Compliance Watch

October 2025 Roundup:
Federal Shutdown Impact on Federally Funded Workers

PROVANT

In the News:

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Federal Government Shutdown Impact on Federally Funded Workers

As the government shutdown continues with no resolution in sight, employers with federally funded work may have questions about whether certain employees unable to work full-time can remain enrolled in benefits.

Applies To: Employers with federal contract workers or other federally funded positions unable to work full-time hours during the government shutdown.

Go Deeper:

Since October 1, 2025, the federal government has remained shut down as Congress is stalled on appropriating more funds for the new fiscal year. While some federal contracts may have funding to potentially allow full-time work to continue, many employers may find themselves unable to keep some of their employees working full-time hours.

Since it is unclear how long the shut down will last, some employers are considering furloughs, leading them to consider the implications to benefits.

Generally speaking, employers should have clear plan language addressing how long employees can remain on benefits when not working full-time, including during a furlough or layoff.

- Without clear furlough or layoff language, the default is typically to end coverage at the end of the month when an employee stops working full-time hours (and offer COBRA, if applicable). The employer will want to check their policies and plan documents for default language.
- For employers subject to the ACA employer mandate who have adopted the lookback method, employees in a full-time stability period should remain eligible for the full-time medical plan at full-time rates for the duration of any full-time stability period(s) that apply. From there, it is just a matter of identifying how the employees can pay their share of the premium when they are not receiving a paycheck.

If the employer's only source of income is federal appropriations, they should work with counsel to decide between furlough or layoff. Ensuring employees can be eligible for

WHAT'S NEW

Ongoing shutdown is causing reduced hours and furloughs for federally funded positions.

Without clear furlough/ layoff eligibility language, coverage usually ends at month-end.

Employees in an ACA full-time stability period generally stay eligible at full-time rates.

Carrier minimum participation rules may threaten continuation of the plan if many employees are furloughed.

TAKEAWAY

Review plan documents now to confirm eligibility during reduced hours and consider plan amendments before allowing furloughed employees to stay covered.

unemployment may be a primary concern. If considering furlough, the employer must be able to continue paying premiums for employees in a full-time stability period.

The employer may want to pay equal attention to ensuring carriers do not terminate all of their plans due to having no active employees. Check with each carrier to determine the minimum number of employees (working 30 hours per week) required to maintain the plans. Since there is no way to offer COBRA on a terminated group health plan, a notice of unavailability of COBRA may be needed if the plans terminate. Establishing new plans once operations can resume will take time and likely reset deductible and out-of-pocket accumulators for employees. It will be a hardship on employer and employees alike if the plans cease to exist.

Practical Impact to Employers:
Employers with employees performing work that is federally funded may need to consult with employment law counsel about their options given the shut down and any obligations imposed by their specific government contract.

If the employer prefers that employees in these situations remain enrolled in benefits during a furlough, but does not have language allowing the eligibility to remain, they need to quickly adopt a plan amendment and run it by their insurance or stop loss carrier for approval. It is risky to allow someone not working full-time to stay on benefits when they are not otherwise eligible, and proceeding without adequate eligibility language may result in self-funding high dollar claims with no stop loss or backstop, including medical, life, and/or disability claims.

For applicable large employers (ALE), an employee who terminates employment must be allowed to rejoin the plan without a waiting period if they return to full-time work within 13 weeks (or 26 weeks if an educational organization). If the shutdown lasts longer than that, then the employer may want to consider adopting a plan amendment to waive the waiting period for this (and future) government shutdown situations.

Finally, when the employer's sole source of income is the federal government, there is a real risk of having to furlough all employees, the employer being unable to honor premium responsibilities for furloughed employees in full-time stability periods, and plans potentially terminated by carriers. Careful consideration should be given to how to keep the plans alive if these risks become reality, while also trying to balance employees' ability to qualify for unemployment.

IRS Releases 2026 Inflation Adjustments, Including FSA Maximums

The IRS issued Rev. Procedure 2025-32 listing certain tax inflation adjustments for a wide variety of benefits arrangements, including health FSA contribution limits, qualified transportation and parking benefits, qualified small employer health reimbursement arrangements (QSEHRAs), the small employer health insurance credit and other adjustments for the 2026 tax year. These adjustments are outlined below:

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	2025	2026
Health Flexible Spending Accounts (Health FSAs)		
Health FSA Annual Employee Contribution Limit	$3,300 for Health FSA plan year starting in 2025	$3,400 for Health FSA plan year starting in 2026
Note: Employers can contribute additional funds to health FSAs above these limits, up to what the employee contributes (or up to $500 regardless what the employee contributes).		
Health FSA Carryover *(Always 20%)*	$660 may be carried over to a plan year beginning in 2026	$680 may be carried over to a plan year beginning in 2027
§132(f) Commuter Benefits		
Qualified Parking	$325/mo.	$340/mo.
Qualified Transit/Vanpool	$325/mo.	$340/mo.
§137 Adoption Assistance		
Maximum Employer Adoption Assistance Excludable from Income	Up to $17,280, begins to phase out at $259,190	Up to $17,670, begins to phase out at $265,080
Qualified Small Employer Health Reimbursement Arrangements (QSEHRAs)		
Self-Only Annual Limit	$6,350	$6,450
Family Annual Limit	$12,800	$13,100
Small Employer Health Insurance Credits		
Maximum credit is phased out based on average wages and the number of full-time equivalent employees in excess of 10	Credit begins to phase out at $33,300 average annual wage	Credit begins to phase out at $34,100 average annual wage
Penalty for Failure to Provide ACA Information Returns (Forms 1094/1095-B and/or -C)		
	Penalty for 2025 forms 1094/1095 due in early 2026	Penalty for 2026 forms 1094/1095 due in early 2027
Failure corrected within 30 days of due date	$60	$60
Failure corrected by August 1 immediately after due date	$130	$130
Failure corrected after August 1	$340	$340
Intentional disregard	$680 or more	$690 or more
Note: All penalties may be assessed twice, once for forms owed to employee/beneficiary, and again for forms owed to the IRS. While penalty caps may apply based on the employer's gross receipts, they are high caps and also apply separately for forms not provided to employees versus forms not provided to the IRS. No cap applies for intentional disregard.		

Employers providing any of the applicable arrangements need to ensure amounts are adjusted and communicated to employees, and plan documents are updated accordingly.

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New Flexibility for Fertility Benefits

On Thursday, October 16, 2025, federal agencies published new FAQs Part 72 granting additional flexibility for employers with respect to fertility benefits by:

- Allowing stand-alone, specified disease insurance for infertility;
- Permitting employee assistance plans (EAPs) to include coaching and navigator services to guide employees and dependents through their infertility service options; and
- Reminding employers of the availability of excepted benefit health reimbursement arrangements (EBHRAs) which can reimburse §213(d) medical expenses, including fertility costs, even for employees not enrolled in the employer's medical plan.

The Trump Administration also announced a new partnership to obtain most favored nation pricing for fertility medication from EMD Serono, as a hopeful catalyst that leads to other decreases in fertility care costs.

Applies To:

Employers interested in expanding fertility benefit options beyond what is covered under their company's medical plan, including benefits for employees not enrolled in the medical plan.

Go Deeper:

Federal regulators at the Department of Labor (DOL), Treasury, and Health and Human Services (HHS) jointly published updated guidance in Affordable Care Act (ACA) FAQs Part 72 to equip employers with ways to expand their fertility benefits beyond what their medical plan might cover today, and to extend benefits to those not enrolled in the medical plan.

Stand-Alone, Specified Disease Insurance for Infertility

For now, the main flexibility focuses on allowing fertility benefits to be offered as "a specified disease or illness insurance policy that covers benefits related to infertility as a type of independent, non-coordinated excepted benefit." Excepted benefits are exempt from much of the ACA, HIPAA, MHPAEA, and a few other group health plan laws. Note that such a policy can be offered on a stand-alone basis even for employees not eligible for the medical plan, and they are compatible with health savings accounts (HSAs).

Under existing regulations, a specified disease policy must meet the following criteria:

A. The benefits are provided under a separate policy, certificate, or contract of insurance;
B. There is no coordination between the provision of the benefits and an exclusion of benefits under any group health plan maintained by the same plan sponsor; and
C. The benefits are paid with respect to an event without regard to whether benefits are provided with respect to the event under any group health plan maintained by the same plan sponsor.

Therefore, specified disease policies do not have to be fixed indemnity policies, although they are typically structured to pay a fixed flat amount for a diagnosis or service regardless of the individual's actual out-of-pocket costs for care. For example, cancer or critical illness policies often pay a lump sum of several thousand dollars for a specified diagnosis, and may provide a further flat amount for certain additional services beyond the initial diagnosis. Likewise, a fertility insurance policy that pays a lump sum when someone is diagnosed with infertility would seemingly be considered an independent, non-coordinated excepted benefit if it met the criteria listed above.

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As a reminder, specified disease insurance benefit payouts are fully taxable to the employee unless the employee pays the full premium after-tax. To avoid tax concerns with benefits the plan pays, it may be ideal to not allow employees to pay these premiums pre-tax. If the employer wants to pay for the specified disease policy, they could gross up taxable pay and then have employees pay the full premium after-tax.

The Departments acknowledge this non-coordinated specified disease insurance guidance fits within the rules that exist today but might be a bit limiting *(for example, it requires an infertility diagnosis before it can pay, must be fully insured, and cannot coordinate with the medical plan, so must pay even if the medical plan provides some initial coverage).* So, they are open to proposing additional flexibility in future rulemaking.

- They could propose a rule allowing fertility benefits to be an always excepted benefit, similar to the rules that treat dental, vision, limited wrap-around, and EAPs as categorically excepted benefits when they meet some restrictions.
  - Such an approach would be more flexible as it would not require a diagnosis of infertility, instead treating this as a type of benefit plan that is always excepted.
- Another proposal could allow fertility benefits as supplemental, excepted health coverage with an increase to the 15% price cap from 2007 guidance.
  - Such an approach would allow coordinating with the medical plan rather than having to pay the full benefit amount upon a diagnosis when the plan offers some initial coverage.

EAPs Can Include Infertility Coaching and Navigator Services

EAPs can also be another type of excepted benefit. The general rule is they must be fully paid for by the employer, cannot impose cost-sharing to the participant, cannot coordinate with the medical plan, and cannot provide significant medical care. FAQ Part 72 clarifies that an EAP could include coaching and navigator services to help employees and their dependents understand their fertility options (without the EAP losing its excepted status).

Excepted Benefit Health Reimbursement Arrangement (EBHRA) Reminder

The FAQs also remind employers that they can extend an EBHRA to anyone eligible for the medical plan, even if they waive the medical plan. This benefit can reimburse up to $2,150 ($2,200 in 2026) for any valid §213(d) out-of-pocket medical care expense (with some restrictions/exclusions for certain insurance premiums). These arrangements could be used to provide tax-favored employer reimbursement of fertility costs that meet the §213(d) definition of medical care. A broad range of fertility treatments qualify, including in-vitro fertilization for the employee, spouse, and dependents, but expenses for third party donors or surrogates do not qualify as explained in IRS Publication 502.

Most Favored Nation (MFN) Pricing of Fertility Medication

The Trump Administration also announced striking a deal for the fertility medication, GONAL-F, and a commitment from the manufacturer, EMD Serono, to build a facility in the U.S. for its manufacturing. Their announcement also outlined future goals to further bring down the costs of fertility care in the U.S.

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Penalties for Non-Compliance:

Employers must be careful when sponsoring benefits that provide or reimburse medical care, as that typically creates a group health plan subject to several federal laws. The excepted benefits outlined in the FAQ Part 72 are designed to guide employers to perhaps offer additional benefits beyond what the medical plan covers and to offer these additional benefits to employees not enrolled in the medical plan without triggering hefty penalties. Done incorrectly, the employer can expect to pay $100 per person per day for a non-compliant plan that violates Affordable Care Act rules.

Practical Impact to Employers:

With the current administration's focus on expanding access and reducing costs for fertility benefits, additional rulemaking is likely in the near future. This new guidance clarifying how fertility benefits can be structured to be excepted more explicitly allows employers to provide fertility benefits beyond what their medical plan covers today, and gives the option to offer them to more employees than just those on the medical plan. It is important for employers to remember that fertility benefits designed to be excepted are likely still considered group health plans subject to federal laws like ERISA, COBRA, and others, even if they are excepted benefits under some laws like the Affordable Care Act and HIPAA. Employers should work with service providers and their counsel to ensure that any infertility offering is structured properly to fit within this now updated compliance framework.

Federal Updates:

Final 1094/1095-B & C Forms for 2025 Issued with Draft Instructions

The IRS issued final forms and draft instructions related to 2025 ACA reporting requirements (due in early 2026):

- 2025 Final 1094-B and 1095-B with Draft Instructions
- 2025 Final 1094-C and 1095-C with Draft Instructions

Note that although the original draft instructions were missing the new alternative distribution method for 1095-C forms authorized under the Paperwork Burden Reduction Act, a new set of draft instructions reflecting those changes was published on October 24. While it is possible that other changes could occur, most indications suggest that the final 2025 instructions will be materially the same as the newly updated draft instructions. And there do not appear to be any other material changes from this year's instructions.

Applies To:

- All employers who were an applicable large employer (ALE) in 2025 based on their calendar year 2024 employment counts, regardless of whether a health plan is offered (1094/1095-C).
  - Includes ALEs with fully-insured and self-funded health plans, including individual coverage health reimbursement arrangements (ICHRAs).
  - Also includes employers who may not have averaged 50 or more full-time and equivalent employees (FTEs) in 2024 but were part of a controlled group or affiliated service group of companies that did average a combined total of 50+ FTEs, making the related entities ALE members of an aggregated ALE group.
- Small employers with level-funded or self-insured health plans, including ICHRAs (1094/1095-B).

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Go Deeper:

Employers subject to these reporting requirements must observe the following deadlines for filing and distributing their 2025 ACA forms in early 2026:

- 1095-C and B forms must be furnished to individuals by March 2, 2026, reflecting a permanent automatic extension of 30 days after January 31.
  - As a reminder, those choosing the new alternative method of distribution for their C-series forms must post a clear, conspicuous, and accessible notice on their organization's website beginning March 2, 2026 and keep it on their website through at least October 15, 2026, informing people how they can download or request their 1095-C.
- Paper filings are due to the IRS by March 2, 2026.
  - Importantly, employers who file in aggregate 10 or more of various types of information returns, including W-2s, 1099s, 1098s and 1095-B or C, must file their 1094/1095-C and B forms electronically. As a result, only very small employers are still able to file paper forms.
- Electronic filings are due to the IRS by March 31, 2026 (applicable to most employers).
  - The penalty for failure to file electronically is $340 for each return for which the failure occurs.

Each failure to provide a required 1095 form to an individual in 2026 triggers a penalty of $340, subject to an annual penalty cap based on the employer's gross receipts. This penalty (and cap) also separately applies for each failure to provide a correct return to the IRS. Correcting errors within 30 days reduces the penalty to $60 per failure. Correcting by August 1 reduces the penalty to $130 per failure. An intentional disregard is penalized at least $680 per failure with no penalty cap.

In addition, the 1095-C instructions were also updated to reflect that the affordability safe harbors and qualifying offer method are applied using the percentage for 2025, which is 9.02%.

As they often do, Publications 5165 (guide for electronically filing ACA information returns for software developers and transmitters), 5258 (ACA AIR submission composition and reference guide), and 5308 (guide for automated enrollment for ACA providers) have also been revised slightly. However, employers are encouraged to work with their payroll provider or other ACA filing platform for assistance with filing electronic returns.

While an additional extension to provide employees with their forms is no longer available, employers can still apply for an extension for their IRS filing deadline by submitting Form 8809 prior to the filing due date.

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Hot Topics:

Time to Prepare for Attestations for Gag Clause Prohibition Compliance Due to CMS by December 31, 2025

Section 201 of the Consolidated Appropriations Act,2021 (CAA-21) requires Plans and Issuers to attest each year by December 31st that they do not have any agreements with prohibited "gag clauses." In preparation , employers should start confirming whether their health plan providers and service agreements contain any prohibited gag clauses, document any requests to remove prohibited gag clauses that exist, and verify whether the online attestation will be completed by a third party or by the employer.

Applies To: All size employers with fully-insured and self-funded medical plans.

Who is Exempt:

- Plans consisting of only excepted benefits.
- Health reimbursement arrangements (HRAs) and individual coverage HRAs (ICHRAs) are not required to attest as these plans do not typically need to enter into agreement with medical providers. Instead, these arrangements are usually integrated with other medical coverage that is required to submit an attestation (e.g., HRAs integrated with group health plan and ICHRAs with individual medical coverage).

Otherwise, all group health plans regardless of size, funding strategy or grandfathered status must submit the required attestation (or arrange to have the attestation performed on their behalf).

Go Deeper:

What is a gag clause and what is prohibited?

The CAA-21 prohibits group health plans and insurance carriers from entering into agreements with providers, insurance carriers, third party administrators (TPAs), or other service providers whose agreements include language that would constitute a "gag clause," specifically:

1. restrictions on the disclosure of provider-specific cost or quality of care information or data to referring providers, the employer plan sponsor, participants, beneficiaries, or enrollees, or individuals eligible to become participants, beneficiaries, or enrollees of the plan or coverage
2. restrictions on electronic access to de-identified claims and encounter information or data for each participant, beneficiary, or enrollee upon request and consistent with the privacy regulations promulgated pursuant to section 246(c) of HIPAA, GINA, and the ADA; and
3. restrictions on sharing information or data described in (1) and (2), or directing that such information or data be shared, with a business associate, as defined in 45 CFR 160.103, consistent with applicable privacy regulations.

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For example, if a contract between a TPA and a group health plan states that the plan will pay providers at rates designated as "Point of Service Rates," but the TPA considers those rates proprietary and therefore includes language in the contract stating that the plan may not disclose the rates to participants, that language prohibiting disclosure is considered a prohibited gag clause, thus not allowed.

As another example, if a contract between a TPA and a plan says that the employer's access to provider-specific cost and quality of care information is only at the discretion of the TPA, that contractual provision would be considered a prohibited gag clause.

Self-insured employer plan sponsors and fully-insured carriers must ensure that their agreements with health care providers, networks or associations of providers, or other service providers offering access to a network of providers do not contain these, or other provisions, that violate the prohibition on gag clauses. However, a health care provider, network or association of providers, or other service provider may place reasonable restrictions on the public disclosure of this information.

What should occur now, in advance of the attestation deadline?

While many insurers and TPAs proactively notify plan sponsors each year that their contracts do not contain prohibited gag clauses, some do not. If such written assurances or certifications have not been received for 2025, employers and advisors are encouraged to reach out to confirm well in advance of the December 31 attestation deadline. In the case that an insurer, TPA, or other service provider contract includes a gag clause, employers and advisors should document all attempts to request their removal.

In addition, employers and advisors need to confirm with carriers, service providers and TPAs what level of assistance will be provided with the attestation process itself.

- Fully-insured group health plans: The plan sponsor and the insurance carrier are both required to submit the GCPCA each year by December 31st. However, a fully-insured plan sponsor may shift liability to the carrier through a written agreement.
- Self-funded and level-funded plans may satisfy the requirement to provide a GCPCA by entering into a written agreement under which the plan's service provider(s) (such as a TPA, including an issuer acting as a TPA) will attest on behalf of the employer plan sponsor. However, even if the plan enters into an agreement with the TPA, the legal requirement to remove any gag clauses and provide an attestation rests on the plan sponsor.

A sample outreach may be worded as follows:

In accordance with Section 201 of the Consolidated Appropriations Act, 2021, we ask that you please confirm that all provider and service contracts in force for any part of 2025 and going forward do NOT include any prohibited gag clauses. If any gag clauses are included, please confirm they are being immediately removed and the date of removal. Finally, we ask that you please confirm whether the gag clause attestation to CMS is a service you provide and, if so, the steps we need to take, if any. If your organization does not submit the attestation on behalf of our Plan, please let us know as soon as possible so that we can make other arrangements.

The responses confirming compliance with these requirements and who must submit the attestation to CMS should be kept on file in case of an audit or dispute.

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Next steps for employers

Documenting your insurers and TPA's assurances of the extent to which their provider and service contracts are compliant, as well as any attempts to have gag clauses removed, is an important first step. For attestations not handled by the insurer or TPA, the employer can then move on to the attestation process itself as the end of December approaches.

In an FAQ published in January 2025, the federal government stated plans with known gag clauses must ensure the online attestation is submitted by December 31 but can explain their concerns under the "Additional Information" box in Step 3 of the submission. So documenting efforts to remove gag clauses is key since the attestation is required no matter what.

Question of the Month

Q: Can we allow employees to pay pre-tax contributions toward accident, cancer, critical illness, and other indemnity worksite benefit premiums?

A: Section 125 allows employers to deduct these voluntary worksite premiums on a pre-tax basis. However, this typically makes all benefits paid from such policies taxable, and most carriers do not issue a 1099 to reflect the taxable benefit received. To avoid confusion and potential problems with the IRS for failing to properly report taxable benefits, it is generally recommended that employers deduct these premiums after-tax, not pre-tax. See the IRS's 2017 chief counsel memorandum here for more information.

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