MY BENEFIT ADVISOR

2026: Second Quarter

Compliance Digest

Compliance Bulletins Released April to June

2026 Compliance Bulletins: Second Quarter

April

May

June

Reminder: San Francisco HCSO Reporting Due May 1, 2026

Issued date: 04/01/26

As a reminder, employers covered under the San Francisco Health Care Security Ordinance ("HCSO") needed to submit the 2025 Employer Annual Reporting Form by May 1, 2026.

Note. This annual reporting includes the reporting requirement associated with San Francisco's Fair Chance Ordinance ("FCO"), also due May 1, 2026. Details related to the FCO are not addressed in this summary; visit the FCO website of the San Francisco Office of Labor Standards Enforcement ("OLSE") for more information.

Employer Annual Form Reporting

Under the HCSO, covered employers must make minimum health care expenditures for each hour worked by covered employees in San Francisco.

Covered employers must also submit an online Employer Annual Reporting Form each year that summarizes how they complied with the HCSO.

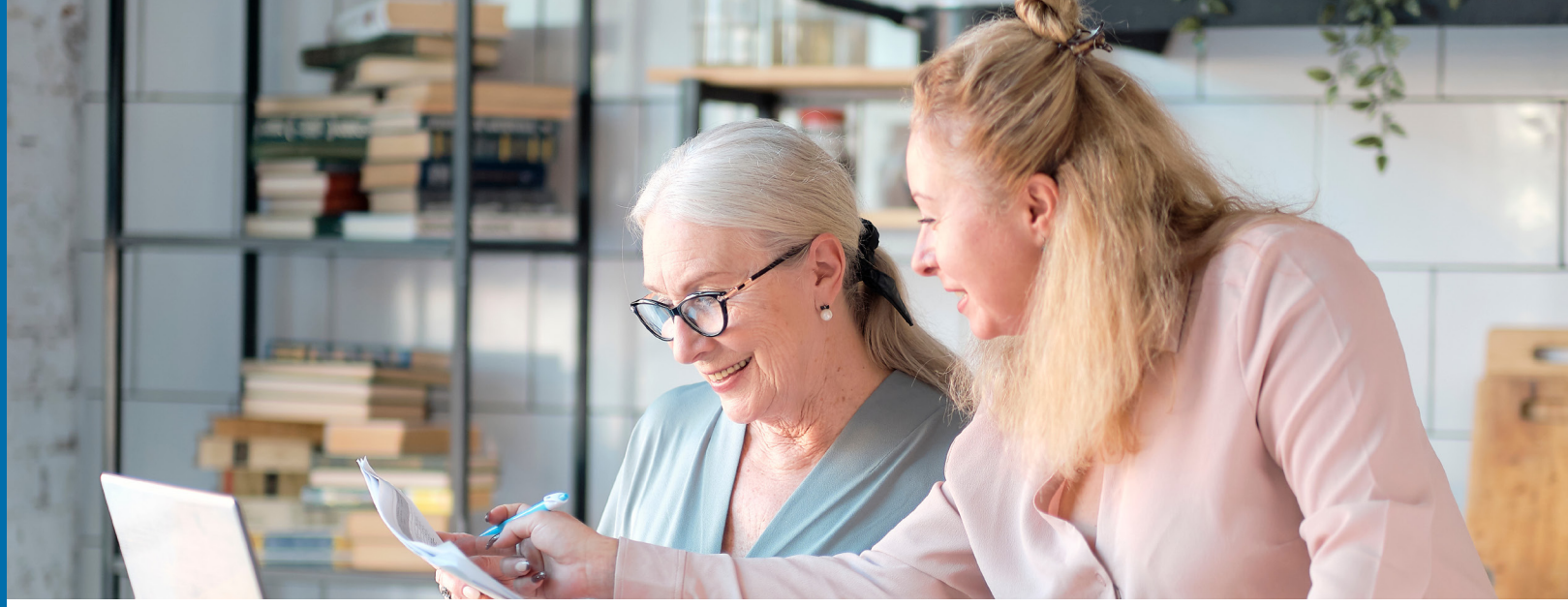
The Form is normally due on April 30th of the following year, but the OLSE has announced that the deadline to submit the 2025 Form has been extended to May 1, 2026. According to FAQs emailed from the OLSE, no submission will be accepted after that date. The penalty for failing to timely submit the Employer Annual Reporting Form is $500 per quarter.

An employer that was not covered by the HCSO and/or the FCO in any quarter of calendar year 2025 does not need to submit the Form. To determine whether the Form is required, an employer will answer the short survey on the first page of the online Form. Employers that were not covered by the HCSO or the FCO in 2025 will be directed to a webpage indicating that they do not need to submit the Form, and no further action is required. Covered employers will be directed to the appropriate online Form.

For employers who wish to preview the Form before completing it online, the OLSE has posted a sample of the 2025 Form and instructions on its website.

HCSO Notice for Employees

If they haven't already, covered employers should make sure to post the official 2026 HCSO Notice in a conspicuous place at any employer workplace or job site where covered employees work. The Notice should also be mailed or emailed to employees who do not work at an employer workplace or job site, such as employees working from home. The Notice is available in several languages at https://media.api.sf.gov/documents/2026_HCSO_Poster_Dec2025.pdf.



CMS Medicare Part D Creditable Coverage Changes for 2027

Issued date: 04/16/26

On April 2, 2026, the Centers for Medicare and Medicaid Services (CMS) issued final rules on calendar year 2027 Medicare Part D Program. CMS updated the rules for employer plans to determine whether their prescription drug coverage is creditable and finally provided an exemption for account-based plans. These rules take effect for plan years beginning on or after January 1, 2027.

Background

Medicare Part D includes a late enrollment penalty (LEP) for individuals who go without "creditable" prescription drug coverage for 63 days or longer after becoming Part D eligible. Creditable coverage is designed to ensure that individuals maintain drug coverage that is at least as good as Medicare's standard Part D benefit.

An employer's prescription drug coverage is considered creditable only if its actuarial value equals or exceeds the actuarial value of standard Part D prescription drug coverage for the applicable year. Employers are required to provide notice to Medicare-eligible individuals as to whether their prescription drug coverage is creditable or not. This notice must be provided annually by October 15 so that individuals can enroll in Medicare Part D coverage within the enrollment window and avoid the LEP.

CMS has generally allowed non retiree drug subsidy (RDS) employers to choose one of two methods to determine creditable coverage:

1. Actuarial equivalence testing, using generally accepted actuarial principles; or

2. The simplified determination methodology

For many employers, the simplified methodology is the preferred method because it avoids full actuarial testing. However, RDS plans must use the actuarial equivalency test.

CMS made major changes to the Medicare Part D benefit beginning in 2025 which substantially increased the actuarial value of standard Part D coverage and older benchmarks such as the 60% threshold in the 2009 simplified methodology no longer reflected the value of the updated Part D benefit. As a result, CMS revised the simplified determination methodology.

Under the 2009 simplified methodology, a plan was considered creditable if it:

- Covered both brand and generic drugs,
- Provided reasonable access to retail pharmacies,
- Paid, on average, at least 60% of participants' prescription drug costs, and
- Met certain deductible or annual/lifetime benefit maximum requirements.

Updated Simplified Determination Methodology

For 2026, CMS adopted a revised simplified determination methodology:

- Coverage of brand name drugs, generic drugs, and biological products,
- Reasonable access to retail pharmacies, and
- Paid, on average, at least 72% of participants' prescription drug costs

To ease transition, CMS allows non-RDS employers to use either the 2009 methodology or 2026 methodology.

2027 and Beyond

Beginning in 2027, CMS will:

- Sunset the 2009 simplified determination methodology, and
- Require plans to determine creditable coverage using either:
    - Actuarial equivalence testing, or
    - The revised simplified methodology.

For 2027, CMS finalized a 73% actuarial value requirement and indicated that this percentage is expected to rise in future years (projected to reach approximately 75% by 2030).

Creditable Coverage Determination for High-Deductible Health Plans

Since HDHPs are designed to shift more plan costs to participants, these plans may find it more difficult to meet creditable coverage status. CMS acknowledged this in its guidance and stated that HDHPs are not automatically non creditable, but higher deductibles can make it harder to meet the required actuarial value unless mitigated by plan design features. Examples in the final rule include:

- Carving out maintenance or preventive medications from the deductible
- Allocating a reasonable portion of the deductible to prescription drugs for actuarial testing
- Offering lower post deductible cost sharing than standard Part D

Relief for Account-Based Plans

CMS also removed the requirement for employers to calculate creditable coverage and provide creditable coverage notices for health reimbursement arrangements (HRA), including Individual Coverage HRAs (ICHRAs) and similar account-based plans. CMS determined that comparing an HRA against a prescription drug plan is not an “apples to apples” comparison because account-based plans are fundamentally different from prescription drug plans.

Employer Action

To prepare for the new creditable coverage rules, employers should consider the following:

- Coordinate with carriers, TPAs, or actuaries to confirm whether your prescription drug benefits meet the applicable actuarial value thresholds.
- Pay special attention to integrated medical and drug plans and high deductible health plan structures.
- Ensure annual Medicare Part D creditable coverage notices accurately reflect the plan’s status.
- Maintain records supporting their CMS creditable coverage determination, including actuarial analyses or simplified methodology documentation.

Regulations Clarify Maryland FAMLI

Issued date: 05/01/26

On March 30, 2026, the Maryland Department of Labor (DOL) published Family and Medical Leave Insurance (FAMLI) regulations to help clarify several important items for covered employers and government entities that employ at least one individual who performs qualified employment in Maryland.

The regulations clarify:

- Contributions to the program;
- Equivalent private insurance plans (EPIPs);
- Claims and benefits;
- Coordination of benefits; and
- Notice requirements.

In addition, the DOL provided a timeframe for covered employers to provide FAMLI with a Declaration of Intent (DOI) to utilize a private plan and confirmed the initial contribution rate.

Background

Maryland passed the Time to Care Act of 2022 (the law) on April 11, 2022, which requires covered employers to provide up to 12 weeks within an application year of paid family and medical leave benefits for certain permitted reasons. Contributions to the state plan of 0.9% of an employee's wages are set to begin on January 1, 2027, with benefits set to begin no earlier than January 1, 2027, and no later than January 3, 2028.

Regulations Published

Contributions to FAMLI

FAMLI is funded by a combination of employer and employee contributions to the state fund. The required contribution is based on a percentage of the employee's wages paid by the employer up to the social security wage base each calendar year.

Employees can be required to contribute to the program provided:

- No more than 50% of the total rate of contribution is required from employees; and
- The employer provides written notice to all covered employees of the contribution withholding at least 1 pay period prior to the commencement of the withholding.

If an employer fails to deduct an employee's share of the required contribution, they are considered to have elected to pay the employee's share for that period and cannot recoup the missed deduction.

Employers with less than 15 employees are only required to remit 50% of the total contribution rate. Employer size is determined annually by averaging the number of employees to which the employer paid wages in each quarter of the previous calendar year. Employees both in Maryland and in other states are counted for this purpose.

Contributions to FAMLI are remitted each quarter and employers are required to file quarterly wage and hour reports with the DOL's FAMLI Division (Division). Contributions are required to be paid on or before the last day of the month immediately following each calendar quarter.

Equivalent Private Plans

A covered employer can meet their obligations under the law by either participating in the state plan or by maintaining an approved EPIP. An EPIP can either be fully insured through an approved commercial insurer or self-funded.

An EPIP may not charge employees more than what is required under the state plan and must provide the same or better benefits as the state plan. An EPIP must be submitted (with an appropriate filing fee based on employer size) and approved by the Division and becomes effective on the first day of the calendar quarter following the date of approval. Approved EPIP applications expire one year from the effective date of the EPIP and employers must re-apply at least 90 days prior to the EPIP's expiration.

If an employer chooses to self-fund their EPIP, the following requirements will apply:

- The employer must have at least 50 employees;
- Proof of solvency must be provided by obtaining a sufficient surety bond; and
- Employee contribution withholdings must be deposited and held in a separate, dedicated account from which benefits are paid and subject to audits by the Division.

Employers with an EPIP are subject to additional reporting requirements which include quarterly claims-level and employer-level data which must be submitted on or before the last day of the month immediately following the close of the quarter. Employers are permitted to authorize EPIP administrators (e.g., a commercial insurance carrier) to file the reports on their behalf.

An employer intending to apply for an EPIP may submit a DOI to the Division. A timely submitted DOI will exempt the employer from contributions to the state plan during the initial contribution period.

Claims and Benefits

A covered employee is permitted to take FAMLI leave for the following reasons:

- To care for or bond with a child during the first 12 months following the child's birth or placement for adoption, foster care, or kinship care;
- To care for a family member with a serious health condition;
- To care for the employee's own serious health condition;
- To care for a service member's serious health condition arising from uniformed service where the employee is their next of kin; and
- Qualifying military exigencies.

An eligible employee can generally apply for leave within 60 days of the anticipated beginning date of leave and no later than 60 days after leave has begun. An application for FAMLI leave must be accompanied by certain required documentation and/or certification of the need for leave depending on the type of leave requested.

A covered employee can receive up to 12 weeks of FAMLI leave and an additional 12 weeks where the employee previously received medical leave and later becomes eligible for bonding leave (or vice-versa) per application year.

An employee's benefit is calculated based on their average weekly wage, which is the employee's earned wages from the employer over the highest of the previous 4 completed calendar quarters divided by 13. The FAMLI benefit will be the sum of:

- 90% of the claimant's average weekly wage up to 65% of the state average weekly wage; and
- 50% of the claimant's average weekly wage that is greater than 65% of the state average weekly wage up to the maximum weekly benefit amount.

Employees on FAMLI leave are entitled to job protection and must return to the same or equivalent position upon their return from leave. An employee's health benefits must also be maintained while on FAMLI leave.

Coordination of Benefits

FMLA can run concurrently with FAMLI and may be used to reduce the maximum duration of FAMLI leave where:

- The employee's FMLA leave was also eligible for FAMLI;
- The employer notified the employee of their potential eligibility for FAMLI when the employee took FMLA; and
- The employee did not apply for FAMLI leave.

Alternative FAMLI Purpose Leave (AFPL) can be required to be used concurrently with FAMLI where the requirement is communicated in writing in advance and the AFPL is:

- Specifically designed to fulfill a purpose of FAMLI;
- Paid;
- Not accrued;
- Not subject to repayment if the employee leaves their position;
- Not available for general purposes; and
- Available without a requirement to exhaust another form of leave.

Where an employer provides general purpose leave (e.g., PTO) it cannot be required to be substituted for FAMLI leave; however, the employer and employee can agree in writing to use general purpose leave to supplement FAMLI benefits up to 100% of the employee's average weekly wage.

An individual receiving unemployment benefits from the state or worker's compensation benefits (except in the case of benefits for permanent partial disability) is not eligible for FAMLI benefits.

Notice Requirements

Employers must provide notice of FAMLI benefits to covered employees:

- Six months prior to the beginning of benefits (i.e., July 2027);
- At hire;
- Annually;
- 30 days prior to the effective date of any changes to the employer's FAMLI procedures or plan; and
- When the employer knows that an employee's leave request may be eligible for FAMLI.

The Division will publish model notices and forms that can be used by employers.

Employees must provide notice to the employer of the need for leave at least 30 days in advance where the need is foreseeable. Where unforeseeable, notice must be provided as soon as practicable. Employees are permitted to take intermittent leave and when intending to do so, the employee must provide the employer with reasonable prior notice and make a reasonable effort to schedule the leave so that it does not cause the employer significant difficulty or expense.

Declaration of Intent Window

Employers intending to utilize an EPIP and wishing to be exempted from the initial contribution period must file a DOI with the DOL between **September 1, 2026**, and **November 15, 2026**. This is not required if an employer intends to participate in the state plan.

Employer Action

Employers should begin to prepare for FAMLI implementation and consider the following:

- Review the regulations and determine whether their leave policies comply with the regulations.
- Determine whether they will participate in the state plan or utilize an EPIP. If using an EPIP, submit their DOI between September 1 and November 15, 2026.
- Register with the Division if covered by the law. Registration will open in Fall 2026 and is necessary to submit required reporting, remit contributions, submit DOI, and EPIP applications.
- Coordinate with employment counsel, leave administrators, payroll providers, and/or commercial insurance carriers to ensure they are ready to begin administering contributions by January 1, 2027, and paying benefits by no later than January 3, 2028.

New Mexico Vaccine Purchasing Act Reporting Reminder

Issued date: 05/01/26

Employers with self-funded medical plans providing coverage to one or more residents in the state of New Mexico must submit its annual report on the number of insured children under the age of 19 no later than July 1, 2026. It applies even if the plan and/or plan sponsor is situsedout of state.

Background

Since the 1990s, the state of New Mexico has had a Vaccines for Children (VFC) program. As part of that program, the state has been the sole purchaser of pediatric vaccines for children in New Mexico, whether provided through private insurance or VFC. Then in 2015, New Mexico passed a law requiring all insurers and group health plans doing business in the state (Covered Entities) to pay their fair share of the pediatric vaccine cost.

Reporting Requirement

Covered Entities must annually report the number of insured children under the age of 19 as of the last calendar day of the previous year (even if that number is zero). The report for December 31, 2025, can be filed as soon as May 1, 2026, and no later than **July 1, 2026**.

The state divides the total projected vaccine cost (plus a 10% reserve) by the total number of reported lives to determine the per-person rate. For 2026 reporting, the cost is $39.78 per covered child under age 19 in New Mexico per quarter ($159.12 annually) which will be invoiced to Covered Entities quarterly, beginning in September 2026.

A group health plan that fails to file a report is liable to pay a late filing fee of $500 per day from the date the report was due. A similar penalty is due for each day any required payment is late.

Previously, there was confusion about whether a Covered Entity had to report if it had not received a letter from the Office of Superintendent of Insurance (OSI). Considering recent changes to the rule and email confirmation from OSI, all Covered Entities should proactively report.

Employer Action

- **Fully insured plans.** Employers with insured medical programs need not take action. Any employer with an insured medical plan can notify the Immunization Program (vpa.fund@state.nm.us) that the plan is insured, providing the name of the carrier, and will be taken out of the invoicing database.

- **No residents of New Mexico.** Employers with no New Mexico residents need not file.

- **Self-funded plans (including level-funded) with at least one resident of New Mexico.** Employers with self-funded plans and one or more New Mexico resident participant and/or dependent should contact their TPAs to determine who will complete the required reporting and payment. **If the TPA will not complete the reporting,** employers should:

    - Request now the number of insured children under the age of 19 on December 31, 2025; and

    - File that information with OSI by July 1, 2026.

Virginia Enacts Paid Family and Medical Leave

Issued date: 05/04/26

On April 22, 2026, the Virginia General Assembly enacted legislation establishing Virginia's Paid Family and Medical Leave (PFML) program. Eligible employees will be able to receive benefits under the program beginning December 1, 2028. Payroll contributions are set to begin April 1, 2028.

The Virginia Employment Commission (VEC) posted a set of FAQs explaining the paid leave requirements.

Overview of Virginia's Paid Family and Medical Leave Program

Virginia's PFML program will be administered by the VEC. Eligible employees may receive up to 12 weeks of paid leave per benefit year for qualifying medical and family reasons.

Covered life events for PFML include:

- Birth, adoption, or foster placement of a child
- The employee's own serious health condition
- Caring for a family member with a serious health condition
- Qualifying military family needs and care for a covered service member
- Seeking defined "safety services" related to domestic violence, harassment, sexual assault, or stalking

Weekly benefits are set at 80% of an employee's average weekly wage and will be capped at 100% based on the statewide weekly wage, which will be adjusted annually.

Job and Benefit Protection

Like federal FMLA, eligible employees are entitled to job restoration to the same or an equivalent position upon return, continuation of benefits (or restoration upon return) and service credit during leave. Employers are also prohibited from retaliation or interference with an employee's right to take leave, and leave may be taken intermittently or on a reduced schedule.

Payroll Contributions

PFML benefits will be funded through mandatory payroll contributions shared by employers and employees and paid into the Family and Medical Leave Insurance Trust Fund. Small employers with less than ten employees do not have to contribute to the fund but must still remit the employee portion. Contribution rates and administrative details will be established through VEC regulations.

Approved Private Plan

Employers can satisfy their obligations through a VEC approved private plan, provided the plan offers benefits and protections are equal to or greater than those required under the statute. Importantly, PFML benefits cannot be waived by agreement, including through collective bargaining.

Employer Action

- Review and update leave and payroll policies
- Assess whether a private plan may be advantageous
- Prepare HR and payroll systems for required contributions
- Train managers on expanded leave rights and job protection rules
- Stay tuned for additional updates as we get closer to the effective date

2025 MHPAEA Report to Congress Offers Reminders to Employer Plan Sponsors

Issued date: 05/05/26

The Department of Labor (DOL) and the Centers for Medicaid and Medicare Services (CMS) recently released the 2025 Mental Health Parity and Addiction Equity Act (MHPAEA) Report to Congress (2025 Report). The 2025 Report breaks down the enforcement work conducted by the DOL enforcement agency, the Employee Benefits Security Administration (EBSA) and CMS, along with the most common compliance failures, and practical considerations employers should take now.

Background

MHPAEA requires group health plans and insurers to ensure that financial requirements (e.g., copays, coinsurance) and treatment limitations (e.g., visit limits, prior authorization) applied to mental health and substance use disorder (MH/SUD) benefits are no more restrictive than those applied to medical/surgical (M/S) benefits.

The Consolidated Appropriations Act of 2021 (CAA) strengthened MHPAEA by requiring plans to:

- Perform and document NQTL comparative analyses
- Make those analyses available to federal or state regulators upon request
- Demonstrate compliance with parity requirements in both design and application

MHPAEA applies to employers with 50 more employees that offer MH/SUD benefits and insurance carriers. Employers have a fiduciary responsibility to ensure their vendors (e.g., MH/SUD carveouts vendors, TPAs, etc.) comply with these standards. For fully insured plans, the carrier is typically responsible for the required NQTL comparative analysis. Self-insured and level-funded plans are responsible for ensuring compliance with MHPAEA and comparative analysis requirements.

The 2025 Report covers enforcement activity from August 1, 2023 through July 31, 2025 and reflects the agencies' ongoing efforts despite a temporary non enforcement policy related to the 2024 final rule.

EBSA and CMS Enforcement Highlights

The majority of EBSA's enforcement activity focused on participant access to opioid use disorder treatment, autism treatment (ABA therapy), and nutritional counseling for eating disorders.

Over the 2-year period, EBSA and CMS each issued initial requests for comparative analyses to group health plans and carriers. Ultimately, fifteen final determinations of noncompliance were issued due to inadequate comparative analyses. Final determinations of noncompliance were not issued if good faith effort was shown to correct violations.

CMS regulates non-ERISA group health plans and insurers. CMS issued 42 requests for comparative analyses and ultimately issued 10 final determinations of noncompliance.

Plans Are Still Falling Short

The 2025 Report confirms that plans continue to struggle with producing complete, statutorily compliant NQTL comparative analyses. Most common deficiencies include failures to define factors used to apply NQTLs. Plans often list factors (e.g., "clinical efficacy," "provider discretion") without explaining what they mean, particularly when comparative analyses were drafted by third parties like consultants that were not familiar with plan operations. Both agencies found that plans could not demonstrate how decisions were actually made.

The Report found that plans often cited standards without providing the underlying data or documentation, and non comparable application between MH/SUD and M/S benefits. For example:

- Prior authorization applied more stringently to MH/SUD
- Network admission standards that disadvantage MH/SUD providers
- Out of network reimbursement methodologies that differ without justification

Employer plans using separate vendors for MH/SUD and M/S benefits frequently submitted incomplete or inconsistent analyses, because neither vendor had full knowledge into the other's processes. Employers also incorrectly assumed that third parties were responsible for compliance, and thus, plan sponsors incorrectly believed their TPA or carrier would prepare the comparative analysis. Agencies emphasize in the report that the plan – not the vendor – is legally responsible.

Corrective Measures Required by Agencies

When violations were found, agencies required plans and insurers to take corrective actions such as:

- Removing impermissible exclusions (e.g., ABA therapy, nutritional counseling, methadone treatment)
- Eliminating or revising prior authorization and concurrent review requirements
- Updating network adequacy monitoring and reimbursement methodologies
- Re adjudicating previously denied claims
- Revising plan documents and template language
- Providing participant notices of violations, as required by statute

In several cases, plans were required to hire external consultants to overhaul their comparative analyses from the ground up.

Practical Considerations for Employers

Employers should not rely solely on the carrier or TPA. Even if a vendor administers the benefit, the employer is the fiduciary and is responsible for compliance. Employers must understand how NQTLs are designed and applied. This includes prior authorization, concurrent review, network standards, reimbursement methodologies, and exclusions since agencies expect detailed, evidence based explanations. If MH/SUD and M/S benefits are administered by different vendors, employers must ensure the analysis integrates both sides. Finally, plans that respond promptly and proactively often avoid final determinations of noncompliance.

Employer Action

- Employers should obtain and review NQTL comparative analyses to ensure analyses cover all required elements under the CAA.
- Confirm vendor responsibilities in writing and consider including responsibilities in vendor agreements such as who prepares the comparative analysis, who provides underlying data, and who updates the analysis when plan terms change.
- Audit NQTLs for parity risk focusing on prior authorization and concurrent review, network admission standards, out of network reimbursement and benefit exclusions (e.g., ABA, nutritional counseling, etc.)
- Review carve out arrangements to ensure MH/SUD and M/S vendors are sharing data and methodologies.
- Update plan documents and internal procedures to remove outdated exclusions and ensure NQTLs are applied consistently.

EBSA Enforcement Sharpens its Focus on Duty of Loyalty

Issued date: 05/06/26

The Employee Benefits Security Administration (EBSA), a division of the Department of Labor (DOL), recently issued a memorandum outlining its enforcement priorities for ERISA covered health and welfare plans (the “Memo”). The guidance is relevant for employers serving as plan sponsors and fiduciaries, as it clarifies how EBSA will assess fiduciary conduct and where enforcement resources will be concentrated. These changes take effect July 17, 2026.

Background

EBSA is responsible for enforcing ERISA requirements applicable to employer sponsored plans, including claims and appeals, COBRA administration, Mental Health Parity, ACA and Consolidated Appropriations Act transparency mandates, disclosure requirements, and the proper handling of plan assets. Employees and their dependents may initiate investigations by filing complaints with EBSA when they believe a plan is not being administered in compliance with ERISA.

When EBSA takes enforcement action, it often results in settlements, required corrective actions, reprocessed claims, restored plan assets, and operational changes. The Memo sets forth EBSA’s four priorities:

- Focus on the most egregious conduct and significant harm
- Ensure no regulation by enforcement and promote fairness, prior notice and clarity
- Require proper reviews by senior leaders of critical enforcement initiatives
- Timely and responsive enforcement

Core Fiduciary Duties for Employers

All ERISA governed employers are subject to four fundamental fiduciary duties:

1. **Duty of Loyalty** – Act solely in the interest of plan participants and beneficiaries
2. **Duty of Prudence** – Act with care, skill, and diligence
3. **Plan Document Rule** – Follow the terms of the plan documents
4. **Duty to Avoid Conflicts of Interest** – Avoid self dealing and prohibited transactions

Failure to meet any of these obligations exposes employers to enforcement risk.

EBSA Key Enforcement Priority: Duty of Loyalty

The Memo makes clear that EBSA's highest enforcement priority will be investigations involving breaches of loyalty, particularly where employers or service providers act in bad faith or place interests other than participants' best interests first.

This includes:

- Improper administration of benefits
- Misuse or misappropriation of plan assets
- Non exempt prohibited transactions
- Conflicts of interest that benefit the employer, a service provider, or a third party
- Actions designed to advance goals unrelated to participant benefits

What Employers Can Expect from EBSA Enforcement

In the Memo, it will target cases involving the greatest harm to participants and beneficiaries and prioritize matters with clear evidence of disloyalty or impermissible conflicts. Senior leadership will review major investigations, and enforcement must be responsive and timely.

The Memo also states that EBSA will avoid regulating through enforcement whenever possible and base enforcement actions on clear statutory language, established regulations, published guidance, or settled case law.

As a result of this more targeted enforcement approach, the volume of investigations may decline. However, plan sponsors should not interpret this shift as diminishing their ongoing fiduciary obligations or as a reduction in enforcement risk.

Employer Action

- Review fiduciary governance practices and ensure decisions are made exclusively in participants' best interests
- Document fiduciary processes, including reasons for vendor selection, plan design, and compliance decisions
- Monitor conflicts of interest involving employers, vendors, and service providers
- Ensure operational compliance with claims procedures, disclosures, parity requirements, COBRA administration, and transparency requirements

IRS Releases Employer Mandate Penalties for 2027

Issued date: 05/11/26

On May 4, 2026, the Internal Revenue Service (IRS) released updated Employer Shared Responsibility (ESR) penalty amounts applicable to Applicable Large Employers (ALEs). These penalty amounts are adjusted annually for inflation.

Background

Applicable Large Employers (ALEs), defined as employers with 50 or more full time employees (including full time equivalents) in the prior calendar year, are required under the Affordable Care Act (ACA) to offer minimum essential coverage (MEC) that provides minimum value (MV) and is affordable to full time employees and their dependents.

Failure to meet these requirements may result in penalties under:

- **IRC §4980H(a)** if the employer fails to offer MEC to at least 95% of full time employees and their dependents, or
- **IRC §4980H(b)** if the employer offers coverage that does not meet minimum value or affordability standards, when at least one full time employee receives a premium tax credit (PTC) through the Health Insurance Marketplace.

Penalties are assessed on a monthly basis and calculated based on the number of months during which a full-time employee receives a PTC.

If the IRS determines that a penalty applies, it will issue a penalty assessment letter based on information reported on Forms 1094 C and 1095 C filed by the employer.

Current Penalty Amounts

- **4980H(a)** – Failure to offer MEC to at least 95% of full time employees and their dependents: **$3,340**
- **4980H(b)** – Failure to offer minimum value (60%) and affordable coverage (9.96%) based on the lowest cost, self only plan: **$5,010**

Penalty Amounts for the 2027 Calendar Year

- **4980H(a)** – Failure to offer MEC to at least 95% of full time employees and their dependents: **$3,780**
- **4980H(b)** – Failure to offer minimum value (60%) and affordable coverage (affordability rate TBD) based on the lowest cost, self only coverage: **$5,670**

The affordability threshold for 2027 is typically released in the fourth quarter of the prior year.

Employer Action Steps

- Review current medical plan offerings to confirm coverage meets minimum value and affordability requirements.
- Monitor upcoming IRS guidance for the 2027 affordability percentage, expected later this year.
- Employers nearing the 50 full time employee threshold, or that experienced growth this year, should calculate ALE status to determine 2027 compliance obligations.
- Newly designated ALEs should become familiar with ESR Mandate requirements, including counting hour rules, full time determinations, reporting obligations, and affordability safe harbors.

New Wisconsin Law Requires Breast Cancer Screening Coverage

Issued date: 05/18/26

On March 19, 2026, Wisconsin Governor Tony Evers signed Gail's Law, which amends and creates statutes relating to the coverage of breast cancer screenings. Under Gail's Law, covered group health plans are required to provide coverage for diagnostic breast examinations and supplemental breast screening examinations.

Group health plans covered by the law include fully insured plans in Wisconsin and self-funded, non-ERISA plans sponsored by counties, cities, villages, towns, and school districts in Wisconsin. Gail's Law is effective for policy years beginning on or after January 1, 2027.

For plans subject to a collective bargaining agreement (CBA), the requirements are effective the later of, when the CBA is newly established, extended, modified, or renewed.

New Requirements

Gail's Law requires group health plans to provide coverage to an individual who is at increased risk of breast cancer or has extremely dense breast tissue for supplemental breast screening examinations. Supplemental breast screening examinations include any medically necessary and appropriate examinations of the breast using MRI or ultrasound when no abnormality is seen or suspected but the individual has an increased risk of breast cancer such as personal or family medical history.

Prohibitions

Gail's Law prohibits coverage from being subjected to additional exclusions and limitations, including deductibles, copayments and restrictions on excessive charges, unless they are also applied to other radiological examinations.

The law also prohibits cost-sharing amounts for a diagnostic breast examination or the first supplemental breast screening examination in a policy year. However, if coverage would cause an individual to lose HSA eligibility, then the IRS minimum deductible should be met first.

Employer Action

- Wisconsin employers with fully insured plans should confirm with their carriers that their plans will comply with Gail's Law moving forward.
- Self-funded and level-funded ERISA plans are not required to comply with this law.
- Employers with non-ERISA self-funded group health plans should revise their plan terms to ensure the required coverage is permitted and work with their third-party administrator to ensure that the relevant claims are processed properly.

Proposed Rules Provide Employers Flexibility to Offer Robust Fertility Benefits

Issued date: 05/19/26

In response to the Executive Order, "Expanding Access to In Vitro Fertilization," the Departments of Labor, Health and Human Services, and Treasury (the Departments) have issued proposed regulations that would recognize fertility benefits as a new category of limited-scope excepted benefits.

If finalized, these rules would apply to group health plans and insurers in the group market for plan years beginning on or after January 1, 2027.

Background

Excepted benefits are generally exempt from certain ACA market reforms—such as annual and lifetime dollar limit restrictions, cost-sharing limitations, Mental Health Parity requirements, and No Surprises Act protections so long as they meet specific design criteria.

In October 2025, the Department of Labor issued ACA FAQ 72, which outlined alternative pathways for employers to offer fertility-related benefits as excepted benefits. These included:

- Non-coordinated benefits (e.g., specified disease policies), primarily available through fully insured products
- Excepted benefit HRAs, subject to relatively low reimbursement limits
- Employee Assistance Programs (EAPs), which cannot provide significant medical care or cost-sharing

These approaches limited the scope and accessibility of fertility benefits.

Fertility Benefits as Limited-Scope Excepted Benefits

The proposed rules would formally add fertility benefits to the list of limited-scope excepted benefits (currently limited to dental, vision, and long-term care). As a result, fertility benefits would be permitted if they meet existing limited-scope criteria, along with new fertility-specific requirements.

To qualify as an excepted benefit, a fertility benefit must meet the following:

1. **Substantially All Standard:** Coverage must include "substantially all" services related to the diagnosis, mitigation, and treatment of infertility, as well as treatment of underlying reproductive health conditions. Services must be medically appropriate and provided under the direction of a licensed medical professional.

Permitted services may include:

- Diagnostic procedures (e.g., laparoscopy for endometriosis)
- Ovulation induction medications
- Evaluation and treatment of male factor infertility
- IVF cycles (coverage may be limited by employers due to cost)
- Fertility awareness methods and preconception care
- Fertility education and counseling (if part of a medically directed program)

2. **Separate or Non-Integrated Coverage:** The benefit must be:

- Offered under a separate insurance policy, certificate, or contract; or
- Not an integral part of the group health plan

For self-insured plans, this generally requires a separate election or claims administration.

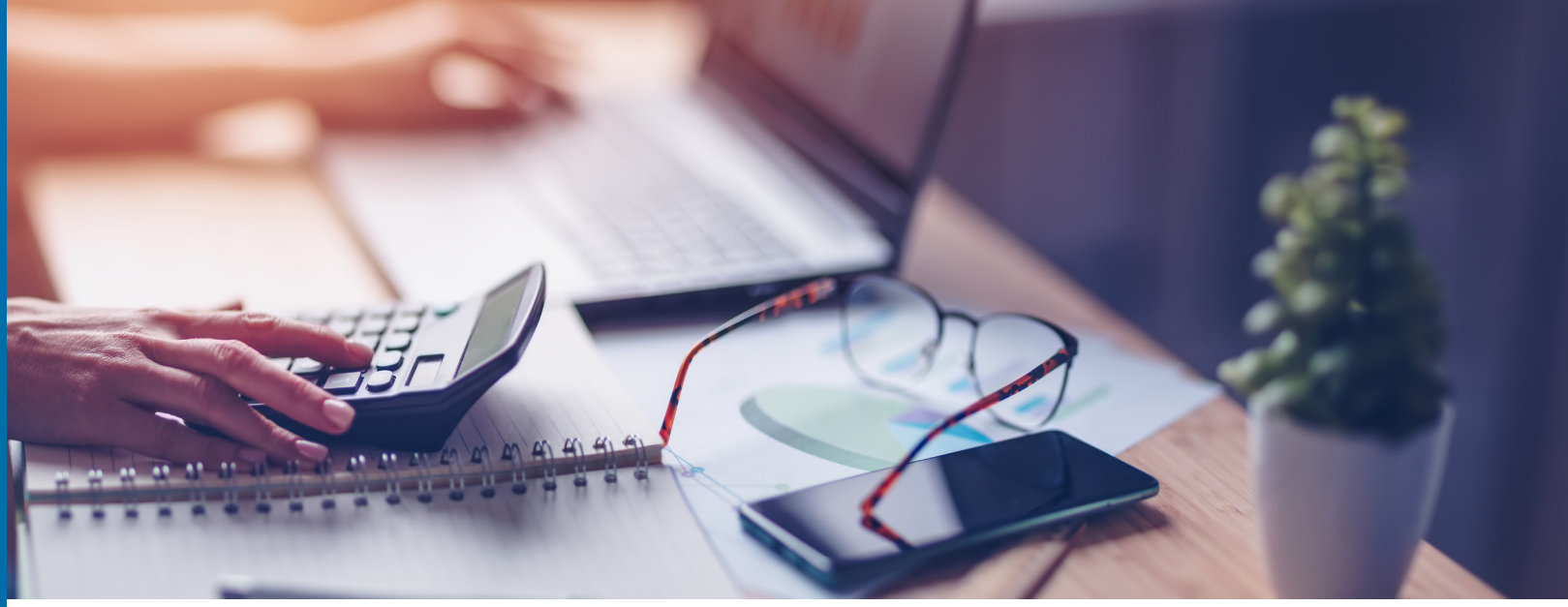
3. **Lifetime Benefit Maximum:** A lifetime maximum of $120,000 per participant (including dependents) would apply, with annual indexing. It remains unclear whether this limit applies per plan basis or across all fertility benefits for an individual.

4. **Required Notice:** Plans must provide a separate notice describing the availability and scope of the fertility benefit, including any limitations. The notice:

- Must be provided at enrollment (including open enrollment materials)
- Must be distributed to newly eligible individuals by their first day of eligibility
- Must be provided annually thereafter

Employer Considerations

- The proposed rules do not address HSA compatibility. Based on current IRS guidance, limited-scope excepted benefits are typically treated as "permitted insurance," which does not impact HSA eligibility. However, additional IRS guidance would be needed to confirm this treatment for fertility benefits.
- Given the level of medical care provided, fertility benefits structured as excepted benefits would likely be subject to COBRA requirements.
- Employers in states with fertility coverage mandates should evaluate whether an excepted benefit design satisfies state requirements. Overlap between a fully insured medical plan and an excepted fertility benefit may create coordination concerns.
- Excepted benefits remain subject to ERISA, including reporting and disclosure obligations such as SPDs, plan documents, and Form 5500 filings.
- Stay tuned for updates!



Massachusetts Releases 2027 MCC Limits

Issued date: 05/28/26

The Commonwealth Health Insurance Connector Authority (Health Connector) recently published Administrative Bulletin 01-26 to provide annual guidance regarding certain provisions of the Minimum Creditable Coverage (MCC) regulation, 956 CMR 5.00. Specifically, this Bulletin describes the calculation of the deductible limits and out-of-pocket maximums for 2027 and provides those respective dollar amounts.

Background

On July 1, 2007, the Massachusetts Health Care Reform Act became effective. A component of this Act included an individual mandate, requiring Massachusetts residents 18 and older to have MCC or pay a penalty on their state income tax return. MCC requirements apply to individuals, not health insurance plans or employers. While employers are not required to provide health plans that meet MCC, their Massachusetts resident employees must enroll in MCC to avoid significant penalties.

Deductible Limits

For 2027, the maximum MCC deductibles are unchanged from the 2026 amounts of **$3,200/$6,400**.

If the plan has a separate prescription drug deductible, the amounts cannot exceed **$400/$800** and the total maximum deductible applies.

Out-of-Pocket Maximums

For 2027, the out-of-pocket-maximums under MCC will be **$12,000/$24,000**.

Employer Action

Administrative Bulletin 01-26 takes effect immediately; the changes applicable to employer-sponsored plans will be incorporated with plan years beginning on or after January 1, 2027.

DOL Penalties Remain Unchanged for 2026

Issued date: 05/29/26

On May 27, 2026, the Department of Labor (DOL) published a statement that they will not make any adjustments to civil money penalties under the Inflation Adjustment Act in 2026, leaving all DOL penalties applicable to employee benefit plans unchanged from their 2025 amounts.

Annual Penalties for 2026 Remain Unchanged

The following updated penalties are applicable to health and welfare plans subject to ERISA.

Description	2025 & 2026 Penalty (CURRENT)
Failure to file Form 5500	Up to $2,739 per day
Failure of a **MEWA** to file reports (i.e., M-1)	Up to $1,992 per day
Failure to provide **CHIP Notice**	Up to $145 per day per employee
Failure to disclose CHIP/Medicaid coordination to the State	$145 per day per violation (per participant/beneficiary)
Failure to provide **SBCs**	Up to $1,443 per failure
Failure to furnish **plan documents** (including SPDs/SMMs) to DOL won request	$195 per day $1,956 cap per request
Genetic information failures	$145 per day (per participant/beneficiary)
De minimis failures to meet genetic information requirements	$3,642 minimum
Failure to meet genetic information requirements – not *de minimis* failures	$21,864 minimum
Cap on unintentional failures to meet genetic information requirements	$728,764 maximum

Employer Action

Private employers, including non-profits, should ensure employees receive required notices timely (SBC, CHIP, SPD, etc.) to prevent civil penalty assessments. In addition, employers should ensure Form 5500s are properly and timely filed, if applicable. Finally, employers facing document requests from EBSA should ensure documents are provided timely, as requested.

IRS Releases HSA, HDHP and Other Limits for 2027

Issued date: 06/03/26

The IRS released updated inflation-adjusted limits for Health Savings Accounts (HSAs), high deductible health plans (HDHPs), direct primary care service arrangements (DPCSAs), and excepted benefit HRAs. These updated amounts apply for calendar year 2027 (or plan years beginning in 2027, as applicable) and reflect ongoing annual cost-of-living adjustments.

2027 Benefit Limits

Benefit	2026 Amount	2027 Amount
HSA Contribution – Self-Only	$4,400	$4,500
HSA Contribution – Family	$8,750	$9,000
HDHP Minimum Deductible – Self-Only	$1,700	$1,750
HDHP Minimum Deductible – Family	$3,400	$3,500
HDHP Out-of-Pocket Maximum – Self-Only	$8,500	$8,700
HDHP Out-of-Pocket Maximum – Family	$17,000	$17,400
Excepted Benefit HRA Maximum	$2,200	$2,250
DPCSA Monthly Fee Limit – Individual	$150	$150
DPCSA Monthly Fee Limit – Family	$300	$300

Employers sponsoring non-grandfathered HSA compatible HDHPs must ensure its family coverage also includes an embedded **individual out of pocket maximum (OOPM)** for each individual covered under the family plan in order to comply with the ACA cost sharing requirements, unless the aggregate family HDHP OOPM does not exceed the ACA individual OOPM ($12,000 for 2027). Any embedded deductibles or OOPMs for family HDHP coverage must at a minimum meet the HDHP minimum deductible for family coverage ($3,400 for 2027).

It should be noted that individuals who are age 55 or older and covered by an HSA-compatible HDHP may make an additional HSA catch-up contribution of $1,000 each year until they enroll in Medicare. This catch-up contribution amount has not increased since 2009.

As a reminder, employers that include DPCSAs must ensure their plans do not exceed the monthly limit, or $1,800 for the year along with other design requirements in order for individuals to retain HSA eligibility. Employers are permitted to bill quarterly, bi-annually, or annually provided the amount is fixed and does not exceed the IRS monthly limit.

Employer Action

- Confirm 2027 HDHP deductible and out-of-pocket limits meet IRS minimum and maximum thresholds.
- Adjust HSA contribution limits and HRA funding caps in payroll and benefits platforms for 2027.
- Prepare open enrollment materials to reflect new limits and explain impacts to employee contributions and plan options.

Chicago Paid Leave Ordinance: 2026 Rule Clarifications

Issued date: 06/08/26

In May 2026, the City of Chicago issued updated rules to clarify how employers must administer paid leave requirements and address common compliance questions. The updated rules took effect June 1, 2026, applying to all covered Chicago employers.

Background

Chicago's Paid Leave and Paid Sick and Safe Leave (PL/PSSL) Ordinance requires employers to provide eligible employees with up to 40 hours of Paid Leave and 40 hours of Paid Sick Leave annually. Chicago PL/PSSL applies to employers with employees working within the City of Chicago.

Key Changes and Clarifications

The June 2026 update introduces a number of compliance clarifications:

- **Joint Employer Responsibility**
  The rules define "joint employment" and confirm that all joint employers are jointly responsible for compliance and must count shared employees toward coverage thresholds.

- **Accrual Clarifications**
  Non-exempt employees must be permitted to accrue leave on all hours worked, including overtime, while exempt employee accrual may be capped at a 40-hour workweek.

- **Expanded Childcare Coverage**
  Paid Sick Leave may be used when a child's "place of care" is unexpectedly unavailable, including informal arrangements such as babysitters or family caregivers.

- **Combined PTO Policies Permitted**
  Employers may satisfy the ordinance through a single PTO policy if employees can accrue up to 80 hours annually and all ordinance requirements (accrual, use, carryover) are met.

- **Successor Employer Obligations**
  Employees must retain accrued leave in business transfers, with both original and successor employers potentially liable for noncompliance.

- **Discipline for Misuse of Sick Leave**
  Employers may take disciplinary action, including termination, for misuse of Paid Sick Leave, including patterns such as unscheduled leave around weekends or after denied PTO requests.

Key Changes and Clarifications

- Review and update PTO and sick leave policies, especially combined PTO programs to ensure compliance with accrual, usage, and carryover requirements.

- Evaluate any staffing arrangements, acquisitions, and vendor relationships to confirm responsibility for joint employment compliance or Merger & Acquisition leave transfer obligations.

- Review payroll and leave administration practices to confirm accruals (including overtime) and document handling of any suspected leave misuse.

New Kansas Law Imposes Compliance Obligations on PBMs

Issued date: 06/26/26

On April 9, 2026, Governor Laura Kelly signed into law the Kansas Consumer Prescription Protection and Accountability Act (the "KCPPAA" or the "Act"). The KCCPA regulates pharmacy benefit managers ("PBMs") and imposes several new compliance obligations on PBMs including requiring the registration of auditing entities, prohibits certain practices such as spread pricing, and also requires pharmacy benefits manager reporting. The law takes effect July 1, 2026.

Kansas Consumer Prescription Protection and Accountability Act

PBM Regulation

In addition to audit and registration requirements, the KCPPA imposes several new requirements regarding rebates and drug costs for PBMs who want to operate in Kansas, including:

- All drug manufacturer rebates must be passed on to health plans;
- PBMs are prohibited from charging health plans more than they reimburse pharmacies (a practice known as "spread pricing");
- Equal reimbursement for all pharmacies and a set minimum dispensing fee of $10.50;
- PBMs cannot collect from a pharmacy any cost share charged to a covered person that exceeds the total submitted charges by the pharmacy or pharmacist to the PBM;
- PBMs cannot reimburse a pharmacy less than either the national average drug acquisition cost or the wholesale acquisition cost;

- PBMs must report at least annually, or upon request by the Kansas Insurance Commissioner (the "Commissioner"), the aggregate amount of rebates received, the aggregate amount of rebates distributed to each health plan or covered entity, and individual amount paid by the health plan or covered entity to the PBM for pharmacist services and individual amount that a PBM paid for pharmacist services;

- PBMs must report annually to the Commissioner and each contracted health plan or covered entity the aggregate difference between the amount that the PBM reimbursed pharmacies and the amount that the PBM charged such health plan or covered entity;

- PBMs must report on a quarterly basis to the Commissioner all drugs appearing on the national average drug acquisition cost list that are reimbursed at 10% and below the national average drug acquisition cost and all drugs that are reimbursed at 10% and above the national average drug acquisition cost and the net acquisition cost for each class of drug appearing on the national average acquisition cost list that the PBM charged each health benefit plan and a copy of this report will be publicly available on the PBM's website for at least 24 months.

The PBM requirements do not apply to self-funded health plans subject to the provisions of ERISA and non-ERISA self-funded health plans by Kansas governmental entities and their political subdivisions as well as church plans.

Fines and Penalties

The Commission may impose penalties on PBMs for noncompliance with the new KCPPA requirements. Penalties are assessed on a per violation basis and will not exceed $1,000 per violation (or $5,000 if the PBM knew or should have known the PBM was in violation of the Act). In addition, any individual who acts a PBM without the required license is subject to a fine not to exceed $100,000.

The Commissioner also has the authority to revoke, suspend or limit a PBM's or insurance company's license for failing to submit to an examination or to comply with any reasonable written request for information. The Commissioner may assess the costs of the examination to the PBM.

Employer Rights and Obligations

Upon request of the plan sponsor, the entity responsible for auditing the PBM must provide a copy of the final report to the plan sponsor, including the disclosure of any money recouped in the audit. No report provided to the plan sponsor can include the protected health information of any individual.

Annually, each health benefit plan or covered entity must report to the Commissioner the aggregate amount of credits, rebates, discounts or other such payments received by the health benefit plan or covered entity from a PBM or drug manufacturer.

Employer Action

PBMs, health plans, and pharmacies must prepare for compliance by July 1, 2026. Regulated entities should review and renegotiate contracts to align with the new requirements, particularly regarding rebate pass-through and reimbursement structures.

Illinois Adopts Family Neonatal Intensive Care Leave Act

Issued date: 06/29/26

Illinois Governor J.B. Pritzker signed the Family Neonatal Intensive Care Leave Act ("NICLA") into law on August 15, 2025, giving many Illinois employees access to unpaid leave when the employee's child is a patient in a neonatal intensive care unit ("NICU").

Starting June 1, 2026, Illinois employers with between 16 and 50 employees must allow employees to use up to 10 days of unpaid leave when an employee's child is a patient in a NICU. Employers with at least 51 employees must provide up to 20 days of unpaid leave for employees with a child housed in a NICU. It appears this employee count includes all employees of the employer but applies to Illinois-based employees.

Family Neonatal Intensive Care Leave Act

NICLA applies to all employees who perform work within Illinois, regardless of hourly status or length of service with the employer.

Key provisions of the Act are as follows:

- *Child* is defined as "a biological, adopted, or foster child, a stepchild, a legal ward, or a child of a person standing in loco parentis."
- Employers may require a "reasonable verification" method for employees who request NICLA and expressly prohibits requesting information that would violate the Health Insurance Portability and Accountability Act ("HIPAA") or any other privacy laws.
- Employees are allowed to take NICLA continuously or intermittently. Employers may require a minimum increment of time that an employee may use NICLA, but are limited to a minimum of two hours.

- For federal Family and Medical Leave Act ("FMLA") eligible employees, NICLA can only be used after the employee has exhausted FMLA benefits.
    - **Note.** FMLA applies to employers with 50 or more employees, while NICLA applies to employers with 16 or more employees. Because NICLA has more lenient eligibility requirements than FMLA, there will be different classes of employees that employers will need to monitor for NICLA eligibility – those that are eligible for FMLA and those that are not.
- Employers are not allowed to retaliate against employees who request this leave and the employee must be reinstated into their position held before the leave with no loss of benefits upon completion of the leave.
- Employees who believe they have suffered from retaliation or a violation of their NICLA rights must file a complaint with the Illinois Department of Labor within 60 days of the last event where the alleged violation occurred. Penalties of up to $5,000 per incident, plus unpaid wages and other penalties, can be sought by IDOL for NICLA violations.

Employer Action

Employers should identify which employees work within Illinois. It appears the law applies to employers located in other states, as well.

Employers will need to track employees who are and are not eligible for FMLA when requesting NICLA leave. Employees not eligible for FMLA should be identified as having priority status for NICLA eligibility. If the employer utilizes an external leave administrator for FMLA, coordination should be developed to ensure that NICLA options are available upon completion of the employee's FMLA benefits.

Leave policies and handbooks should be updated to clearly identify NICLA eligibility and interaction with FMLA.

Los Angeles Requires Health Benefit Payments for Hotel Workers

Issued date: 06/30/26

Beginning July 1, 2026, covered employers in the City of Los Angeles subject to the Citywide Hotel Worker Minimum Wage Ordinance ("CHMWO") must pay a health benefit rate of $4.25 per hour (adjusted annually) to covered hotel employees. If the employer does not provide health benefits, the health benefit payment must be provided as an additional hourly wage. The ordinance permits limited waivers in certain circumstances.

This update provides a high-level overview of the ordinance as it relates to the health benefit payment requirements for hotel employers.

Hotel Employers Covered under the Ordinance

A covered Hotel Employer is:

1. Any person who owns, controls, or operates a hotel in the City of Los Angeles;

2. Any person who owns, controls or operates any premises connected to or operated in conjunction with the hotel's purpose; or

3. Any person who employs Hotel Workers to provide services at the hotel.

The CHMWO generally applies to hotels within the geographic boundaries of the City of Los Angeles with 60 or more guest rooms and hotels with 50 or more guest rooms located within the Airport Hospitality Enhancement Zone. For more information on determining Hotel Employers, see here.

Hotel Workers Covered under the Ordinance

A Hotel Worker is an individual whose primary place of employment is at one or more covered hotels and who is employed directly by the Hotel Employer, or by a person who has contracted with the Hotel Employer to provide services at the Hotel.

The following are not considered Hotel Workers covered by the CHMWO:

- *Managerial and supervisory employees* – employees who have the authority to hire, transfer, suspend, lay off, recall, promote, discharge, assign, reward, or discipline other subordinate employees, or the responsibility to direct them, adjust their grievances, or, in effect, recommend such action. The exercise of such authority must require the use of independent judgment.

- *Confidential employees* – any employee whose duties involve access to confidential information, usually in regard to the employer's labor relations.

Hotel Employer Requirements

Beginning on July 1, 2026, a Hotel Employer must either make a health benefit payment towards the provision of health care benefits for a Hotel Worker or, if no health benefits are provided, pay the Hotel Worker the health benefit payment as an additional wage per hour.

If the Hotel Employer's hourly health benefit payment is less than the health benefit rate in effect, the difference must be paid to the Hotel Worker as an additional hourly wage.

The health benefit expenditure rate schedule is as follows:

- **Effective July 1, 2026,** the health benefit rate is $4.25 per hour.

- **Effective July 1, 2027,** the health benefit rate is $6.00 per hour.

- **Effective July 1, 2028,** and annually thereafter each July 1, the health benefit rate will match the health benefit rate applicable to airport workers pursuant to Section 10.37.3(a) of the Los Angeles Administrative Code.

Covered Hotel Employers must post the required CHMWO notice, which includes the current health benefit rate, in a conspicuous place at any workplace or job site where a covered employee works.

Health benefits that qualify under the ordinance include health coverage, dental, vision, mental health, and disability income.

Coverage not credited toward the cost of health benefit coverage include retirement benefits, accidental death and dismemberment insurance, life insurance and other benefits that do not provide medical or health related coverage.

Waivers and Exemptions

There are three limited circumstances for which a waiver or exemption from the CHMWO requirement may apply:

- **Collective Bargaining Agreement ("CBA").** A CBA may supersede the requirements of the CHMWO for hotel workers covered by the CBA. All parties to the CBA must expressly waive the benefits required by the CHMWO.

- **Limited Hardship Waiver for Hotel Employers.** A Hotel Employer may apply with the Office of Wage Standards ("OWS") for a one-year waiver from the CHMWO based on financial hardship with supporting documentation.

- **Employee Health Benefit Waiver.** A Hotel Worker may request a waiver of the health benefit provisions of the CHMWO with the OWS if they receive health benefits under Medicare, a health plan through the U.S. Department of Veteran Affairs, or a health plan in which the Hotel Worker's spouse, domestic partner or parent is a participant or subscriber. If the waiver is in effect, the employee remains entitled to the minimum hourly wage and an additional monthly payment of either $100 (for a full-time employee) or $50 (as a part-time employee). For more information on waivers and exemptions, see here.

Employer Action

Hotel Employers subject to the CHMWO should prepare to comply with its requirements, including accounting for employees covered by the ordinance that may not otherwise be eligible under the group health plan (e.g., part-time employees). Employers should ensure required notices are posted and proof of benefit expenditures are maintained.

2026 PCORI Fee Filing Reminder for Self-Insured Plans

Issued date: 06/30/26

The Patient-Centered Outcomes Research Institute ("PCORI") fee filing deadline is **July 31, 2026,** for all self-funded medical plans and some HRAs (including individual coverage HRAs ("ICHRAs")) for plan years (including short plan years) ending in 2025. Carriers are responsible for paying the fee for insured policies.

The plan years and associated PCOR fee amounts due July 31, 2026, are as follows:

Plan Years Ending	Amount of PCOR Fee
January 31, 2025	$3.47/covered life/year
February 28, 2025	$3.47/covered life/year
March 31, 2025	$3.47/covered life/year
April 30, 2025	$3.47/covered life/year
May 31, 2025	$3.47/covered life/year
June 30, 2025	$3.47/covered life/year
July 31, 2025	$3.47/covered life/year
August 31, 2025	$3.47/covered life/year
September 30, 2025	$3.47/covered life/year
October 31, 2025	**$3.84/covered life/year**
November 30, 2025	**$3.84/covered life/year**
December 31, 2025	**$3.84/covered life/year**

Employers with self-funded health plan years ending in 2025 should use the 2nd quarter Form 720 to file and pay the PCORI fee by July 31, 2026. The information is reported in Part II.

IRS Form 720 is a quarterly form that is used to report and pay many different taxes, including fuel and other transportation excise taxes. The IRS has adapted the Form 720 to be used for this annual reporting requirement. Each year, the PCOR section is updated with the fee rates in June for the July 31st due date (the 2nd quarter form).

Please note, Form 720 is a tax form (not an informational return form such as Form 5500), and as such, the employer or an accountant would need to prepare it. Parties other than the plan sponsor, such as third-party administrators and USI, cannot report or pay the fee.

Resources

For a copy of Notice 2025-61, visit https://www.irs.gov/irb/2025-45_IRB#NOT-2025-61

For a copy of the regulations, visit: http://www.gpo.gov/fdsys/pkg/FR-2012-12-06/pdf/2012-29325.pdf

For additional information, please visit the following IRS sites:

- Form 720, Quarterly Federal Excise Tax Return – instructions and forms: https://www.irs.gov/forms-pubs/about-form-720.
- Patient-Centered Outcomes Research Trust Fund Fee, Questions and Answers: https://www.irs.gov/newsroom/patient-centered-outcomes-research-institute-fee
- PCOR Filing Due Dates and Applicable Rates Chart: https://www.irs.gov/affordable-care-act/patient-centered-outreach-research-institute-filing-due-dates-and-applicable-rates

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