OCTOBER 2025

INSIGHT

Supreme Court Holds Retirees Not Protected by the Americans with Disabilities Act

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Recently, in resolving a circuit court split, the Supreme Court held in *Stanley v. City of Sanford*[1] that a retiree is not a "qualified individual" under the Americans with Disabilities Act (ADA).

The case involved a retired firefighter (Karyn Stanley) in the City of Sanford, Florida who sought increased health insurance options after her retirement.

When Ms. Stanley was hired by the City in 1999, retirees were offered health insurance until age 65 for those with 25 years of service and for those who retired earlier due to disability. A few years after Ms. Stanley was hired, in 2003, the City modified this benefit.

The revised policy retained the health insurance availability until age 65 only for retirees with 25 years of service while those who retired earlier due to disability would receive only 24 months of coverage.

Ms. Stanley retired in 2018 due to disability, meaning she was entitled to only 24 months of health insurance under the revised policy.

Ms. Stanley filed suit, claiming that the City violated the ADA by providing different health insurance benefits to those who retire with 25 years of service and those who retire due to disability.

The district court dismissed her ADA claim, finding that she was not a "qualified individual" under Title I of the ADA, since the alleged discrimination occurred after she retired. The district court's decision was affirmed by the Eleventh Circuit Court.

The Supreme Court reviewed, specifically looking at whether a retired employee who does not hold or seek a job is a "qualified individual" under the ADA. The statute provides that a covered employer may not discriminate against a qualified individual in regard to compensation (which includes retirement benefits). Under the ADA, a "qualified individual" is someone "who, with or without reasonable accommodation, can perform the essential functions of the employment position that [she] holds or desires."[2]

[1] 145 S.Ct. 2058 (2025) (*See* https://www.supremecourt.gov/opinions/24pdf/23-997_6579.pdf)
[2] 42 U.S.C. § 12111(8)

First, the Supreme Court looked to the statutory language itself, noting that the statute uses present-tense verbs ("holds," "desires," "can perform"), defines "reasonable accommodation" in terms of accommodations that make sense in the context of current employees and applicants but not retirees, and provides examples that discuss discrimination against job holders and seekers.

The Court found these to be indications that the protections extend solely to individuals who are able to do the job they hold or seek at the time they suffer discrimination.

In reaching its conclusion, the Court also looked to its precedent, specifically *Cleveland v. Policy Management Systems Corporation*[3], where it found that a plaintiff who asserts that the individual is "unable to work" would appear to negate an essential element of the individual's ADA case and may fall outside the ADA's protections.

While the Court held that "qualified individual" coverage would not extend to retirees, as they do not hold and are not seeking a job at the time of the discrimination, they did review a few scenarios where an individual who is retired at the time they file suit may find protection.

Specifically, protections may be available if the retiree can prove they were:

- Disabled and a qualified individual at the time the discriminatory retirement-benefits policy was adopted by their employer.
- Affected by the change while they were a qualified individual.
- Subject to a discriminatory compensation decision or other practice while they were a qualified individual.

Writing for the majority, Justice Neil Gorsuch emphasized that, "The statute protects people, not benefits, from discrimination." The decision concludes by reinforcing that for a successful claim, a plaintiff must plead and prove that at the time of the alleged discrimination, the individual held or desired a job and could perform its essential functions with or without reasonable accommodation.

Therefore, as there are situations where a retiree could state a successful claim, employers should use caution when modifying post-employment benefits.

Reporting and Withholding of Uncashed Retirement Checks

The proper reporting and withholding for uncashed (and reissued) retirement plan checks has been an ongoing issue for retirement plans. In 2019, the Internal Revenue Service (IRS) issued limited guidance relating to uncashed checks under Revenue Ruling 2019-19[4] to address reporting and withholding on an uncashed check that is received, but not cashed by the recipient.

Building on that guidance, the IRS recently issued Revenue Ruling 2025-15[5], more broadly addressing reporting and withholding obligations when a check is uncashed, cancelled, and then reissued.

[3] 526 U.S. 795 (1999)
(*See* https://tile.loc.gov/storage-services/service/ll/usrep/usrep526/usrep526795/usrep526795.pdf)
[4] https://www.irs.gov/pub/irs-drop/rr-19-19.pdf
[5] https://www.irs.gov/pub/irs-drop/rr-25-15.pdf

Revenue Ruling 2025-15 expressly analyzes the following situation:

- A section 401(a) plan[6] makes a distribution and withholds federal income tax, as required under Internal Revenue Code (Code) Section 3405[7].
- The withheld federal income tax is remitted to the Treasury Department.
- A check for the remainder of the distribution is mailed to the retirement plan member.
- The member does not cash the check during the six-month period following the distribution.
- The employer cancels the check and mails a second check to the same member.

For this scenario, the ruling provides that the initial reporting and withholding is retained. Though there are situations where adjustments to withholding are permitted, the ruling provides that where the initial check remains uncashed (even if it is cancelled), no adjustment or refund of the withheld amounts is permitted, since the amount withheld on the amount of the first check was the correct amount under applicable withholding rules.

Further, the fact that the first check is cancelled, returned as undeliverable, or remains uncashed for any other reason does not change the Form 1099-R reporting requirements for that check. In other words, the initial Form 1099-R reporting is correct and a corrected Form 1099-R does not need to be filed.

If a second check is later issued (or reissued) to the payee who did not cash the first check, and the amount of the second check is not more than the first check, no federal income tax withholding is required when the second check is issued, and no corresponding Form 1099-R reporting is required (so long as the first check was properly reported).

Conversely, if the amount of the second check is more than the first check (for example, because of interest accrual on a member's contributions), the additional amount is subject to federal income tax withholding and Form 1099-R reporting (unless the increased amount is less than the $10 de minimis reporting exception).

Revenue Ruling 2025-15 is consistent with prior IRS rulings that concluded that reporting and withholding obligations generally apply at the time a retirement plan check is distributed. While Revenue Ruling 2025-15 provides some helpful guidance, questions and complexities still remain.

Specifically, the ruling does not address: 1) the validity of mailing a check to an address on file that the plan administrator has reason to believe is incorrect; 2) a different issuer issuing the second check (such as where the amount has been transferred to the PBGC's missing participant program); or 3) issuing the second check to anyone other than the recipient of the first check (such as to the member's surviving spouse).

In addition, complexities may arise where a distribution includes after-tax amounts or where the distribution is issued as a direct rollover to another eligible retirement plan or IRA.

Therefore, notwithstanding this useful guidance, payments to missing or unresponsive members will likely continue to raise reporting and withholding questions for retirement plans.

[6] The ruling assumes that the member (or other recipient) has not made a withholding election under Code Section 3405 and has no investment in the contract under Code Section 72, and that the plan has no employer securities, designated Roth accounts, or other features with unique tax considerations.

[7] https://www.govinfo.gov/content/pkg/USCODE-2023-title26/pdf/USCODE-2023-title26-subtitleC-chap24-sec3405.pdf

One Big Beautiful Bill Act: Health and Welfare Provisions

On July 4, 2025, President Trump signed into law the One Big Beautiful Bill Act (the OBBB)[8]. Among other provisions, the OBBB contains many health and welfare-related provisions, as described below.

1. Health Savings Account (HSA) Provisions

a. Telehealth

A high deductible health plan (HDHP) generally cannot cover telehealth pre-deductible, and an individual is not eligible for HSA contributions if the individual is covered by a telehealth arrangement outside the HDHP (except for preventive care). There was temporary statutory relief allowing a safe harbor for "telehealth and other remote care services," but that relief expired for plan years beginning on or after January 1, 2025.

The OBBB reinstated that relief, retroactive to plan years beginning after December 31, 2024. Specifically, under the OBBB, an HDHP can cover telehealth and other remote care services pre-deductible, and an individual is eligible for HSA contributions if the individual is covered by a telehealth and other remote care services arrangement outside the HDHP.

b. Direct Primary Care Service Arrangement

An individual is generally not eligible to contribute to an HSA if the individual is covered by another "health plan." In 2020, the Internal Revenue Service (IRS) issued proposed regulations and took the position that a Direct Primary Care Service Arrangement (DPCSA) would be a disqualifying "health plan" unless it was limited to permitted coverage (e.g., dental or vision) or preventive care.

The OBBB revised the HSA statute, effective January 1, 2026, to provide that a DPCSA is not a disqualifying "health plan."

For this purpose, a DPCSA means an arrangement under which the individual is provided Internal Revenue Code (Code) Section 213(d)[9] 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.

The aggregate monthly fees for all DPCSAs under which the individual is covered must be: 1) $150 or less for a DPCSA that only covers the individual; or 2) $300 or less for a DPCSA that covers more than one individual (adjusted for inflation).

"Primary care practitioners" is defined by reference to Social Security Act Section 1833(x)(2)(A)[10], which defines that term to mean an individual who is a: 1) physician who has a primary specialty designation of family medicine, internal medicine, geriatric medicine, or pediatric medicine; or 2) nurse practitioner, clinical nurse specialist, or physician assistant.

The statute does not define "primary care services" except to provide that it does not include: 1) procedures that require the use of general anesthesia; 2) prescription drugs (other than vaccines); or 3) laboratory services not typically administered in an ambulatory primary care setting. The statute directs the IRS and Department of Treasury to consult with the Department of Health and Human Services (HHS) and issue guidance regarding this definition.

[8] https://www.congress.gov/bill/119th-congress/house-bill/1
[9] https://www.law.cornell.edu/uscode/text/26/213
[10] https://www.law.cornell.edu/uscode/text/42/1395l

In addition, with certain exceptions, an HSA cannot pay for health insurance without adverse tax consequences. The OBBB revised the statute, effective January 1, 2026, to provide that an HSA can pay DPCSA fees on a tax-free basis.

c. HSA-Compatible Individual Coverage HDHPs

To be eligible for HSA contributions, an individual must be covered by an HDHP with a certain minimum deductible and maximum out-of-pocket limit. The OBBB revised the statute, effective January 1, 2026, to provide that bronze and catastrophic plans available as individual coverage through the ACA Exchanges are HSA-compatible HDHPs, even if they do not meet the minimum deductible or maximum out-of-pocket limit that otherwise apply to HSA-compatible HDHPs.

2. Dependent Care Assistance Program Provision

The annual tax exclusion for dependent care assistance program benefits is limited to $5,000 ($2,500 if the employee is married and files a separate tax return). Effective for taxable years beginning in 2026, the OBBB increases this exclusion to $7,500 ($3,750 if the employee is married and files a separate tax return).

3. Educational Assistance Program Provisions

a. Exclusion Amount

The annual tax exclusion for educational assistance program benefits is limited to $5,250. This amount is not indexed. Effective for payments made after 2026, the OBBB indexes this exclusion amount based on the cost-of-living.

b. Student Loan Payments

Educational assistance programs can pay or reimburse qualified student loan payments, but only for payments made by December 31, 2025. The OBBB makes this provision permanent such that programs can continue to pay or reimburse qualified student loan payments after December 31, 2025.

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