use Disorder
- **MHPAEA** – Mental Health Parity and Addiction Equity Act
- **NDT** – Nondiscrimination Testing
- **NQTL** – Non-Quantitative Treatment Limitation
- **OMB** – Office of Management and Budget
- **OON** – Out-of-Network
- **OOPM** – Out of Pocket Maximum
- **PBM** – Pharmacy Benefit Manager
- **PEPM** – Per Employee Per Month
- **PHI** – Protected Health Information
- **PTC** – Premium Tax Credit
- **PY** – Prior Year/Plan Year
- **RFP** – Request for Proposal
- **SBC** – Summary of Benefits and Coverage
- **SMM** – Summary of Material Modifications
- **SPD** – Summary Plan Description
- **TPA** – Third Party Administrator

PBM Transparency Rules

PBM Disclosure Requirements:

Large Group Employer (100 or more employees)	**Small Employer** (less than 100 employees)
A summary document that includes all the following: ○ Total net spending by the plan and out-of-pocket costs by participants ○ Total compensation paid by the plan to the PBM ○ Total compensation paid by the PBM to pharmacies (as well as the spread amount) ○ Total rebates, fees, and other remuneration received by the plan and PBM ○ Dispensing channel (including retail, mail order, or specialty pharmacy) ○ List of medications filled by brand/generic status, along with wholesale acquisition cost (per day and dosage) ○ Name of each medication dispensed ○ Net price for the cost of treatment, for single, 30-, and 90-day supply costs ○ Total remuneration provided by drug manufacturers to participants (e.g., copay assistance, manufacturer coupons, and others) ○ Description of formulary tiers and utilization management used by therapeutic class- step-therapy, and gross and net cost ○ Top 50 medications with the highest spending if a single medication cost is greater than $10,000 or the gross spend is in aggregate greater than $10,000 for the reporting period ○ Information on affiliated pharmacies (including plan design steerage features, prices versus non-affiliates, net acquisition costs).	Summary document that includes the following information: ○ Total premiums paid by the employer to the PBM ○ Compensation paid to pharmacies by the PBM for each covered drug; ○ For each pharmacy claim, the difference between the amount paid by the employer for pharmacy costs and what the PBM paid the pharmacy and, ○ Name of each dispensed drug