

2026 Health & Welfare Compliance Requirements

The following should be carefully reviewed for [plan years that begin in 2026](#). This chart is not exhaustive and does not include many ongoing compliance requirements. Please work with your service team to review USI's full Compliance Checkup for a broader picture of your employee benefits compliance requirements.

Content in this checklist will change as guidance is issued.

General Requirements Affecting Health and Welfare Plans

✓	Topic	Applies to	Description
	Transparency in Coverage – Machine-Readable Files	Non-grandfathered medical plans	Plans and carriers should ensure Machine Readable Files (“MRFs”) for (1) in-network rates and (2) out-of-network (“OON”) allowed amounts are made public and updated monthly. Guidance is expected to implement the prescription drug MRF, providing information on negotiated rates and historical net prices for covered prescription drugs. Plans should discuss with TPAs and PBMs responsibilities for preparing and posting the prescription drug MRF. Employers sponsoring a fully insured arrangement can rely on the carrier to post this information when there is an agreement between the plan and the carrier. If the carrier fails to provide full or timely information, the carrier (not the plan/employer) is liable. A self-funded plan may satisfy the disclosure requirement by entering into a written agreement under which a TPA posts the MRFs on its public website on behalf of the plan. However, if the TPA fails to do so, the plan is liable. Employers without such a written agreement should post a link to the TPA's MRFs on their public facing website. Plan sponsors should confirm whether carriers and/or TPAs will prepare and publicly post files as required under the law. If TPAs will not post the files, employers may need to post a link on their website.
	Air Ambulance Disclosure	All group medical plans	<i>Not in effect, pending final rules.</i> - Plans must submit data regarding air ambulance services on a calendar year basis. - Reporting is required for the calendar year that begins on or after the final rule is published. Reporting due 90 days after the close of that calendar year. - At this time, a final rule has not been published.
	Compensation Transparency	ERISA-covered group health plans	- Fiduciaries of a group health plan (regardless of size) must obtain a written disclosure of services and compensation from “brokers” and “consultants” earning at least \$1,000 in direct or indirect compensation. - Definition of broker/consultant appears broad, may include parties who are not considered traditional brokers/consultants (e.g., pharmacy benefit managers, wellness vendors, and third-party administrators). - It is expected that guidance issued later this year will make it clear that these entities should be providing this compensation disclosure. - Fiduciaries should receive the disclosure reasonably in advance of each contract date and renewal date. - Fiduciaries will be required to report brokers/consultants to the DOL if they do not comply.

✓	Topic	Applies to	Description
	Prohibition on Gag Clauses on Price and Quality Data	All group medical plans	Plans and carriers may not enter into an agreement with a provider, network, TPA or other service provider offering access to a network of providers that directly (or indirectly) restricts the plan from: - providing provider-specific cost or quality of care information or data; - electronically accessing de-identified claims and encounter data for each participant or beneficiary; and - sharing such information, consistent with applicable privacy regulations. Disclosure. Annually plans must submit an attestation of compliance. Future guidance expected as to how plans will submit this information and when collection will begin. Attestations are due each December 31. <i>Fully insured group health plans:</i> The carrier and the group health plan are required to submit the attestation. However, when the carrier submits it, the Departments consider the issuer and plan to have satisfied the requirement. Confirm that your carrier will submit on behalf of the plan. <i>Self-funded (including level-funded) group health plans:</i> A plan sponsor may enter a written agreement with a TPA or other service provider to attest on the plan's behalf. In this case, the legal requirement remains with the plan (i.e., if the TPA fails, the plan remains responsible). Some TPAs require the group health plan to submit the attestation and are unwilling to do so on behalf of the plan.
	RxDC Reporting	All group medical plans	- Group health plans and carriers are required to report annually to the government specific information on pharmacy benefits and costs. - This includes the 50 most common brand dispensed prescriptions, the 50 most costly drugs, and the 50 drugs with the greatest year-over-year costs. This is in addition to other information including the impact of rebates on premiums and out-of-pocket costs. - Reporting is on a calendar year basis and due by the following June 1. - For calendar year 2025, the reporting is required by June 1, 2026. <i>Fully insured plans</i> may enter into a written agreement with their carriers to transfer responsibility and liability for reporting to the carrier (recommended). <i>Self-funded plans</i> may enter into a written agreement with their TPAs or PBMs to fulfill reporting function on behalf of the plan, however plan (and plan sponsor) remain liable for failures. Coordination with TPAs and PBMs is needed to facilitate accurate and timely reporting. - When stop loss and/or pharmacy is carved out the TPA may not file complete reporting. Employers may need to set up a HIOS account to submit certain data and plan files to CMS. It is common that an employer will need file a D1 and P2 in this context. - Be on the lookout for information requests from carriers/TPAs. There is usually a strict deadline for response if you want your vendor to submit reporting on your behalf to CMS.

✓	Topic	Applies to	Description
	Grandfathering	Grandfathered medical plans	- Employers should revisit grandfathered status requirements, weighing the restrictions of remaining grandfathered against the additional requirements that apply to non-grandfathered plans. - An employer must look back to the coverage in effect on March 23, 2010, to know whether a change results in a loss of this status. - If grandfathered status is retained, provide appropriate notice to participants and beneficiaries in all materials describing the group health plan and maintain records documenting the retention of this status for as long as it is claimed. - Once grandfathered status is lost, even if inadvertently, it cannot be regained. This is true even if the defect causing the loss of grandfathered status can be cured.
	Cost-Sharing Limits	Non-grandfathered medical plans	For plan years beginning on or after January 1, 2026, non-grandfathered plans cannot impose out-of-pocket limits on EHBs that exceed the following limits: \$10,600 for self-only coverage; and \$21,200 for coverage other than self-only. Additionally, with respect to family coverage, an individual out-of-pocket maximum of \$10,600 applies to each person with family coverage.
	Cost-Sharing Limits	Reference-based price programs (or other similar arrangements)	Plans with this type of structure should carefully review whether there is adequate access to quality providers willing to accept the reference price as a payment in full. ¹ Otherwise the plan may be required to count an individual's out-of-pocket expenses and pay amounts that exceed the OOPM even if provided "out-of-network" (including balance billing amounts for the provider who did not accept the reference price toward the out-of-pocket maximum limitation). There is ongoing litigation, the result of which may impact these arrangements.
	Cost-Sharing Limits	Qualified HDHPs	For plan years beginning on or after January 1, 2026, qualified HDHPs are subject to the following limits: - Minimum deductible: \$1,700 self-only coverage and \$3,400 coverage other than self-only (an individual embedded deductible in family coverage cannot be less than \$3,400). - Maximum out-of-pocket: \$8,500 self-only coverage and \$17,000 family coverage.²
	HSA Contributions	HSAs	The maximum contribution to an HSA for calendar/tax year 2026 is: \$4,400 for self-only coverage; \$8,750 for coverage other than self-only. Account holders who are at least 55 years of age may make a \$1,000 catch-up contribution.

¹ The Departments have issued various FAQs specifying factors that will be considered to determine whether the reference-based price structure (or similar network design) is a reasonable method. Notably, FAQ 21 lays out five specific requirements the Departments will look at including the type of services, whether there is reasonable access, whether the providers meet quality standards, whether there is an exceptions process and disclosure regarding the pricing structure and providers. See FAQ 21 <https://www.dol.gov/sites/dolgov/files/ebsa/about-ebsa/our-activities/resource-center/faqs/aca-part-21.pdf> and FAQ 31 <https://www.dol.gov/sites/default/files/ebsa/about-ebsa/our-activities/resource-center/faqs/aca-part-31.pdf>.

² This is lower than what is required under the ACA. Non-grandfathered HDHPs must follow both sets of out-of-pocket maximum rules.

✓	Topic	Applies to	Description
	Telehealth Relief	HDHPs and HSAs	- Optional relief for free (or reduced cost) coverage for telehealth and other remote care services before the minimum deductible is satisfied has been permanently extended (effective January 1, 2025). - Employers may choose to provide free (or reduced cost) telehealth or other remote care services to members in the HDHP/HSA plan without disqualifying individuals from HSA eligibility. - There is no guidance as to what constitutes “other remote care services.” Further guidance is expected.
	Direct Primary Care Relief	HDHP and HSAs	Beginning January 1, 2026, certain direct primary care arrangements (“DPC”) will not be disqualifying coverage for purposes of HSA eligibility. To qualify the DPC must: - Consist solely of primary care services provided by primary care practitioners; and - Have a monthly fee of \$150 or less (\$300 or less for family coverage) Direct primary care does not include: - Any procedures that require the use of anesthesia - Prescription drugs (other than vaccines) - Lab services not typically administered in an ambulatory setting Further guidance is expected. HSA account holders may pay for the cost of a DPC through their HSA subject to the dollar limits above.
	Preventive Care – Legal Update	All non-grandfathered group health plans	The Supreme Court upheld the preventive care mandate – confirming that the “A” and “B” recommendations made by the USPSTF after March 23, 2010, must continue to be covered without cost-sharing by non-grandfathered group health plans in network. The requirements to cover contraceptive services, preventive care and screenings, breastfeeding services and supplies, cervical cancer screening, and pediatric preventive care recommended by HRSA, in addition to immunizations recommended by ACIP, were not impacted by the decision. As such, non-grandfathered plans must continue to cover those services without member cost sharing.
	Preventive Items and Services	Self-funded qualified HDHPs	Employers should consider adding coverage of allowed pre-deductible expenses, including beta-blockers, insulin, and inhalers for individuals with chronic conditions. IRS Notice 2024-75 confirms the following may be treated as preventive care in a HDHP: - All types of breast cancer screenings, - Continuous glucose monitors (“CGMs”) for individuals diagnosed with diabetes, - Insulin delivery devices, and - Over-the-counter (“OTC”) oral or emergency contraceptives and male condoms.

✓	Topic	Applies to	Description
	Preventive Care – COVID-19 Vaccines	All non-grandfathered group health plans	Non-grandfathered group health plans must cover, without cost-sharing in-network³ <i>qualifying coronavirus preventive services</i> (including immunizations) within 15 business days⁴ once the particular vaccine becomes authorized under an Emergency Use Authorization (“EUA”) or approved under a Biologics License Application (“BLA”), and according to the scope of the applicable EUA or BLA.⁵ This includes boosters. Awaiting further guidance from ACIP whether the recommendations around COVID-19 vaccines may change.
	Preventive Items and Services	Employers with religious or moral objection to providing some or all contraceptive services	Employers with sincerely held religious or moral objection to providing some (or all) contraceptives services under the ACA may be able to exclude such coverage from their group health plans. ▪ Litigation in this area is ongoing. ▪ Employers should discuss such exclusions with counsel. ▪ Fully insured plans may be subject to state insurance laws requiring such coverage (and therefore exclusion not permitted).
	Dependent Care FSA Limits	Dependent Care FSA (also called DCAP)	Beginning January 1, 2026, a DCAP can reimburse up to \$7,500 annually (\$3,750 if married filing separately). ▪ Increase in limit not required. ▪ Increase may adversely affect nondiscrimination testing. This is a statutory increase from the long standing \$5,000 limit. There is no inflation adjustment. If electing the higher amount, the cafeteria plan document may require amendment prior to January 1, 2026.
	Health FSA Limits	Health FSAs	<i>The 2026 limits have not been announced yet.</i> For plan years beginning in 2025, the limit on annual salary reduction contributions to a health flexible spending arrangement (“health FSA”) provided under a cafeteria plan is \$3,300. Inflation adjustment for health FSA carryovers. ▪ A health FSA with a 2025 plan year may carryover up to \$660 (amount carried over into 2026). Plan amendment and notification required.

³ During the Public Health Emergency, a group health plan was also required to cover without cost-sharing out-of-network.

⁴ The requirement for immediate coverage ended with the expiration of the Public Health Emergency.

⁵ This includes any amendment to the EUA or BLA for a particular vaccine, including the administration of an additional dose to certain individuals, booster doses or the expansion of the age demographic for whom the vaccine is authorized or approved.

✓	Topic	Applies to	Description																										
	PCOR Fee	All medical plans and HRAs	Health plans are assessed an annual fee to fund a Patient-Centered Outcomes Research (PCOR) program through September 30, 2029. ▪ <u>Insured plans</u>: Insurance carriers pay the fee directly. ▪ <u>Self-insured plans, including HRAs (and ICHRAs)</u>: The employer pays the fee to the IRS each year by July 31 using the 2nd quarter Form 720 (quarter ending 6/30). The next payment is due on July 31, 2026, as follows: <table><tr><th>Plan Years Ending</th><th>Amount of PCOR Fee</th></tr><tr><td>January 31, 2025</td><td>\$3.47/covered life/year</td></tr><tr><td>February 28, 2025</td><td>\$3.47/covered life/year</td></tr><tr><td>March 31, 2025</td><td>\$3.47/covered life/year</td></tr><tr><td>April 30, 2025</td><td>\$3.47/covered life/year</td></tr><tr><td>May 31, 2025</td><td>\$3.47/covered life/year</td></tr><tr><td>June 30, 2025</td><td>\$3.47/covered life/year</td></tr><tr><td>July 31, 2025</td><td>\$3.47/covered life/year</td></tr><tr><td>August 31, 2025</td><td>\$3.47/covered life/year</td></tr><tr><td>September 30, 2025</td><td>\$3.47/covered life/year</td></tr><tr><td>October 31, 2025</td><td>\$TBA/covered life/year</td></tr><tr><td>November 30, 2025</td><td>\$TBA/covered life/year</td></tr><tr><td>December 31, 2025</td><td>\$TBA/covered life/year</td></tr></table> Note that special rules apply to short plan years.	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	\$TBA/covered life/year	November 30, 2025	\$TBA/covered life/year	December 31, 2025	\$TBA/covered life/year
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	\$TBA/covered life/year																												
November 30, 2025	\$TBA/covered life/year																												
December 31, 2025	\$TBA/covered life/year																												
	Evidence of Insurability (“EOI”)	Supplemental life insurance policies	Recent DOL enforcement activities highlight issues with carriers failing to secure EOI for supplemental life insurance policies but continue to collect premiums for the coverage. Ensure there are procedures in place when assisting the life insurance carrier with collection of EOI and premiums for supplemental life insurance. See USI's Compliance Update, Life Insurance Carriers Agree to Claim Reforms in DOL Settlements (Nov. 9, 2023), for additional details.																										

✓	Topic	Applies to	Description
	Mental Health Parity and Addiction Equity Act (MHPAEA)	Employers with more than 50 employees offering group health plan coverage that includes Mental Health and/or Substance Use Disorder ("MH/SUD") benefits Non-grandfathered insured plans, including small group coverage Six benefit classifications: 1) inpatient in-network, 2) inpatient out-of-network, 3) outpatient in-network, 4) outpatient out-of-network, 5) emergency care, 6) prescription drugs	Review the plan's SPD and SBC to determine whether there are provisions that may raise MHPAEA issues, such as: - Not providing coverage in all classifications: if MH/SUD benefits are provided in one classification (prescription drugs), they must also be provided in every classification in which medical/surgical ("M/S") benefits are provided. - Any Non-Quantitative Treatment Limit ("NQTL") that is applied only to MH/SUD benefits and not to any M/S benefits in the same classification. For example: - Nutritional or dietary counseling is excluded to treat eating disorders but covered to treat medical conditions (e.g., obesity and diabetes). - Exclusions of ABA therapy for the treatment of autism spectrum disorder ("ASD"). Including age limits (i.e., no coverage after age 18) on treatment of ASD/ABA therapy. - More restrictive dosage limits on prescription drugs to treat MH/SUD conditions than those to treat medical conditions. - Limitations on in-patient or out-patient treatment for eating disorders based on facility type. - Group health plans must conduct a comparative analysis of the design and application of NQTLs and provide to the DOL (or participants and beneficiaries) upon request within 10 days of the request. Self-funded plans and/or carveout arrangements (i.e., PBM carveout) will need to work with third-party administrators to determine capabilities for providing such a report. Final rules that added additional requirements under MHPAEA are not being enforced pending a review by the Departments.⁶ A self-compliance tool is available,⁷ https://www.dol.gov/sites/dolgov/files/EBSA/laws-and-regulations/laws/mental-health-parity/self-compliance-tool.pdf.
	Health Plan Benefit Design – Abortion Coverage Post-Dobbs	Group health plans	- Laws regulating abortion services fall to the states. - At least 12 states ban and 29 states limit abortions. - Employers should review what group health plans currently provide, where employees work and reside, and what if any next steps to consider, which may include: - Removing coverage for abortion. - Do nothing or wait and see. - Adding a travel reimbursement benefit for individuals who cannot access care within a certain radius. - There are significant legal implications for both the group health plan and the employer to consider; changes should be discussed with counsel.

⁶ This includes:

- Defining covered MH/SUD conditions in accordance with the most current version of the ICD or DSM.
- Providing meaningful benefits (including a core treatment) for each covered MH/SUD condition in every classification in which meaningful benefits are provided for M/S conditions.
- Fiduciary certification that a prudent process was used to select the service provider performing the comparative analysis.
- The comparative analysis is considered a plan document.

⁷ The DOL did not update the 2020 Self-Compliance Tool as required by law.

✓	Topic	Applies to	Description
	HIPAA Reproductive Privacy	Group health plans	The 2024 final regulations that would prohibit the use or disclosure of PHI to investigate or prosecute patients, providers, and others involved in the provision of legal reproductive health care, including abortion care, were vacated by a federal court. The Notice of Privacy Practice may need to be updated by 2/16/2026 for certain revisions made in the non-vacated portion of the rule. Pending a model notice from HHS. Plan sponsors of self-funded medical plans and their vendors may need to revise the following if they were updated to incorporate additional protections for reproductive PHI: ▪ Policies and procedures ▪ Training ▪ Risk assessment ▪ Business associate agreements
	Cybersecurity	ERISA-covered health and welfare plans	Ensure prudent selection and monitoring of service providers which may entail, in part: ▪ Requesting current service providers to provide written representations of steps they take to secure PII and health data from cyber threats. ▪ On a periodic basis (perhaps yearly), requesting current service providers to provide written updates on changes and other developments in their cybersecurity efforts. ▪ Posing questions in the request for proposal ("RFP") pertaining to cybersecurity.
	Health Plan Benefit Design – Discrimination Based on Sexual Orientation or Gender Identity	Employers with at least 15 employees	In 2020, the Supreme Court held that sex discrimination under Title VII of the Civil Rights Act includes discrimination based on an employee's sexual orientation and gender identity. Recently, courts have ruled inconsistently regarding whether against employers in Title VII claims involving exclusions of coverage for gender dysphoria treatments. ▪ Employers sponsoring health and welfare programs should assess whether their health programs may discriminate against employees who are gay or transgender. ▪ This may include exclusions for medically necessary medical services associated with health care for transgender participants (e.g., surgical benefits, hormone therapy, mental health care). ▪ Employers should consult with legal counsel and proceed with caution if implementing plan designs or eligibility rules based on sexual orientation or gender identity. Exclusions for treatment of gender dysphoria may be problematic under Title VII along with other laws (e.g., MHPAEA). State insurance and employment laws may also prohibit such discrimination. ▪ Some states have enacted state laws prohibiting gender affirming care for minors. Generally, these laws relate to banning puberty blockers, hormone therapy or gender affirming surgeries for minors. These laws generally apply to providers offering the care. The Supreme Court upheld a Tennessee law barring providers from offering gender-affirming care.

✓	Topic	Applies to	Description
	Health Plan Benefit Design – Sec. 1557 Discrimination	Providers, insurance carriers and other entities that receive financial assistance from the federal government relating to a health program or activity such as Medicare or Medicaid	- HHS finalized rules for Section 1557 entities. - Carriers and TPAs who receive financial assistance from the government (e.g., premium tax subsidies for Marketplace coverage) are subject to these provisions. - In February 2025, the administration rescinded guidance that prohibited discrimination on the basis of gender identity. Sec. 1557 entities may not be liable under 1557 for exclusions or limitations related to gender identity under the current interpretation. 1557 Entities and those not subject to Section 1557 may still have liability for discrimination claims under Title VII (see above).
	Employer Penalty: Understand Potential Penalty Exposure	ALEs	“A” Penalty. Applies if the ALE does not offer at least 95% of all ACA FTEs and their children to age 26 minimum essential coverage (“MEC”) and one FTE receives a subsidy in the Marketplace. \$2,000 (as adjusted for inflation, \$3,340 for 2026) X total number of FTEs in excess of 30. “B” Penalty. Applies if the ALE offers coverage to at least 95% of all ACA FTEs (and their children to age 26), but that coverage is <i>unaffordable</i> or does not provide <i>minimum value</i> (or as to any excluded 5% of ACA FTEs and one FTE receives a subsidy in the Marketplace). \$3,000 (as adjusted for inflation, \$5,010 for 2026) X the total number of ACA FTEs who receive the subsidy in the Marketplace (maximum penalty is capped at the “A” penalty).
	Employer Penalty: Identify Application and Method of Compliance	Employers	- Determine ALE status (i.e., whether the employer has at least 50 full-time employees (“FTEs”) each calendar year, considering all common law employees in the entire controlled group and counting each part-time employee as a fraction of an FTE). - Determine full-time status using the monthly measurement method or look-back measurement method. - Offer coverage to FTEs and dependent children. - Evaluate minimum value. - Evaluate affordability and elect a safe harbor.⁸ - Ensure that all plan language accurately reflects the selections.

⁸ For 2026: An employer will not be subject to a penalty with respect to an FTE if the employer meets the 95% MEC offer requirement and that employee's required contribution for 2026 for the employer's lowest cost self-only coverage that provides MV does not exceed:

- 9.96% of W-2 wages (Box 1 on Form W-2); or
- 9.96% of the employee's rate of pay (either \$/hour multiplied by 130 hours or monthly salary); or
- 9.96% of applicable FPL:
 - Jan. 1, 2026 renewals use 9.96% of the applicable 2025 FPL, **\$129.89/mo.**; Alaska **\$162.26/mo.**; Hawaii **\$149.31/mo.**
 - All other 2026 renewals use 9.96% of the applicable 2026 FPL when announced (usually in January).

✓	Topic	Applies to	Description
	Employer Penalty: Reporting	All ALEs, with additional requirements for ALEs with self-insured health plans	All ALEs must use Forms 1095-C and 1094-C to report offers of coverage (or no offer of coverage) to ACA FTEs. - For calendar year 2025, Forms 1095-C are due to ACA FTEs by March 2, 2026. Alternative Furnishing Method. Employers may take advantage of relief and not issue Forms 1095-C to full-time employees and covered individuals unless requested, subject to a notice requirement. - For calendar year 2025, Forms 1094-C and all Forms 1095-C must have been filed electronically with the IRS by March 31, 2026 (unless filing by paper, then February 28, 2026). - Electronic filing is required when filing 10 or more forms (applies to all information returns types). ALEs with self-funded health plans must also report MEC information for each covered member on these Forms, including covered non-ACA FTEs (e.g., part-time employees and COBRA qualified beneficiaries). Information on family members who have coverage through the covered member (e.g., a spouse or child) must be included. Corrections may be filed electronically if 10 or more forms are filed and applies to all information return types.
	MEC Reporting	Non-ALEs with self-insured plans	- Employers that are not considered ALEs but offer a self-funded group health plans (including level funded) are responsible for MEC reporting on behalf of covered members. - Small employers with self-insured plans may use Forms 1094-B and 1095-B. This report includes individuals who receive coverage through the covered member (e.g., spouse, children). The timeframe for submitting these reports is the same as described above for Forms 1094-C and 1095-C. - For calendar year 2025, Forms 1095-B are due to covered individuals by March 2, 2026. Alternative Furnishing Method. Employers may take advantage of relief and not issue Forms 1095-B to covered individuals unless requested, subject to a notice requirement. - For calendar year 2025, Forms 1094-B and all Forms 1095-B must have been filed electronically with the IRS by March 31, 2026 (unless filing by paper, then February 28, 2026). - Electronic filing is required if filing 10 or more forms (applies to all information returns types).
	Employer Penalty: Reporting and Penalty Assessments	Employers	- The IRS has notified certain employers regarding missing or incomplete Form 1094-C and 1095-C filings (Letter 5699). - The IRS has issued Letter 226J notifying employers of potential penalty assessments, generally for reporting done two years prior. ALEs should ensure that they review and handle them timely. - Employers should continue to comply with the employer mandate until and unless guidance is issued. - Penalties for incomplete or inaccurate forms may apply. - Resources are available for USI clients to assist with the response to the IRS.

✓	Topic	Applies to	Description
	Family Coverage: Affordability	Employers offering family coverage	- Employees and family members who don't enroll in the employer sponsored coverage may be eligible for premium tax credits to purchase coverage in the Marketplace. - Employer sponsored coverage may be considered unaffordable for family members when the portion of the annual premium the employee must pay for family coverage exceeds 9.96% for 2026 of household income. - Does not apply to QSEHRAs or ICHRAs. - This change does not affect affordability for purposes of the employer mandate (still based on the employee's cost for self-only coverage in the lowest cost MV plan option). - Employers may (but are not required to) amend their cafeteria plan to allow prospective election changes to enable family members to drop employer coverage and access the Marketplace.
	Marketplace Notices	Employers	- The Marketplace is supposed to issue a notice if any employee of an employer receives a subsidy in the Marketplace. - If an applicable large employer ("ALE") receives this notice on an ACA full-time employee, the employer should verify whether there is any penalty exposure (i.e., inquire as to whether the individual was offered affordable health insurance coverage). - The Marketplace Notice is NOT a notice that a penalty is imminent. Any penalty assessment notice will come from the IRS. - Ensure good recordkeeping processes to demonstrate offers of coverage, acceptance, waivers, affordability and minimum value as applicable.
	Medicare Part D Notice	Employers offering drug coverage	- Employers should know whether prescription drug coverage for plan years beginning in 2026 is creditable (or non-creditable) for purposes of Medicare Part D and provide accurate notification to plan participants and CMS. - Carriers should provide this information for fully insured arrangements. PBMs and TPAs may provide this information for self-funded plans (sometimes for a fee). - An alternative simplified method is available in 2026. - Note that, even though the Medicare Part D benefit has been improved beginning in 2025, many HDHPs will still be creditable. - USI has tools and resources to support determinations if TPAs will not provide this determination.
	ACA's Integration Requirement and Prohibition of Employer Payment of Individual Insurance Policies	HRAs	HRAs must be integrated with group health plans and generally may not reimburse individual policy premiums, except as permitted: Qualified Small Employer HRA (QSEHRA). A small employer (fewer than 50 full-time employees) with no group health plan can offer reimbursements up to indexed amounts (\$6,350 self-only / \$12,800 family for 2025). Reimbursement of individual policies permissible. <i>The 2026 limits have not been announced yet.</i> Retiree HRA. An HRA covering fewer than two participants who are active employees. Individual Coverage HRA. Beginning 2020, an HRA can be integrated with an individual policy if the employer does not offer a group plan to same class of employees. ALEs must evaluate affordability for Employer Penalty purposes. Excepted Benefit HRA. Employers can offer an EB HRA offering reimbursements up to \$2,200 for 2026. A group medical plan must be offered, but the employee doesn't have to enroll in it. Stand-Alone HRA for Dental and/or Vision Expenses.

✓	Topic	Applies to	Description
	Wellness Incentives	Employers using incentives with wellness programs	▪ Incentive based wellness programs continue to be complicated. ▪ Effective January 1, 2019, the court vacated the ADA and GINA Title II rules regarding wellness incentives. ▪ The most conservative approach is to remove incentives associated with employee or spousal medical exams or spousal completion of health risk assessments. ▪ Some employers may be comfortable continuing programs with reward thresholds at or below the pre-2019 rules which generally limit the incentive to no more than 30% of the total cost of self-only coverage in the lowest cost health plan option offered by the employer to any employee. ▪ Employers looking at rewards beyond the 30% limits should consult with their own counsel. ▪ Proposed rules that would permit only <i>de minimis incentives</i> (very low monetary value) when a wellness program uses medical exams or disability related inquiries, have been withdrawn.⁹
	Wellness Incentives – Tobacco Cessation Programs	Employers using incentives with wellness programs	▪ Increase in litigation against health plans with premium surcharges on tobacco users. ▪ Lawsuits generally allege that employers fail to: – Provide a reasonable alternative to earn the reward without being tobacco free; – Disclose that availability of the reasonable alternative; and or – Provide the full reward once the reasonable alternative is met ▪ Employers should review tobacco surcharge programs in their health plans (or discounts for non-tobacco users) to ensure compliance with the HIPAA wellness program rules.
	Transportation Benefits	Employers offering transportation benefits	<i>The 2026 limits have not been announced yet.</i> For calendar year 2025, the monthly exclusion limitation for qualified parking expenses is \$325, and the monthly exclusion limitation for transportation in a commuter highway vehicle (vanpool) and for any transit pass is \$325. <i>The employer deduction for all transportation fringe benefits was unavailable beginning January 1, 2018.</i> Some states (New Jersey, Illinois, Washington DC) and cities may require transportation benefits.
	Highly Compensated and Key Employee Definitions	Cafeteria plans, life insurance discrimination (Sec. 79)	The compensation threshold for a highly compensated individual or participant (for purposes of Section 125 nondiscrimination testing) is \$160,000 in CY 2025 for 2026. The dollar limitation concerning the definition of a key employee is \$230,000 in CY 2025 for 2026.

⁹ The withdrawn proposed rule included an exception under the ADA safe harbor to the de minimis incentive level for a wellness program that is a group health plan and complied with the HIPAA requirements for a health contingent program (outcomes or activity based).

✓	Topic	Applies to	Description
	State Individual Mandate Reporting	Employers providing health insurance coverage to employee in California, D.C., Massachusetts, New Jersey, Rhode Island, and Vermont	As described below, providing information to residents of the affected states as well as filing with certain state government agencies is generally required annually for compliance. If fully insured, determine whether the carrier satisfies these obligations. If self-funded, coordinate with the Forms 1095-C preparer for support in meeting these obligations. ▪ California employers that sponsor a health plan must file Forms 1095-C or 1095-B with the state's Franchise Tax Board on all CA residents covered by the plan. ▪ D.C. employers with at least 50 employees (including one resident of D.C.), must sign up and file information returns with the Office of Tax and Revenue. Third party vendors may facilitate this reporting. ▪ Massachusetts Form MA 1099-HC must be provided to covered residents of MA reflecting information about minimum creditable coverage and employers with at least 6 MA resident/employees must file a HIRD with the Commonwealth. ▪ New Jersey – Forms reporting on offers of coverage to employees are to be sent to the NJ Division of Taxation. Reporting deadlines align with ACA requirements. ▪ Rhode Island employers must file federal Forms with the RI Division of Taxation. ▪ Vermont residents report coverage status on state tax returns. No employer obligations provided the federal requirement to distribute 1095-C forms remains.
	San Francisco Health Care Security Ordinance	Employers with employees working in the City or County of San Francisco	▪ Covered employers must make required health care expenditures on behalf of covered employees (employed 90+ days and regularly work at least 8 hours per week in San Francisco). ▪ For 2026: – 100+ employees:¹⁰ \$4.11/hour – 20 to 99 employees:¹¹ \$2.74/hour ▪ Usually through the employer group health plan or by making the expenditure to the City program
	Illinois Essential Health Benefit (EHB) Disclosure	Employers providing health insurance to employees	▪ Employers must provide the IL EHB Disclosure to all employees eligible for the group health plan working Illinois. ▪ Disclosure should be provided to new hires, annually to Illinois employees and upon request. For more information, visit https://www2.illinois.gov/idol/Laws-Rules/FLS/Pages/Consumer-Coverage-Disclosure-Act.aspx.
	State Fees on Self-Insured Plans	Self-funded plans	▪ Self-insured plans may see surcharges applied to their benefit programs with respect to certain state assessments (e.g., 1% tax on claims paid in Michigan and the New York public goods pool for claims incurred in New York). ▪ Washington PAL assessment. ▪ Idaho, New Mexico, New Hampshire, Alaska, and Rhode Island have mandatory annual vaccine assessments. New Mexico requires reporting by July 1.
	State Required Paid Leave (any reason)	Various	▪ Illinois, Maine, and Nevada.

¹⁰ Count all employees, not just those working in San Francisco, for this purpose.

¹¹ No expenditure applies to businesses with few than 20 employees or a non-profit with fewer than 50 employees.

✓	Topic	Applies to	Description
	State Required Paid Sick Leave	Various	Many states require paid sick leave for employees, including Arizona, California, Colorado, Connecticut, Washington D.C., Maryland, Massachusetts, Michigan, Minnesota, New Jersey, New Mexico, New York, Oregon, Rhode Island, Vermont, and Washington.
	State Required Paid Family Leave	Various	Many states require paid family leave, including California, Colorado, Connecticut, Delaware (2025), Washington D.C., Maine (2025), Maryland (2025), Massachusetts, Minnesota (2026), New Hampshire (voluntary), New Jersey, New York (with 20 hours of paid prenatal care annually, effective January 1, 2025), Oregon, Rhode Island, Vermont (voluntary), and Washington.
	City and Other Required Paid Leave	Various. <i>This summary does not address all applicable city or other local mandates.</i>	- Some cities that have passed sick leave laws include Chicago, Los Angeles, New York City, Philadelphia, Pittsburgh, and Seattle. - Westchester County, New York also passed a sick leave law. - These are examples only.
	State Continuation of Coverage¹²	Various	- Several states require insured group health plans (generally medical only) to extend continuation of coverage under certain circumstances that include: extending coverage to young adults who age off a group health plan at age 26, enrollees whose coverage ends after 18 months of federal COBRA, and for certain spouses who may lose coverage due to legal separation, divorce or the enrollee's death. - Includes California, Connecticut, Florida, Georgia, Illinois, Louisiana, Maryland, Massachusetts, Minnesota, Missouri, Nebraska, New Hampshire, New Jersey, New York, Oregon, Pennsylvania, South Dakota, Texas, and Wisconsin.
	Commuter and Parking Cashout Benefits	Various	Commuter: Washington D.C., Illinois, and New Jersey; (city and county commuter benefits are not included in this checklist but may apply). Parking Cashout: California, Washington D.C., and Rhode Island.
	State Long-Term Care	Washington	- State-run long-term care insurance program. - Contributions via employee payroll deductions began July 1, 2023. - Certain exemptions are available.

¹² This summary does not include states with “mini-COBRA” for small employers having less than 20 employees.