

2026: Third Quarter

Compliance Digest

Compliance Bulletins Released July to September

2026 Compliance Bulletins: Third Quarter

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2027 Illinois Health Benefit Law Changes

Issued date: 07/07/26

The Illinois Insurance Code (“IIC”) applies to most group and individual health insurance policies written by Illinois insurance companies.

Since these are state insurance requirements, they are preempted by ERISA’s federal requirements and do not apply to ERISA-covered self-funded group health plans. State requirements do apply to governmental self-funded group health plans when the County, Municipal, and School Codes are also amended. The following laws amended the IIC as well as the County, Municipal, and School Codes.

The following provisions have an effective date of January 1, 2027:

Provision	New Requirement
Hippotherapy & Therapeutic Riding (SB0069 / Public Act 104-0068)	Plans will be required to provide coverage for medically necessary services, including hippotherapy, that incorporate equine movement as part of a therapeutic intervention.
Genetic Testing (SB0175 / Public Act 104-0073)	Plans will be required to provide coverage for karyotype testing or related hormone testing to diagnose Klinefelter syndrome.
Laser Hair Removal (HB3248 / Public Act 104-0289)	Plans will be required to provide coverage for laser hair removal if the procedure is a prescribed medical treatment. The coverage shall apply to individuals with conditions including, but not limited to, body dysmorphia, hidradenitis suppurativa, polycystic ovary syndrome, or other similar skin conditions if the procedure is a prescribed medical treatment.
Peripheral Artery Disease Screening (SB1418 / Public Act 104-0379)	Plans will be required to provide coverage, no less than once every 12 months, for a peripheral artery disease screening test for any at-risk individual.

Provision	New Requirement
Mental Health & Substance Abuse Parity (HB 1085 / Public Act 104-0446)	Plans will be required to provide coverage for 60-minute psychotherapy and cannot impose more onerous documentation requirements on the provider than is required for other psychotherapy. Mirrors Federal MHPAEA provisions.

Employer Action

For fully insured plans written in Illinois, the respective insurance carriers should be aware of and make the required changes to their policies.

For non-ERISA self-funded plans, employers should work with their TPA to ensure that the required changes are made to their plans.



Nebraska Law Requires Coverage for Certain Pediatric Disorders

Issued date: 07/08/26

In April, Governor Pillen of Nebraska signed LB762 (“the Law”) into law, requiring insurance coverage for treatments of certain pediatric autoimmune disorders.

In addition to defining pediatric acute-onset neuropsychiatric syndrome (“PANS”) and pediatric autoimmune neuropsychiatric disorder associated with a streptococcal infection (“PANDAS”), the law requires Nebraska health insurance providers to provide treatment for PANS and PANDAS. Treatments may include, but are not limited to antibiotics, medication and behavioral therapies, plasma exchanges, and intravenous immunoglobulin.

The Law is effective for plan years beginning on or after January 1, 2027, and applies to fully insured plans written out of Nebraska and self-insured plans that are not subject to ERISA; the Law does not apply to self-insured plans that are subject to ERISA.

Employer Action

Nebraska employers with fully insured plans should work with their carriers to confirm that the applicable PANS and PANDAS treatments will be covered by their plans beginning on or after January 1, 2027.



IRS Announces 2027 ACA Affordability Indexed Amount

Issued date: 07/28/26

The IRS recently announced in [Revenue Procedure 2026-26](#) that the Affordable Care Act (“ACA”) affordability indexed amount under the Employer Shared Responsibility Payment (“ESRP”) requirements will be **10.22%** for plan years that begin in 2027. This is an increase from the 2026 percentage amount (9.96%).

Background

Rev. Proc. 2026-26 establishes the indexed “required contribution percentage” used to determine whether an individual is eligible for “affordable” employer-sponsored health coverage under Section 36B (related to qualification for premium tax credits when buying ACA Marketplace coverage). However, the IRS explained in IRS Notice 2015-87 that a percentage change under Section 36B will correspond to a similar change for affordability under Section 4980H ESRP requirements.

Determining Affordability in 2027

An employer will not be subject to a Section 4980H penalty with respect to an ACA full-time employee (“FTE”) if that employee’s required contribution for 2027 meets one of the following safe harbors:

1. The W-2 safe harbor.

The employee’s monthly contribution amount for the self-only premium of the employer’s lowest cost coverage that provides minimum value is affordable if it is equal to or lower than **10.22% of the employee’s W-2 wages** (as reported on Box 1 of Form W-2). Application is determined after the end of the calendar year and on an employee-by-employee basis. Box 1 reflects compensation subject for federal income taxes, which would exclude amounts such as employee contributions to a 401(k) or 403(b) plan, and towards other benefits through a cafeteria plan.

2. Rate of pay safe harbor.

The employee's monthly contribution amount for the self-only premium of the employer's lowest cost coverage that provides minimum value is affordable if it is equal to or lower than **10.22% of the employee's computed monthly wages**. For hourly employees, monthly wages are equal to 130 hours multiplied by their rate of pay. For salaried employees, monthly wages are equal to their monthly salary. Note, the rate of pay safe harbor is not available for tipped employees or employees compensated solely on commissions.

Note. For example, an hourly employee has a \$20/hour rate of pay. For a 2027 plan year, coverage is "affordable" for the employee if the employee's cost for self-only coverage does not exceed \$265.72/month $((\$20 \times 130 \text{ hours}) \times 0.1022)$.

3. Federal Poverty Level ("FPL") safe harbor.

Coverage is affordable if it does not exceed **10.22% of the FPL**.

For a 2027 calendar year plan, coverage is affordable under the FPL safe harbor if the employee monthly cost for self-only coverage in the lowest cost plan that provides minimum value is not more than **\$135.92** (48 contiguous states), \$169.90 (Alaska), or \$156.36 (Hawaii). Note, this amount may increase (or decrease) when the 2027 FPL guidelines are issued.

Employer Action

Employers budgeting and preparing for the 2027 plan year should review these affordability safe harbors when analyzing employee contribution amounts for the coming year.

For Revenue Procedure 2026-26, please visit: <https://www.irs.gov/pub/irs-drop/rp-26-26.pdf>.



IRS Begins Issuing 226-J Letters for Tax Year 2024

Issued date: 07/29/26

In July of 2026, the IRS began issuing 226-J letters to Applicable Large Employers (“ALEs”) for the 2024 calendar year. Letter 226-J describes the proposed Employer Shared Responsibility Payment (“ESRP,” also referred to as a “penalty”) owed for a calendar year.

Note. ALEs that offer group health plan coverage are often surprised to receive a Letter 226-J. While in some cases the penalty assessment is valid, often there are errors in Forms 1094-C or 1095-C that trigger proposed penalty assessments. Usually correcting the filings through the response to the Letter 226-J can mitigate penalty exposure.

The IRS compiles Letter 226-J based on information provided in employer ACA filings, along with information reported by individuals who received premium tax credits through the Marketplace. The IRS uses the information provided on employers’ Form 1094-C and related Forms 1095-C to determine whether employers met their obligations under the ACA ESRP requirements.

Letter 226-J includes an “ESRP Summary Table” that shows how the IRS arrived at the proposed penalty amount. This table indicates whether the employer is subject to the “A” penalty for failure to offer coverage to at least 95% of ACA full-time employees (“ACA FTEs”) or the “B” penalty for failure to offer coverage that is affordable or minimum value. The Letter also includes an “Employer Premium Tax Credit (PTC) Listing” which identifies which ACA FTEs received PTCs during the calendar year, and how those subsidies correlate with the employer’s offer of coverage as documented on the 1095-C.

Employers should compare the information reflected in these tables to their original ACA filings and supporting records to determine whether the proposed assessment is accurate.

The letter will identify the tax year and include a response deadline that is at least 90 days after the date of the letter. Employers generally respond using Form 14764 (“ESRP Response”), along with any explanation and supporting documentation needed to dispute the proposed assessment. It is important that the IRS receive the response by the deadline printed on the letter. In order to appeal any penalty, the IRS must receive a timely response to the initial Letter 226-J.

An employer that requests corrections in response to an IRS inquiry related to these forms may be liable for penalties based on the number of forms that are corrected. For forms filed in calendar year 2024, the penalties are:

- \$330/form for failure to furnish accurate Forms 1095-C to the employee.
- \$330/form for failure to file accurate Forms 1094-C and 1095-C with the IRS.

A reasonable cause exception remains available and may provide relief from penalties for entities that can show a reasonable cause for failing to timely or accurately complete their reporting requirements.

Employer Action

- Monitor incoming mail for IRS Letter 226-J and other ACA Employer Shared Responsibility Payment (ESRP) notices.
- Retain ACA reporting documentation, including Forms 1094-C and 1095-C, for several years after filing.
- Maintain records of employee offers of coverage and enrollment elections.
- Keep current and historical plan documents and Summary Plan Descriptions readily accessible.
- Preserve affordability calculations used to determine ACA compliance.
- Document employee classifications (e.g., full-time, part-time, variable-hour) and any related eligibility determinations.
- Retain employee waiver and declination forms for individuals who were offered coverage but did not enroll.
- Be prepared to provide supporting documentation if the IRS proposes an ESRP assessment.
- Remember that the IRS may assess ACA penalties for up to six years after the ACA reporting deadline.
- Seek assistance when completing or correcting Forms 1094-C and 1095-C to help ensure reporting accuracy.



DOL Proposes New Electronic Disclosure Safe Harbor

Issued date: 08/03/26

On July 22, 2026, the Department of Labor (“DOL”) issued proposed regulations creating a new electronic disclosure safe harbor for group health plans. If finalized, the proposal would provide an alternative to the DOL’s existing electronic disclosure rules and would allow group health plans to furnish required ERISA disclosures electronically using a notice-and-access framework similar to the electronic disclosure safe harbor currently available for retirement plans.

The proposal is intended to modernize disclosure requirements by expanding the ability of group health plans to provide required notices electronically.

If finalized “as is,” the rule would apply beginning on the first day of the first calendar year following the date the final rule is published.

Background

Under the DOL’s existing 2002 electronic disclosure safe harbor, electronic delivery generally is available only for:

- Participants who are “wired at work,” meaning they have work-related access to the employer’s electronic information system and electronic access is integral to their job duties; and
- Other participants and beneficiaries who affirmatively consent to receive documents electronically.

For individuals who are not “wired at work,” the current safe harbor requires affirmative consent and a number of related disclosures regarding electronic delivery, withdrawal rights, hardware and software requirements, and access procedures. Many plan sponsors found this process administratively burdensome and were challenged to provide documents electronically for individuals who are not “wired at work.”

In 2020, the DOL adopted a separate electronic disclosure safe harbor for pension benefit plans, providing additional flexibility to electronic delivery of plan information. This new proposed rule would extend a similar notice-and-access approach to group health plans.

Proposed Electronic Disclosure Safe Harbor

Under the proposal, a group health plan administrator could satisfy ERISA's disclosure requirements by posting required documents to a website or other electronic repository and providing participants and beneficiaries with a Notice of Internet Availability.

Covered Individuals

The proposed safe harbor would apply to participants, beneficiaries, and other individuals entitled to receive ERISA disclosures who provide an electronic address, such as:

- A personal email address;
- A work email address; or
- A company-issued or personal smartphone number capable of receiving electronic notices.

In addition, dependent children who are beneficiaries under the plan and have attained age 18 would be eligible to receive disclosures directly if they provide their own electronic address.

Covered Documents

The proposed safe harbor would broadly apply to any document or information that a group health plan administrator is required to furnish under Title I of ERISA. Briefly, this includes:

- Summary Plan Descriptions ("SPDs")
- Summary Material Modifications ("SMMs")
- Summary Annual Reports ("SARs")
- COBRA notices
- HIPAA notices (i.e., special enrollment, wellness notices; not HIPAA privacy notices)
- Children's Health Insurance Program Reauthorization Act ("CHIPRA") notices
- Summary of Benefits and Coverage ("SBCs," where applicable)
- Claims and appeals notices

If a health insurance carrier and a group health plan sponsor enter into a written agreement under which the issuer agrees to provide the information required under ERISA, the carrier may also utilize this safe harbor.

Unlike the electronic disclosure safe harbor for retirement plans, the proposal would also permit use of the safe harbor for documents that are furnished only upon participant request.

Note. As proposed, the safe harbor only applies to certain group health plan documents. It does not extend to all welfare benefits, including life insurance and disability plans. Employers that use a wrap plan document and wrap SPD that incorporates health plan benefits and other welfare plan benefits may be challenged to use the safe harbor under the proposed rule (at least for furnishing the SPD). Hopefully, this can be addressed through the notice and comment period and the relief extended to other welfare benefits.

Notice of Internet Availability (“NOIA”)

To utilize the new safe harbor, group health plans generally would provide a NOIA each time a covered document is made available on the website, including when a document is provided upon request. In certain circumstances, annual combined NOIAs could be used.

The NOIA would be required to include:

- The title or subject line: “Disclosure About Your Health Plan;”
- A statement informing the individual that important health plan information is available;
- Identification by name or a brief description of the document being provided;
- A website address or hyperlink providing access to the document;
- Information regarding the right to obtain paper copies free of charge;
- Information regarding the right to opt out of electronic delivery; and
- Contact information for the plan administrator or designated representative.

The notice must be written in a manner calculated to be understood by the average plan participant and generally must be furnished separately from other communications.

Website Requirements

The proposal would require plan administrators to ensure that covered documents are posted on a website or electronic repository that satisfies specific requirements.

Among other requirements:

- Documents must be available no later than the date they otherwise must be furnished under ERISA;
- Documents generally must remain available for at least one year or until superseded by a newer version;
- Documents must be presented in a format suitable for reading online and printing, and in a format that allow the covered document to be permanently retained;
- Documents must be electronically searchable; and
- The website must protect the confidentiality of personal information.

Note. The proposed rule would permit use of secure websites, portals, and mobile applications. However, the DOL specifically declined to create an email-delivery alternative similar to the one available for retirement plans because group health plan disclosures often contain sensitive health information, including protected health information (“PHI”).

Availability of Paper Documents

The proposal includes several safeguards intended to protect participants and beneficiaries who prefer paper communications:

- *Free Paper Copies:* Participants and beneficiaries would have the right to request paper copies of covered documents free of charge. Importantly, unlike the retirement plan safe harbor, the proposal would require group health plans to provide additional paper copies free of charge upon request.
- *Right to Opt Out:* Covered individuals would have the right to globally opt out of electronic delivery and instead receive all disclosures in paper form. Plan administrators would be required to establish reasonable procedures for processing paper-copy requests and opt-out elections.
- *Invalid Electronic Addresses:* Administrators would be required to monitor for invalid or inoperable electronic addresses. If an electronic notice is returned as undeliverable, the administrator would need to take reasonable steps to obtain a valid electronic address or revert to paper delivery.

Initial notification

Before relying on the safe harbor, administrators would be required to provide an initial notification explaining:

- Disclosures will be provided electronically;
- Which electronic address that will be used for the individual;
- How to access documents;
- How long the document will be available electronically;
- The right to obtain free paper copies; and
- The right to opt out of electronic delivery.

Special Rules

The proposed regulations include several additional provisions addressing:

- Employees who separate from employment and lose access to employer-provided email addresses;
- Annual combined notices for certain recurring disclosures;
- Temporary website outages and technical disruptions; and
- Compliance with other applicable laws, including HIPAA privacy and security requirements.

The DOL also proposes corresponding amendments to the ERISA claims regulations to allow adverse benefit determinations and appeal decisions to be furnished using the new safe harbor.

Employer Action

At this time, the proposed regulations are not final and no action is required. Employers should not rely on this safe harbor for electronic delivery of notices until it is finalized.

- If finalized, the new safe harbor would give employers significantly greater flexibility to deliver health plan disclosures electronically without obtaining affirmative consent from most participants and beneficiaries.
- Employers currently relying on paper delivery or the existing 2002 electronic disclosure safe harbor may want to evaluate whether the new notice-and-access framework could improve administrative efficiency.
- Plan sponsors should continue coordinating with carriers, third-party administrators, COBRA administrators, and other vendors regarding responsibility for furnishing required notices.
- Employers should also ensure vendors have processes in place to maintain and support any electronic disclosure platforms used for compliance purposes.



California's Restructured MCO Tax Expected to Increase Premiums

Issued date: 08/04/26

California's restructuring of its Managed Care Organization ("MCO") tax under Senate Bill 125 ("SB 125") is expected to increase premiums for many fully insured California health plans.

Several carriers subject to this tax indicate that they intend to incorporate these costs into health care premiums. If approved by the Centers for Medicare & Medicaid Services ("CMS"), the change will go into effect as of January 1, 2027.

While much remains uncertain, the following FAQs summarize what is currently known about the MCO tax and the potential impact on employer-sponsored health plans. We will continue to monitor any new developments or updates.

Q1. What is the MCO tax?

The MCO tax is a health care provider-related state tax imposed on MCOs in California. California uses the revenue from this tax to help fund the state's Medi-Cal program (California's Medicaid program) and to draw down additional federal Medicaid matching funds. While the MCO tax applies to both Medi-Cal and commercial health plans, the tax rate on Medi-Cal plans has been historically higher.

Q2. What's new with the MCO tax?

Due to changes in federal Medicaid under the One Big Beautiful Bill Act ("OBBBA"), the existing MCO tax in California will not meet federal requirements after December 31, 2026. These new federal rules prohibit taxes that assess higher rates on Medi-Cal plans than commercial plans or otherwise place a disproportionately high tax burden on Medi-Cal plans.

To meet new federal requirements, California reformed its MCO tax through Senate Bill 125, which passed June 29, 2026. The tax was restructured to apply the rate of **\$8.85 per covered life per month** (roughly **\$100 annually per covered life**) to both Medi-Cal plans and private insurers, subject to modification by California's Department of Health Care Services ("DHCS"), the agency responsible for administration of this tax, or per law. The tax, as enacted, would be in effect for calendar years 2027, 2028, and 2029.

In response, many health insurance carriers have indicated they intend to pass on the additional tax to consumers, likely resulting in higher premiums for fully insured health plan policies in California.

Q3. Does the MCO tax affect employer-sponsored fully insured health plans in California?

Likely yes. While the tax is imposed on carriers and not directly on employer-sponsored health plans, carriers have indicated they will be reflecting the anticipated MCO tax impact in renewals and pricing for fully insured plans. Therefore, HMOs and other fully insured commercial group health policies written in California will likely be affected by this tax in the form of increased rates and premiums.

Further clarification from the state and carriers as to which plans the tax will affect and the timing of the impact would be welcome.

Q4. Does the MCO tax affect employer-sponsored self-funded health plans in California?

The tax is not expected to directly impact self-funded health plans subject to ERISA. However, MCOs that also provide third-party administrative services to self-funded plans could seek to increase administration costs as a result of additional taxation.

Q5. When and how will this take effect?

As enacted by California, the tax is set to take effect January 1, 2027. However, California's DHCS must seek approval by CMS to implement this tax. To date, they have not received this approval.

Additionally, on July 24, 2026, citing the projected increase in health insurance costs for families and small businesses, six members of California's Republican congressional coalition sent a formal request to the Department of Health and Human Services and CMS requesting they deny federal approval of the restructured MCO tax.

In addition to the tax needing CMS approval to become finalized, the carriers' approaches to addressing the tax may vary. Some carriers have indicated they intend to pass on the full amount of the tax, but others may decide to absorb some of that cost. Also, for non-calendar year plans, some carriers have indicated they will implement the tax mid-year, while others may not.

Thus, it is unclear at this time whether this new tax will take effect and how it may (or may not) be reflected in rates for 2027.

Q6. What are the next steps for an employer?

No action is necessary at this time. If the tax is approved by CMS, employers with fully insured plans in California should prepare for the potential of increased premiums.



Massachusetts Announces Guidance on PFML Tax Treatment

Issued date: 08/17/26

Previously, the Internal Revenue Service issued [IRS Revenue Ruling 2025-4](#), which among other things, informed that medical leave benefits attributable to employer contributions are taxable wages. In an effort to mitigate the impact of this guidance, new [Massachusetts legislation](#) shifts employer contributions from medical leave to family leave, effective January 1, 2027.

The Massachusetts Department of Family and Medical Leave (“DFML”) recently announced the 2027 contribution rate to be determined by DFML on or before October 1 will reflect the legislative change for contribution rates that take effect beginning on January 1, 2027. The DFML employer contribution rates and calendar [webpage](#) provide an example of the 2027 contribution rate split for employers with 25 or more covered individuals. As a reminder, there will be no change for employers with fewer than 25 employees as there is no required employer contribution for medical leave for these employers.

Employer Action

The DFML informs that its tax information applies to employers in the state program. It recommends that employers consult their tax professional regarding private plans or self-funded plans. All employers should work with their payroll processors, tax professionals and private plan vendors as applicable. We will continue to monitor this issue and provide a compliance update when the 2027 contribution amounts are announced in the next few months.



Minnesota Maintains PFML Premium Rates for 2027

Issued date: 08/18/26

In 2023, Minnesota enacted a paid family and medical leave (“PFML”) program that provides paid leave for most employees in the state starting in 2026. PFML qualifying events include caring for serious health conditions—either for the employee or a family member, bonding with a new child, and responding to incidents of domestic violence, sexual assault, or stalking.

2027 Premium Amounts

The Minnesota Department of Employment and Economic Development (“DEED”) has confirmed the PFML premium rate for large employers will remain at 0.88% of the taxable wages of covered employees in 2027. Similarly, the premium rate for small employers will stay unchanged at **0.66%**.

Employers may choose to pay the entire premium or share the cost with employees; however, employers may not charge employees more than 50% of the required premium. Therefore, a large employer may not charge employees more than 0.44% of the premium. For small employers, the limit on employee contributions remains at 0.22% of the premium.

Employer Action

Employers should continue to budget appropriately for PFML and update any leave-related documents as necessary to ensure that employees are aware of their rights.



Illinois Expands Workplace Protections for Menopause-Related Conditions

Issued date: 08/26/26

Illinois employers have another workplace accommodation and discrimination law to add to their compliance checklist. On August 7, 2026, Governor JB Pritzker signed the Illinois Menopause Equity and Care Act. Effective January 1, 2027, the law expands employee rights and employer obligations under the Illinois Human Rights Act (IHRA), with additional health insurance coverage requirements taking effect January 1, 2028.

What the New Law Does

Beginning January 1, 2027, the IHRA will prohibit discrimination and harassment based on “menopause-related conditions.” The law defines these conditions broadly to include perimenopause, menopause, and associated medical or symptomatic conditions. Examples include:

- Vasomotor symptoms
- Sleep disruption
- Cognitive changes or mood changes
- Osteoporosis-related changes

Employers may not take adverse employment actions or allow harassment based on an employee’s menopause-related condition.

New Accommodation Requirements

The Act also requires employers to provide reasonable accommodations for menopause-related conditions, similar to accommodations already available for pregnancy-related conditions.

Potential accommodations may include:

- Flexible scheduling
- Modified work hours
- Temperature- or climate-adjusted workspaces
- Additional breaks
- Seating modifications
- Temporary job restructuring or reassignment where appropriate

As with other accommodation requests, employers should engage in an interactive process to determine whether a reasonable accommodation can be provided without creating an undue hardship.

Notice and Policy Updates Required

Employers must notify employees of their rights regarding accommodations for pregnancy and menopause-related conditions through required workplace postings and employee policies.

Health Plan Coverage Changes Coming in 2028

The law also includes significant insurance-related provisions.

Effective January 1, 2028, insured individual and group health insurance policies issued, renewed, or amended in Illinois must cover medically necessary evaluation and treatment for perimenopause and menopause in accordance with evidence-based guidelines. Covered services may include hormone therapy, non-hormonal therapies for vasomotor symptoms, and medications for menopause-related osteoporosis.

In addition, group health insurance policies covering more than 25 employees must provide an annual menopause or perimenopause health visit for individuals age 45 and older without cost-sharing, except where necessary to preserve Health Savings Account (HSA) eligibility under federal tax rules.

Employer Action

Employers should begin preparing now for the upcoming requirements:

Before January 1, 2027

- Review and update anti-discrimination and accommodation policies.
- Update employee handbooks to address menopause-related accommodations.
- Ensure required workplace notices and postings are updated when state guidance becomes available.
- Train HR professionals, supervisors, and managers on recognizing and responding appropriately to accommodation requests.

Before January 1, 2028

- Discuss with carriers to understand how insured health plan coverage will be modified.
- Review employee communications and open enrollment materials for required coverage changes.
- Confirm whether plan designs will need adjustments to accommodate the annual menopause/perimenopause health visit requirement.



2026 MLR Rebate Checks to Be Issued Soon to Fully Insured Plans

Issued date: 08/31/26

As a reminder, insurance carriers are required to satisfy certain medical loss ratio (“MLR”) thresholds. This generally means that for every dollar of premium a carrier collects with respect to a major medical plan; it should spend 85 cents in the large group market (80 cents in the small group market) on medical care and activities to improve health care quality. If these thresholds are not satisfied, rebates are available to employers in the form of a premium credit or check.

If a rebate is available, carriers are required to distribute MLR checks to employers by September 30, 2026.

Importantly, employers must distribute any amounts attributed to employee contributions to employees and handle the tax consequences (if any).

This does not apply to self-funded plans.

What do I do with this MLR rebate check?

Insurance carriers are required to satisfy certain medical loss ratio (“MLR”) thresholds. This generally means that for every dollar of premium a carrier collects with respect to a major medical plan; it should spend 85 cents in the large group market (80 cents in the small group market) on medical care and activities to improve health care quality. If these thresholds are not satisfied, rebates are available to enrollees.

This does not apply to self-funded plans.

The rules around rebates are complex and require careful review with ERISA counsel. Among other things, an employer receiving a rebate as a policy holder will need to determine:

- who receives a rebate (e.g., current participants v. former participants);
- the form of the rebate (e.g., premium reduction v. cash distribution);

- the tax impacts of any such rebate (on both the employer and participants receiving the rebate); and
- what, if any, communication to provide participants regarding the rebate.

The following questions and answers are designed to provide information as to what employer action may be necessary.

What will the rebate amount be?

Carriers determine MLR on a state basis by market segment (individual, small group, or large group). Carriers do not disaggregate by type of plan within these markets (e.g., PPO v. HMO v. HDHP) or by policyholder so the carrier will have to let you know the amount.

A carrier is not required to provide a rebate to an enrollee if the total rebate owed is less than \$20 per subscriber (\$5.00 when a carrier pays the rebate directly to each subscriber). This rule regarding de minimis amounts only applies to the carrier, not to employers refunding amounts to participants.

Will there be any communication?

Yes.

For each MLR reporting year, at the time any rebate of premium is provided, a carrier must provide the policyholder and each current enrollee who was also enrolled in the MLR reporting year in a form prescribed by HHS.

Employers do not have to notify employees, but they may want to address the notices being distributed by the carriers. Language similar to the following provides a starting point for such a notice:

Employees should have received a notice of rebate from [carrier]. In short, [Employer] received a rebate check in the amount of \$____. Amounts attributable to participant contributions will be used to [reduce premium amounts] for [currently enrolled employees] in accordance with legal requirements. These amounts will be reflected in the [September ____] paychecks.

What will the form of rebate to the employer be?

Carriers may issue rebates in the form of either a premium credit (i.e., reduction in a premium owed), a lump-sum payment, a lump-sum reimbursement to the account used to pay the premium if an enrollee paid the premium using a credit card or direct debit, or a “premium holiday,” if this is permissible under state law.

When will the rebate be issued?

Rebates must be paid by **September 30** each year. A carrier that fails to timely pay any rebate must additionally pay the enrollee interest at the current Federal Reserve Board lending rate or 10% annually, whichever is higher, on the total amount of the rebate, accruing from the date payment was due.

Do employers have to give some or all of the rebate to participants?

Yes, unless they paid 100% for all tiers of coverage.

Carriers will generally send rebate checks to employers and employers must mete out any amounts attributed to employee contributions to employees and handle the tax consequences.

There is no one formula for employers to use, but guidance has been provided to aid employers.

ERISA-covered group health plans

To the extent that rebates are attributable to participant contributions, they constitute plan assets. Plan assets must be handled in accordance with the fiduciary responsibility provisions of Title I of ERISA.

If the employer is the policyholder, determining the plan's portion, if any, may depend on provisions in the plan or the policy or on the manner in which the plan sponsor and the plan participants have shared in the cost of the policy. If the plan or its trust is the policyholder, in the absence of specific plan or policy language to the contrary, the entire rebate would constitute plan assets, and the policyholder would be required to comply with ERISA's fiduciary provisions in the handling of rebates that it receives.

The HHS regulations and related DOL guidance for ERISA plans leave to the policyholder the decision as to how to use the portion of a rebate that constitutes plan assets, subject to ERISA's general standards of fiduciary conduct. The DOL notes that, in choosing an allocation method, "the plan fiduciary may properly weigh the costs to the plan and the ultimate plan benefit as well as the competing interests of participants or classes of participants provided such method is reasonable, fair and objective." An allocation does not necessarily have to exactly reflect the premium activity of policy subscribers. A plan fiduciary may instead weigh the costs to the plan and the competing interests of participants or classes of participants when fashioning an allocation method, provided the method ultimately proves reasonable, fair, and objective. If the fiduciary finds that the cost of passing through the rebate to former participants would exhaust most of those rebates, the proceeds can likely be allocated to current participants.

Guidance does not address how to handle an MLR rebate where the amount is inconsequential (e.g., a dollar per participant). Taking a cue from DOL Field Assistance Bulletin No. 2006-01, a fiduciary may be able to conclude, after analyzing the relative costs, that no allocation is necessary, when the administrative costs of making correction far exceed the amount of the allocation.

If a plan provides benefits under multiple policies, the fiduciary is instructed to allocate or apply the plan's portion of a rebate for the benefit of participants and beneficiaries who are covered by the policy to which the rebate relates provided doing so would be prudent and solely in the interests of the plan according to the above analysis. But, according to the DOL, "the use of a rebate generated by one plan to benefit the participants of another plan would be a breach of the duty of loyalty to a plan's participants."

Plans that are neither covered by ERISA nor are governmental plans (e.g., church plans)

With respect to policyholders that have a group health plan but not a governmental plan or a plan subject to ERISA, carriers must obtain written assurance from the policyholder that rebates will be used for the benefit of current subscribers or otherwise must pay the rebates directly to subscribers.

The final rule issued on February 27, 2015, provides that subscribers of non-federal governmental or other group health plans not subject to ERISA must receive the benefit of MLR rebates within three (3) months of receipt of the rebate by their group policyholder, just as subscribers of group health plans subject to ERISA do.

When do rebates need to be made to participants?

As soon as possible following receipt and, in all cases, within 3 months of receipt.

What is the form of rebate to participants?

There is no one way to determine this, but guidance has been provided to aid employers.

Reductions in future premiums for current participants is probably the best method.

If proceeds are to be paid to participants in cash, the DOL is likely to require that payments go to those who participated in the plan at the time the proceeds were “generated,” which may include former employees. An option that may be easier to administer is to keep the proceeds in the plan and provide a “premium holiday” (suspension of required premiums) or a reduction in the amount of employee-paid premiums.

The interim final regulations for non-ERISA governmental plans require that rebates be used to reduce premiums for all health plan options for subscribers covered when the rebate is received, to reduce premiums for current subscribers to the option receiving the rebate, or as a cash refund to current subscribers in the option receiving the rebate. In each case, the regulations allow the rebate to be allocated evenly or in proportion to actual contributions to premiums. Note that the rebate is to be used to reduce premiums for (or pay refunds to) employees enrolled during the year in which the rebate is actually paid (rather than the MLR reporting year on which the rebate was calculated).

To recap, here are some options to consider:

- Reduce future premiums for current plan participants. This is administratively easy with limited tax issues with respect to participants.
- Cash payments to current participants. This is administratively burdensome and results in tax consequences to participants.
- Cash payments to former participants. This is administratively burdensome and results in tax consequences to former participants.

The employer could also consider, with counsel, whether providing benefit enhancements or payment of reasonable plan expenses would be considered permissible.

What are the Federal tax implications to employees?

Pre-Tax Premium Payments

When employees pay their portion of the premiums for employer-sponsored health coverage on a pre-tax basis under a cafeteria plan, MLR rebates will be subject to federal income tax and wages. Briefly:

- For rebates that are distributed as a reduction in premium (thus reducing an individual's pre-tax premium payment during the year), there is a corresponding increase to the employee's taxable salary that is also wages taxable for employment tax purposes.
- Rebates that are distributed as cash will result in an increase in taxable income that is also wages subject to employment taxes.

The result is the same regardless of whether the MLR rebates are provided only to employees participating in the plan both in the year employees paid the premiums being rebated and the year in which the MLR rebates are paid, or to all employees participating in the plan during the year the MLR rebates are paid (even if some employees did not participate in the plan during the year to which the rebate applies.)

After-Tax Premium Payments

When employees pay their portion of the premiums on an after-tax basis, MLR rebates generally are not subject to federal income tax or employment taxes. This applies when the rebate is provided as a reduction in premiums or as a cash. The result is the same regardless of whether the MLR rebates are provided only to employees participating in the plan both in the year employees paid the premiums being rebated and the year in which the MLR rebates are paid, or to all employees participating in the plan during the year the MLR rebates are paid (even if some employees did not participate in the plan during the year to which the rebate applies).

What are the tax implications to employers?

Employers should review the tax implications of a rebate with tax advisors. Generally, amounts used for benefits (e.g., to pay premiums with respect to insured plans) should not be taxable.

When employees pay premiums on a pre-tax basis, does reducing a participant's premiums mid-year allow them to make election changes?

Probably not.

If employee contributions are paid on a pre-tax basis and there is a mid-year rate change, the cafeteria plan must determine whether such a change is permitted under the Section 125 rules.

If the plan incorporates the permitted election change rules, the relevant issue is whether this change in cost is permitted under the regulations.

- If there is an insignificant decrease, there can be an automatic adjustment.
- If there is a significant decrease, employees may make a corresponding change including commencing participation in the cafeteria plan for the first time for the option with a decrease in cost.

Generally, MLR rebates are expected to be fairly low dollar amounts and may not rise to the level of a significant change. Employers should consider either taking the position that the cost change is insignificant or that the cost change is significant and the "corresponding change" is to simply allow the reduction or increase. The cafeteria plan document should be consistent with the employer's position.



Louisiana Expands PBM Regulation Through Acts 474 and 913

Issued date: 09/08/26

Over the last two legislative sessions, Louisiana enacted two significant pieces of pharmacy benefit manager (“PBM”) legislation.

- Act 474 of the 2025 Regular Session (HB 264) established broad new requirements relating to PBM reimbursement practices, rebate retention, transparency, reporting, and patient steering.
- Act 913 of the 2026 Regular Session (HB 1236) builds upon those reforms by modifying the reimbursement methodology applicable to local pharmacies and requiring PBMs to pay a professional dispensing fee. (Signed June 12, 2026)

Together, these laws continue Louisiana’s trend toward increased regulation of PBMs and greater oversight of pharmacy reimbursement arrangements. While many provisions are directed at PBMs, employers sponsoring group health plans should understand the potential impact on prescription drug costs, PBM contracting, and pharmacy network arrangements.

Rebate Retention Prohibited

Act 474 prohibits a PBM from retaining manufacturer rebates. Instead, all rebates received from drug manufacturers must be passed through to the health plan sponsor and utilized as shared savings through lower premiums, reduced participant cost-sharing, broader prescription drug coverage, or other plan design mechanisms. The allocation of rebates must be identified in plan design documents and contractual arrangements.

The law also requires PBMs to annually certify under oath to the Louisiana Commissioner of Insurance that they have complied with the rebate pass-through requirements. Violations may be treated as unfair or deceptive acts in the business of insurance and may be subject to regulatory enforcement.

Expanded PBM Transparency Requirements

Act 474 imposes extensive annual reporting obligations on licensed PBMs. Beginning each year, PBMs must submit transparency reports to the Louisiana Department of Insurance containing information such as:

- Total manufacturer rebates received;
- Administrative fees received;
- Negotiated price concessions;
- Rebates passed through at the point of sale;
- Amounts reimbursed to local and non-local pharmacies;
- Specialty drug rebate information;
- Other services provided by the PBM or affiliates; and
- Details regarding the PBM's vertical integration structure, including relationships with insurers, pharmacies, wholesalers, group purchasing organizations, and providers.

Prohibition on Spread Pricing and Effective Rate Pricing

Act 474 strengthens Louisiana's restrictions on PBM reimbursement practices by prohibiting spread pricing and prohibiting the use of effective rate pricing for local pharmacies. Spread pricing occurs when a PBM charges a health plan more for a prescription drug than the amount paid to the dispensing pharmacy, retaining the difference as compensation.

Although Act 474 became effective in 2025, enforcement of certain spread pricing and rebate provisions is delayed until January 1, 2027.

Local Pharmacy Reimbursement Protections

Act 474 created a new reimbursement framework designed to ensure that local pharmacies are reimbursed at or above acquisition cost for covered drugs and services. Effective January 1, 2026, PBMs administering claims on behalf of health plans (other than Louisiana's Office of Group Benefits) must utilize a reimbursement methodology based on National Average Drug Acquisition Cost ("NADAC") or another benchmark approved by the Commissioner of Insurance.

The law also requires PBMs to maintain an appeal process allowing pharmacies to challenge reimbursement amounts that fall below acquisition cost. If a payment error is identified, the PBM must increase reimbursement to at least acquisition cost and notify all pharmacies using the same customary supplier or wholesaler that a claim payment error occurred and that the pharmacy may reverse and resubmit the claim to correct the error. The PBM must make retroactive price adjustments in the next payment cycle.

Act 913 Add Mandatory Professional Dispensing Fees

Act 913 substantially revises the reimbursement provisions enacted under Act 474. Most significantly, Louisiana replaced the prior adjustment-factor methodology with a requirement that PBMs pay a professional dispensing fee to local pharmacies.

Beginning January 1, 2026, PBMs must:

- Use NADAC as the reimbursement benchmark or, if unavailable, wholesale acquisition cost (“WAC”);
- Pay a professional dispensing fee that is no less than the dispensing fee established under the Louisiana Medicaid program;
- Ensure the professional dispensing fee reflects pharmacists’ actual dispensing and professional service costs; and
- Treat the dispensing fee as a non-recoverable cost that cannot later be recouped from the pharmacy.

Act 913 also revises the definition of acquisition cost to reflect the actual invoice cost paid by the local pharmacy, subject to specified minimum standards. The law further clarifies that acquisition cost cannot be determined solely at the discretion of the PBM or third-party administrator.

Retroactive Claim Reprocessing Requirement

One of the most notable provisions of Act 913 is its retroactive application requirement. PBMs may be deemed compliant if they reprocess applicable claims back to January 1, 2026, using a reimbursement formula that includes the statutory pricing benchmark and a professional dispensing fee of at least nine dollars per claim.

As a result, employers and carriers may experience financial impacts associated with retroactive claim adjustments and increased pharmacy reimbursement obligations.

Patient Steering Restrictions

Act 474 strengthens existing patient choice protections by restricting PBMs from steering participants to pharmacies in which the PBM has an ownership interest or control. PBMs must disclose ownership relationships and inform participants of their right to use an alternate pharmacy. PBMs are also prohibited from retaliating against participants who elect to use another pharmacy.

Application to Employer-Sponsored Health Plans

The statutes broadly apply to PBMs administering pharmacy benefits for Louisiana health plans and health insurance issuers. However, as with similar PBM legislation adopted in other states, certain provisions may face ERISA preemption challenges when applied to self-funded employer-sponsored health plans.

Louisiana has not created a broad exemption for ERISA self-funded plans within these provisions. Plan sponsors should monitor future litigation and regulatory guidance regarding the extent to which these requirements may be enforced against PBMs serving self-funded plans.

Employer Action

Employers should consider taking the following actions:

- Review PBM contracts for rebate pass-through provisions and fee disclosures.
- Confirm whether all manufacturer rebates are being returned to the plan.
- Discuss with PBMs how Act 474 and Act 913 may affect pharmacy reimbursement rates and overall plan costs.
- Evaluate whether retroactive claim reprocessing could affect plan pricing or future renewals.
- Review specialty pharmacy and network arrangements for compliance with Louisiana's anti-steering requirements.
- Monitor ongoing developments regarding ERISA preemption and implementation guidance.



ICHRAs Renamed CHOICE Arrangements

Issued date: 09/11/26

On September 3, 2026, the Centers for Medicare and Medicaid Services (“CMS”) and the U.S. Small Business Administration (“SBA”) announced that individual coverage health reimbursement arrangements (“ICHRA”) will now be referred to as CHOICE arrangements. CHOICE stands for a “custom health option and individual care expense” arrangement.

A CHOICE arrangement remains a type of health reimbursement arrangement (“HRA”) that allows employers to provide employees with tax-free funds to purchase their own individual health insurance, and, in some cases, other eligible medical expenses, instead of offering a traditional group health plan. Importantly, this announcement reflects a change in terminology only and does not alter the existing legal or compliance requirements applicable to these programs.

CMS and SBA are actively promoting CHOICE arrangements as an alternative health coverage strategy for employers evaluating benefit options during their upcoming enrollment season.

Employer Action

There are no specific action items because of this name change.

However, employers interested in exploring CHOICE arrangements should be aware that these programs are subject to numerous plan design, eligibility, affordability, nondiscrimination, employee classification, and ACA compliance requirements. As a result, a thorough review should be conducted before implementation to ensure the arrangement aligns with the employer’s workforce strategy and compliance obligations.



DOL Issues New Guidance on Wellness Programs

Issued date: 09/14/26

On August 26, 2026, the Departments of Labor, Health and Human Services, and Treasury (Departments) released FAQs about [Affordable Care Act and Health Insurance Portability and Accountability Act Implementation Part 74](#), providing important clarification regarding health-contingent wellness programs, tobacco cessation programs, and required participant disclosures.

The guidance primarily addresses questions about whether employers must provide wellness rewards retroactively when an employee completes a reasonable alternative standard (RAS) during the plan year and clarifies when wellness program notices must include information about alternative ways to earn rewards.

Background

Many employer-sponsored health plans use wellness incentives to encourage healthy behaviors. These incentives often take the form of:

- Premium discounts
- Tobacco surcharges
- Reduced deductibles or copays
- Other plan rewards tied to health-related activities or outcomes

Under HIPAA and ACA nondiscrimination rules, health-contingent wellness programs must provide a RAS for individuals who cannot meet the program's initial health-related requirement. Examples include allowing an employee who uses tobacco to complete a tobacco cessation program instead of meeting a tobacco-free standard, or providing an alternative method for earning a biometric screening reward.

Enforcement Relief on Retroactive Reward

One of the most significant clarifications involves how plans apply wellness rewards when an individual completes a RAS midyear.

The preamble to the 2013 wellness regulations stated that employees who satisfied a reasonable alternative standard during the year should receive the same “full reward” available to employees who met the original standard at the beginning of the plan year. This suggested that rewards should be applied retroactively.

The Departments acknowledged that the regulatory text itself does not clearly require retroactive application of rewards. As a result, until additional guidance is issued, the Departments will not take enforcement action against plans that apply rewards prospectively after the reasonable alternative standard has been satisfied, provided all other health-contingent wellness program requirements are met.

Impact on Tobacco Surcharge Programs

The new FAQs are particularly relevant for plans that impose tobacco surcharges.

The Departments reaffirm prior guidance stating that a plan may allow employees to avoid a tobacco surcharge by agreeing to participate in a tobacco cessation program at enrollment and completing that program during the plan year. The plan generally is not required to offer additional opportunities to earn the reward midyear.

Disclosure Requirements Remain Important

The FAQs also clarify when plans must disclose the availability of a reasonable alternative standard. A notice is required in:

- Materials describing the terms of a health-contingent wellness program.
- Outcome-based wellness program communications informing an individual that they failed to meet the initial standard.

These notices must include:

- Information about the availability of a reasonable alternative standard.
- Contact information for obtaining that alternative.
- A statement that recommendations from the individual's personal physician will be accommodated.

A notice generally is not required when materials merely mention that a wellness program exists without describing its specific terms. For example, a Summary of Benefits and Coverage (SBC) that simply notes cost-sharing may vary based on wellness program participation would not trigger the disclosure requirement.

Employer Action

- Determine whether your tobacco surcharge or tobacco-free incentive program includes a compliant reasonable alternative standard and whether participants have adequate time to complete it.
- Confirm how wellness rewards are currently administered and document whether rewards are applied prospectively or retroactively when alternative standards are satisfied.
- Review enrollment materials, wellness program descriptions, vendor communications, and participant notices to ensure required alternative standard disclosures are included where necessary.
- Employers using third-party wellness vendors should verify that program materials, participant notices, and reward structures align with HIPAA wellness program requirements.
- Employers that currently apply wellness rewards retroactively and wish to rely on this non-enforcement policy should discuss changes with legal counsel.



San Francisco HCSO Expenditures and Reporting Update for 2027

Issued date: 09/18/26

The San Francisco Health Care Security Ordinance (“HCSO”) minimum expenditure rates for 2027 have been released, and the HCSO Annual Reporting Form for calendar year 2026 is due on April 30, 2027.

2027 Minimum Expenditure Rates

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

Employer Size	Number of Employees	2026 Health Care Expenditure Rate	2027 Health Care Expenditure Rate
Large	All employers with 100 or more employees	\$4.11 per hour payable	\$4.49 per hour payable
Medium	Businesses with 20-99 employees Nonprofits with 50-99 employees	\$2.74 per hour payable	\$2.99 per hour payable
Small	Businesses with 20-99 employees Nonprofits with 50-99 employees	Exempt	Exempt

The hours payable under the HCSO for each employee are capped at 172 hours per month. Therefore, for 2027 the maximum required health care expenditure for a covered employee of a large employer is **\$772.28** per month (\$4.49/hour x 172 hours). For a medium-sized employer, the maximum required expenditure for a covered employee is **\$514.28** per month (\$2.99/hour x 172 hours).

Managerial, supervisory, or confidential employees who earn more than a specified amount are exempt from the minimum health care expenditures requirement under the HCSO. For 2026, the earnings threshold for these employees to be exempt from the HCSO is \$128,861 per year (or \$61.95 per hour). As of January 1, 2027, the new threshold will be **\$131,763** per year (or **\$63.35** per hour).

Annual Form Reporting

Covered employers must submit an online report each year that summarizes how they complied with the HCSO. The web-based HCSO Annual Reporting Form for the prior calendar year is typically available on the San Francisco Office of Labor Standards Enforcement (“OLSE”) HCSO website by April 1 and must be submitted by April 30. For example, the HCSO Annual Reporting Form for calendar year 2026 is expected to become available on the HCSO website by April 1, 2027, and is due by April 30, 2027.

Employer Action

Covered employers should ensure that they will be making the required minimum health care expenditures in 2027 at the new rates for employees in San Francisco and maintain records showing compliance with the HCSO requirements.

The 2027 version of the HCSO poster, which must be posted in all workplaces with covered employees, is expected to become available by December 2026. Covered employers should monitor the San Francisco HCSO website (linked below) to obtain and post the 2027 version of the poster by January 1, 2027.

Covered employers should also be prepared to submit the HCSO Annual Reporting Form for calendar year 2026 no later than April 30, 2027.



Proposed Rule Addresses DCAP Nondiscrimination Testing

Issued date: 09/21/26

The Treasury and Internal Revenue Service (“IRS”) issued a proposed rule addressing nondiscrimination rules for dependent care assistance programs (“DCAPs”).

The proposed rule provides some of the first regulatory guidance as it relates specifically to DCAP nondiscrimination testing. Fortunately, the rule provides:

- Much needed clarification of the nondiscrimination tests required under Code Section 129 for DCAPs;
- Helpful guidance that makes it easier for employers to satisfy the 55% average benefits test, a test that is commonly failed; and
- Examples to illustrate how the testing works in practice.

This guidance is helpful and timely given the recent statutory increase in the DCAP limit to \$7,500 for plan years beginning in 2026. Many employers were concerned that offering a higher DCAP limit could increase the risk of nondiscrimination testing failures.

The rule is currently proposed and will go through the relevant notice and comment period. However, it may be relied upon until final guidance is issued.

Background

Generally, DCAPs cannot discriminate in favor of highly compensated employees (“HCEs”). HCEs are defined as employees who:

- had compensation during the preceding plan year exceeding \$160,000 (adjusted annually) or
- were more-than-5% owners at any time during the current or preceding plan year.

A non-HCE is an employee who is not an HCE.

To satisfy this requirement, a DCAP must satisfy four nondiscrimination tests: (1) Contributions and Benefits, (2) Eligibility, (3) Owners Concentration and (4) 55% Average Benefits Test.

If a DCAP fails nondiscrimination testing, the amounts received by HCEs for dependent care assistance are no longer excludable and must be included in the HCE's gross income. There is no impact to non-HCEs.

DCAP Nondiscrimination Testing

The proposed rule provides helpful clarification on DCAP nondiscrimination testing.

Contributions & Benefits Test

The contributions or benefits provided under a DCAP must not discriminate in favor of HCEs or their dependents. A plan that provides benefits on the same terms for all eligible employees satisfies this requirement.

Eligibility Test

The DCAP must benefit employees who qualify under an eligibility classification that is: (1) reasonable based on objective business criteria, and (2) does not discriminate in favor of HCEs.

For this purpose, an employee is eligible for a DCAP only if the employee has a meaningful opportunity to receive benefits, via salary reduction or otherwise, regardless of whether any benefits were received.

1. *Reasonable classification.* Any eligibility classification must be reasonable based on established objective business criteria, such as job categories, nature of compensation (e.g., salaried/hourly) or geographic location.
2. *Nondiscriminatory classification.* This can be satisfied through one of two tests:
 - *Facts and Circumstances.* Looking at all the facts and circumstances, the classification is nondiscriminatory. Not one factor is determinative in this analysis, but relevant factors include:
 - The underlying business reason for the classification.
 - The percentage of employees eligible under the plan (the higher the percentage the less likely to be nondiscriminatory).
 - Whether the number of employees eligible under the plan in each salary range is representative of the number of employees in each salary range of the employer's workforce.
 - How close the plan comes to satisfying the numerical safe harbor.
 - *Numerical Safe Harbor.* The numerical test provides that a plan is not discriminatory if the plan's ratio percentage (the ratio of non-HCE participation to HCE participation) is greater than or equal to an employer's applicable safe harbor percentage.
 - The ratio percentage is calculated by dividing the eligibility percentage of non-HCEs (number of eligible non-HCEs ÷ total number of non-HCEs) by the eligibility percentage of HCEs (number of eligible HCEs ÷ total number of HCEs).
 - The safe harbor percentage is 90% (with some reductions).

The following employees are excluded from the eligibility testing:

- Employees who have not attained the age of 21 and have not completed one year of service; and
- Employees covered by a collective bargaining agreement where the benefits were negotiated in good faith.

Owners Concentration Test

Not more than 25% of the total dependent care benefits provided during the year may be provided to individuals who own more than 5% of the employer (or their spouses or dependents).

The rule clarifies that if this test fails, a plan may still correct the failure by including in income any excess ownership contribution to the affected owner under a prescribed formula on their Form W-2 for the applicable year.

55% Average Benefits Test

The average benefit provided to non-HCEs must equal at least 55% of the average benefit provided to HCEs.

Importantly, the proposed rule clarifies that for purposes of this test only count those employees who are receiving benefits from the DCAP. *Employees who are eligible but do not elect to participate can be excluded from the calculation.* This is a significant clarification and should help improve the ability for these arrangements to pass the 55% average benefits test.

The proposed rule also confirms that employers may correct failures by including the excess benefits in income of the affected HCE before the Form W-2 reporting deadline for the year in which the excess benefits were provided.

The following employees are excluded from the 55% average benefits testing:

- Employees who have not attained the age of 21 and have not completed one year of service;
- Employees covered by a collective bargaining agreement where the benefits were negotiated in good faith; and
- Employees with compensation below \$25,000.

When To Run the Tests?

The rule confirms nondiscrimination testing must be satisfied as of the last day of the plan year.

However, it's best to consider earlier testing so that corrections can be made in the event of a testing failure and excess contributions.

Employer Action

The proposed rule is welcome news to provide better guidance and clarification on DCAP testing. It may be relied upon until a final rule is published. Employers will want to coordinate with their DCAP administrators to understand changes in DCAP testing processes to align with the new guidance.



DOL Publishes Guidance on MHPAEA Enforcement

Issued date: 09/24/26

On September 8, 2026, the Department of Labor’s (“DOL’s”) Employee Benefits Security Administration (“EBSA”) published Field Assistance Bulletin 2026-03 (“FAB 2026-03”) and an accompanying web page (the “Enforcement Guidance Tool”), providing MHPAEA enforcement guidance.

Collectively, FAB 2026-03 and the Enforcement Guidance Tool:

- Outline EBSA’s priorities when enforcing MHPAEA’s nonquantitative treatment limitation (“NQTL”) requirements;
- Identify warning signs of potential MHPAEA compliance issues; and
- Provide a list of best practices for plan sponsors to consider with respect to MHPAEA compliance.

Background

Briefly, MHPAEA generally prohibits certain group health plans and carriers from imposing more restrictive limitations on mental health/substance use disorder (“MH/SUD”) benefits than those applied to medical and surgical (“M/S”) benefits. The Consolidated Appropriations Act, 2021 (“CAA-21”) amended MHPAEA, requiring plans and carriers to provide a comparative analysis of their NQTLs upon request.

In 2024, the Departments of Labor, Health and Human Services, and the Treasury (collectively, the “Departments”) issued a final rule (the “2024 Final Rule”) that expanded various aspects of MHPAEA, including the comparative analysis requirements. However, as a result of ongoing litigation, the Departments announced they would not enforce the 2024 Final Rule and will re-examine their approach to MHPAEA enforcement. Accordingly, plan sponsors should continue complying with CAA-21’s statutory provisions, including the comparative analysis requirement, and refer to final rules previously issued in 2013. The Departments announced further guidance would be forthcoming.

EBSA's Enforcement Priorities for NQTL Compliance

FAB 2026-03 provides that EBSA will prioritize MHPAEA NQTL comparative analysis enforcement efforts in three categories that present the greatest potential for significant harm to participants and beneficiaries:

1. Separate Treatment Limitations (Including Exclusions) for MH/SUD Benefits – EBSA will generally focus enforcement on situations where plans or carriers impose blanket treatment exclusions applicable to only MH/SUD benefits. However, EBSA may also investigate more limited exclusions, particularly in response to participant complaints.
2. Medical Necessity Standards and Review Processes – EBSA will focus enforcement on processes used to determine medical necessity, including prior authorization, concurrent review, and retrospective claims review standards. Plans and carriers are required to make the criteria used for medical necessity determinations available to participants, beneficiaries, and regulators upon request.
3. Network Adequacy Standards – EBSA signaled that network adequacy remains a significant enforcement priority given longstanding concerns regarding access to in-network MH/SUD providers. When network adequacy parity issues arise, EBSA will ensure plans and carriers:
 - Consider all available options; and
 - Help participants and beneficiaries access covered MH/SUD treatments without incurring out-of-network costs due to insufficient in-network availability.

Although EBSA is primarily focused on the three areas described above, the agency emphasized that it retains authority to investigate other NQTL issues, particularly when responding to participant complaints.

Enforcement Guidance Tool

The Enforcement Guidance Tool provides a non-exhaustive list of “red flags” and accompanying examples that EBSA has seen in investigations signaling potential MHPAEA compliance issues, including:

- Excluding specific services for covered MH/SUD conditions, particularly if such services are not excluded for M/S conditions;
- Stricter medical necessity, prior authorization, concurrent review, or documentation requirements for MH/SUD claims than for comparable M/S claims;
- Standards that make it more difficult for MH/SUD providers to join the network than comparable M/S providers; and
- Reimbursement methodologies that contribute to the lack of available in-network MH/SUD services.

Additionally, the Enforcement Guidance Tool emphasizes that health plan fiduciaries must prudently select and monitor plan service providers and are responsible for ensuring benefits administration complies with MHPAEA. Fiduciaries should not rely solely on third party administrators, behavioral vendors, or carriers to ensure MHPAEA compliance.

The Enforcement Guidance Tool provides a list of potential MHPAEA-focused questions that EBSA recommends plan fiduciaries should ask existing and prospective service providers.

The Enforcement Guidance Tool also notes that plan sponsors should look beyond their plan documents to examine how NQTLs are applied in practice. The Enforcement Guidance Tool provides a list of best practices that plan sponsors should keep in mind when monitoring MHPAEA compliance in a plan's operations, including, but not limited to:

- Identifying which MH/SUD and M/S benefits are subject to medical necessity, prior authorization, concurrent review, documentation, or respective review requirements and comparing how these processes work in practice for both benefit classifications;
- Asking the network administrator how, exactly, the administrator determines whether the MH/SUD network is adequate;
- Comparing certain data points between MH/SUD and M/S benefits, such as wait times, reimbursement practices, and out-of-network utilization;
- Properly tracking and responding to participant complaints; and
- Creating and following a written policy for monitoring MHPAEA compliance.

Lastly, the Enforcement Guidance Tool explains how plan sponsors can best prepare for an NQTL compliance audit, providing tips that plans can reference during audits and examples of how plans have resolved concerns during NQTL investigations.

Employer Action

FAB 2026-03 and the Enforcement Guidance tool do not create new substantive requirements for employers. Rather, this guidance offers insight into areas of MHPAEA NQTL compliance that EBSA may be more likely to scrutinize. While this information is helpful, the guidance does not include a model (or sample) comparative analysis.

In light of FAB 2026-03 and the Enforcement Guidance Tool, employers sponsoring group health plans that are subject to MHPAEA should continue to review MHPAEA compliance and work with their carriers, TPAs, and other service providers. Specifically, employers should consider

- Reviewing any plan exclusions or treatment limitations for MH/SUD benefits to confirm they do not create compliance concerns;
- Evaluating medical necessity, prior authorization, concurrent review, and retrospective review processes affecting MH/SUD benefits for potential parity concerns;
- Assessing network adequacy standards and reimbursement methodologies for potential parity concerns;
- Confirming with carriers and TPAs that NQTL comparative analyses are current, complete, supported by appropriate data, and can be furnished upon request; and
- Monitoring future regulatory developments and guidance from the Departments. Reports indicate additional rulemaking may be published before the end of 2026.



Washington Paid Family and Medical Leave Program - Updates for Employers

Issued date: 09/29/26

Washington has adopted several [new and amended](#) Paid Family & Medical Leave (PFML) rules that affect employer reporting, premium payments, penalties, and employee eligibility. These rules take effect October 2, 2026.

Key Employer Changes

- **New Penalty Waiver Process:** Employers may now apply for a waiver of certain PFML penalties. The new rule establishes the application process and the criteria the department will use when evaluating waiver requests.
- **Payment Plans for Delinquent Premiums:** Employers with outstanding PFML premium obligations may request a payment plan. The department has discretion to approve requests and has established rules regarding minimum monthly payments, missed payments, and related requirements.
- **Additional Opportunity Before Penalties:** Employers that fail to submit required reports will receive an additional reminder step before a formal warning letter is issued, providing more time to correct reporting issues before penalties are assessed.
- **Simple Interest on Late Premiums:** The department will now calculate interest on delinquent employer premiums using simple interest rather than compound interest.
- **Expanded Small Business Assistance Grants:** The rules clarify that the limit applies to ten grants received, rather than ten applications submitted annually, reflecting a legislative change enacted last year.
- **Easier Access to Payment Plans:** Employers generally will not need to demonstrate “good cause” to be considered for a payment plan. The department’s default approach is to offer payment plan options to help employers resolve delinquent payments.

Employee-Related Clarifications

- Employees serving an unemployment insurance waiting period are not eligible for PFML benefits during that period.
- Job restoration protections now require employees to have worked at least 180 days since their most recent hire date before taking leave.
- Employees who owe benefit overpayments may request a lower monthly repayment amount if financial circumstances warrant.
- Employees found to have committed fraud are ineligible for benefits during the period of fraud, and any associated eligibility credits are forfeited.

Employer Action

- Review your PFML reporting and premium payment processes
- Update internal leave policies to reflect the revised job restoration rules
- Familiarize yourself with the new penalty waiver and payment plan options to help minimize compliance risks

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