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Rewards Policy Insider
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In this Issue:

Upcoming Compliance Reminders for Calendar Year Employee Benefit Plans

September 2025

15th: PBGC premium filing deadline

30th: Summary Annual Report (SAR) deadline

October 2025

14th: Medicare Part D Creditable Coverage Notice

15th: Extended Form 5500 filing deadline (if requested)

Note: This is meant to be a reminder of certain upcoming compliance deadlines for employee benefit plans operating on a calendar year basis. It is not an exhaustive list of compliance obligations. Specific plans may be subject to different obligations and deadlines depending upon a variety of factors, including the plan type, plan year, and whether or not the plan is subject to ERISA, among other things.

Department of Labor Rescinds Approval of Company's Diversity Program for Investment Managers

In July, the Department of Labor ("DOL") rescinded Biden-era guidance that had concluded that ERISA permits a company to operate a program that reimburses investment management fees billed by investment managers that qualify as "diverse" if they are retained by the company's employee benefit plans. In updated guidance, DOL now says that the program – which is part of the company's initiative to advance racial equity in the financial services industry – is unlawful.

Background

DOL occasionally issues written "advisory opinions" to individuals or organizations for the purpose of interpreting ERISA as it applies to a specific set of facts. Only the party requesting the opinion may rely on it, but advisory opinions are generally seen as a wider signal of DOL's thinking on a particular ERISA-related matter.

In 2023, under the Biden Administration, DOL issued Advisory Opinion 2023-01A, which responded to a financial services provider's request for DOL to weigh in on the company's Racial Equity Asset Manager Program (the

"Program"). Under the Program, the company pays some or all of the investment management fees for diverse investment managers if they are retained by the company's employee benefit plans. Subject to several conditions, the Program allocates amounts to the company's plans to pay some or all of the investment management fees for these diverse managers. Each participating plan has a committee appointed by the company that selects the investment managers based on a series of factors.

In the 2023 advisory opinion, DOL greenlit the Program and concluded that ERISA does not prohibit the Program from reimbursing the fees of diverse investment managers from corporate assets for employee benefit plans for which the company is the plan sponsor. DOL also answered a number of specific questions about the program. For example, DOL said that it would not be considered a fiduciary act to reimburse a diverse investment manager's fees because that is a "settlor" activity (i.e., an activity that does not implicate ERISA's fiduciary duties because it merely relates to plan establishment, termination, or design decisions).

2025 Guidance Rescinds Prior Approval of Diverse Asset Manager Program

On July 21, 2025, DOL released Advisory Opinion 2025-01A, which rescinds the 2023 advisory opinion. In the new advisory opinion, DOL says that the 2023 guidance "no longer reflects the views" of the agency, and concludes that the Program is "not lawful" because it allocates benefits on the basis of race and therefore violates civil rights law. The advisory opinion goes on to say that the company "should take immediate action to end all illegal activity" within the Program and within "any other initiative, plan, program, or scheme it operates under the banner of diversity, equity, and inclusion."

Companies considering similar programs should be aware of this new stance that the Trump Administration's DOL has adopted with respect to the Program.

Illinois Enacts PBM Reform Law; Federal Judge Blocks Arkansas Law Prohibiting PBMs from Owning Pharmacies

On July 1, Illinois Governor Jay Pritzker signed the Prescription Drug Affordability Act to ban "spread pricing" and "steering" by pharmacy benefit managers (PBMs) in Illinois, and to implement other PBM-related reforms. In Arkansas, a federal district court judge temporarily blocked a new law that would prohibit PBMs from owning pharmacies in that state.

Illinois Prescription Drug Affordability Act

As noted, the new Illinois law prohibits PBMs in that state from "spread pricing," which the bill defines as charging health plans more for a drug than the PBM

reimburses the pharmacy. The bill also prohibits "steering," which includes requiring a participant to use a pharmacy in which the PBM has an ownership interest or controls, or plan designs – such as different cost-sharing requirements – to encourage participants to use pharmacies the PBM owns or controls.

The bill also requires PBMs to surrender all fees they collect from pharmaceutical manufacturers to the plan sponsor. PBMs also must agree to annual audits by plan sponsors to ensure compliance with this and other requirements.

These and other reforms, which the bill applies to both fully-insured and self-insured ERISA plans, generally begin taking effect on January 1, 2026.

Additionally, the bill requires PBMs to pay a $15 per covered individual fee each year to the state's new Prescription Drug Affordability Fund. The first payment is due by September 1, 2025.

Arkansas Act 624

In general, Arkansas Act 624, which is scheduled to take effect on January 1, 2026, prohibits PBMs from owning or operating pharmacies in Arkansas. The Pharmacy Care Management Association (PCMA) and certain PBMs sued to invalidate the law based on the U.S. Constitution's commerce clause and various other constitutional and federal legal grounds.

The commerce clause gives Congress the exclusive power to regulate interstate commerce. As a result, states are generally prohibited from discriminating against interstate commerce. According to the district court, the PCMA and other plaintiffs "are likely to prevail" on their commerce clause claim, and so it is proper for the court to block enforcement of the law until this and other substantive claims are resolved.

Arkansas has appealed the injunction to the 8th Circuit Court of Appeals. But whether that appeal is successful or not, these are really just the first steps in what will likely be another long battle over the lengths to which states can go to regulate PBMs.

New ERISA Lawsuit Targets Health Plan's PPO Options

A lawsuit filed by former participants in a university's group health plan alleges that one of the plan's PPO options, which has higher premiums but lower deductibles than the other PPO options, offers no financial or medical benefit when compared to the other options. In a novel argument, the plaintiffs say that the plan sponsor has breached its ERISA fiduciary duties by offering this option and misleading participants into believing it could reduce their out-of-pocket costs.

Background

The lawsuit, which was filed in late June in an Illinois district court, involves a university's group health plan that offers three PPO options, which vary in monthly premiums, out-of-pocket maximums, and deductibles. The low-deductible option has higher monthly premiums in exchange for a lower annual deductible, while the high- and mid-deductible options offer lower premiums but higher annual deductibles. According to the plaintiffs, the university informs participants that choosing the two lower-premium/higher-deductible options means they will likely pay more in out-of-pocket costs than they would if they choose the high-premium/low-deductible option.

Lawsuit Targets PPO Options

The plaintiffs, who are former participants in the university's plan, allege that the plan sponsor breached its fiduciary duties under ERISA by (1) failing to appropriately select the plan's PPO options, under which the high-premium/low-deductible option provides the same value as the two lower-premium/higher-deductible options but costs more; and (2) failing to disclose this information to participants. In other words, the plaintiffs allege that the plan sponsor misleads participants by informing them that they will likely pay more in out-of-pockets costs with the two lower-premium options, but in reality, the high-premium option results in the highest payroll deductions for monthly premiums while not providing any additional financial or medical benefits over the lower-premium options.

The plaintiffs' claims rely on a theory they refer to as "financial dominance," which says that one option is "dominated" by another when it provides the same value to a consumer yet costs more than the alternative. The plaintiffs say that the fact that the lower-premium options "dominate" the high-premium option has caused participants to pay excessive health care costs.

The plaintiffs argue that the university is aware of these unfair differences, but has not taken any steps to remedy the problem, and continues to tell participants that the high-premium option is the most financially advantageous.

Outlook

This case is representative of a new wave of litigation against health and welfare plans seeking to impose ERISA's fiduciary standards onto health plan design. The lawsuit also puts forward a novel allegation that a plan sponsor offering a "financially dominated" plan option violates ERISA's duties of loyalty and prudence.

One question the district court may eventually address is whether offering a particular plan option is considered a "fiduciary" function – which is subject to ERISA's fiduciary duties – or a "settlor" function (e.g., decisions to adopt or modify a welfare plan), which falls outside the bounds of ERISA. This case is still in the very early stages, but plan sponsors should watch for developments because it has the potential to broaden the scope of health plan activities that fall under the umbrella of ERISA.

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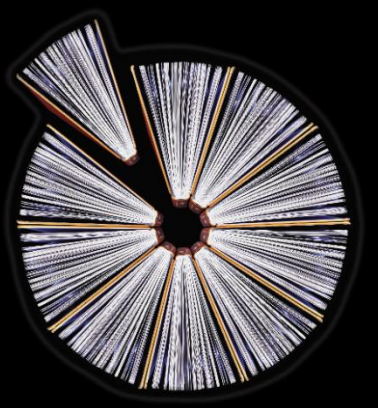

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