OFFICE HOURS WEBINAR:

# Employee Benefits Year in Review

January 15, 2026

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# Today's Topics

## 2025 EB Year in Review

***Plus What to Expect in 2026!***

- The One Big Beautiful Bill (OBBB) added multiple new interesting employee benefits-related considerations for employers as we kick off the new year.
- The ACA continues to be the defining legislation in this field for the generation. The annual updates are routine, but a new ACA reporting option keeps it fresh.
- The CAA is almost as big in scope and importance as the ACA despite a small fraction of the headlines. Only a few minor items remain to implement.
- What else is topical and interesting? COBRA's 40th birthday provides an excuse to revisit some of the key compliance considerations.

## Year in Review Topics:

1. **OBBB:** The biggest legislative news of 2025 was the passage of the massive OBBB reconciliation bill. With respect to employee benefits, changes are less dramatic—but meaningful overall. Includes HSAs, DCFSAs, student loans, and Trump Accounts.
2. **The ACA Employer Mandate & ACA Reporting:** ACA reporting season has arrived with welcome changes to streamline the process by no longer requiring distribution to employees—plus the new affordability percentage and employer mandate penalty amounts for 2026.
3. **CAA:** 2020's mega-bill health plan-related provisions have now kicked into full gear as we are at the point of full implementation. A review of where we stand and what's still yet to come.
4. **2026 Landscape:** What might the Trump Administration EB-related priorities be for 2026? We look into the crystal ball.
5. **Other News:** 2026 limits, Medicare Part D updates for next year, HIPAA reproductive rule vacated, following the J&J class action and related cases that grabbed headlines and are developing interesting questions, California adds IVF mandate.
6. **This Is 40:** COBRA turns 40 and we celebrate the anniversary by reviewing some of the common compliance concerns, questions, and pitfalls for employers all these years later.

01

# The One Big Beautiful Bill

## New Employee Benefits Options for 2026

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# OBBB Adds Permanent Telehealth Relief

**Full Details:** How the One Big Beautiful Bill Affects Employee Benefits

## HSA Eligibility Preserved

**HDHPs can provide first dollar coverage for telehealth or other remote care services**

- Means that individuals covered under a HDHP who waive the deductible for telehealth services or other remote care can maintain HSA eligibility
- Includes non-preventive telehealth/remote care

**CARES Act/CAA 2022 Relief: Originally applied for plan years beginning on or before December 31, 2021**

- CAA 2022 extension applied from April – December 2022

**CAA 2023: Extension of relief made it available through 2024**

- Extension applied to plan years beginning after December 31, 2022 and before January 1, 2025
- Included 2023 and 2024 for calendar plan year HDHPs

## New in OBBB – Telehealth Relief Secured

**First-Dollar Telehealth Relief is Now Permanent**

- Prior to the OBBB, the original version of the 2025 end-of-year funding bill included a two-year extension of the telehealth relief (through 2026)
- That bill was subsequently streamlined from 1,500+ pages to 100+ pages, and the HSA relief extension provision was removed
- OBBB's inclusion of telehealth relief then came as a surprise because all versions of the OBBB prior to the final version did not include it
- OBBB's permanent relief is effective retroactive to start of 2025

**First-Dollar Telehealth Relief is an Optional Plan Provision**

- HDHPs are not required to offer free telehealth care
- The relief simply permits it without causing loss of HSA eligibility

**Fully Insured Plan**

- Up to the insurance carrier whether to make first-dollar telehealth and remote care available

**Self-Insured Plan**

- Employers can work with TPA and stop-loss provider to make this plan design decision

# Direct Primary Care (DPC) Coverage Permitted

**Full Details:** How the One Big Beautiful Bill Affects Employee Benefits

## New in OBBB—DPC No Longer Considered Disqualifying Coverage Starting 2026

- Prior to the OBBB, it was not clear how DPC models of coverage could be integrated with HSA eligibility
- Typical DPC arrangements have a monthly fee that covers services like office visits for illnesses and chronic condition management
- These are services that an HDHP can cover only after the deductible is met, which makes this change a big deal for DPC arrangements
- DPC coverage is now explicitly HSA-compatible

## The DPC Specifics

### Coverage Limitations

- DPC monthly fees cannot exceed $150/month (2026) for individual coverage
- DPC monthly fees cannot exceed $300/month (2026) for family coverage
- Cannot include procedures with general anesthesia
- Cannot include prescription drugs (other than vaccines)
- Cannot include lab services normally outside of primary care setting

### HSA-Eligible Expense

- DPC coverage is now considered qualified expense for tax-free HSA medical distributions
- Subject to the same $150/$300 per month limitation
- Not treated as a general medical expense under Sec. 213(d)
- Instead, OBBB adds DPC as a permitted premium expense in the same manner as COBRA, LTC, premiums while on unemployment, and Medicare

# OBBB: Dependent Care FSA Increased to $7,500

**Full Details:** The OBBB Dependent Care FSA Increase Could Backfire

## Increased Limit Effective as of 2026

First Dependent Care FSA Increase in 40 Years

- One Big Beautiful Bill (OBBB) increases limit to $7,500 ($3,750 for married couples filing separately)
- Congress set the dependent care FSA limit at $5,000 in 1986 without indexing it to inflation
- With the exception of a one-year blip (the 2021 ARPA increase to $10,500) the dependent care FSA has been stuck at that level
- If it had been indexed to inflation, the limit would be roughly $14,500
- Increase is big news, but unfortunately it still is not indexed to inflation going forward—another act of Congress is required to lift in future

### Section 125 Cafeteria Plan Amendment

- Work with FSA TPA to ensure plan is updated to include the new limit going forward
- Also want to ensure that all dependent care FSA benefit summary materials provided to employees include $7,500 limit

### 55% Average Benefits Test Still a Concern

- Highly compensated employees tend to elect the dependent care FSA to a greater degree in general
  - 55% benefits test will continue to be a struggle for employers to pass

### Child and Dependent Care Tax Credit Compounds Issue

- The OBBB also significantly enhanced the CDCTC alternative to the dependent care FSA
  - Non-HCEs may find it is better to shift to the CDCTC, further reducing DCFSA participation among that group

### Future of Dependent Care FSA Limit

- Only Congress can change the dependent care FSA limit
- The OBBB does not include an index for inflation to increase the limit going forward
  - Any additional contribution limit increases going forward will require Congress again—hopefully next time with an index for inflation!

# Educational Assistance: Two Main Types of Programs

**Full Details:** How the One Big Beautiful Bill Affects Employee Benefits

## Section 127:
Qualified Educational Assistance Program

**Basic Rule:**

- Employers can exclude up to $5,250 annually (***new in OBBB: indexed as of 2027***) for educational assistance under §127
- Includes cost of books, equipment, fees, supplies, and tuition

**Main Advantages:**

- Educational expenses do not need to be work-related
- Can reimburse expenses exceeding $5,250 on a taxable basis
- ***New in OBBB: Student loan repayment assistance made permanent***

**Main Disadvantages:**

- Capped at $5,250 annual limit for tax-free reimbursement
- Requires a written plan document (IRS template available)
- Must provide reasonable notification of the availability and the terms of the program to all eligible employees
- Subject to nondiscrimination rules to ensure the program does not discriminate in favor of HCEs as defined in §414(q)

## Section 132(d):
Working Condition Fringe Educational Assistance

**Basic Rule:**

Educational assistance can be provided as a tax-free working condition fringe under §132 where it meets one of the following:

1. The education is required by the employer or by law for the employee to keep his or her present salary, status, or job; or
2. The education maintains or improves skills needed in the job

**Main Advantages:**

- No annual limit
- No written plan document required
- No nondiscrimination rules

**Main Disadvantages:**

- Must be work-related educational expenses (unlike §127)
- Cannot be needed to meet the minimum educational requirements of the employee's present trade or business
- Cannot be part of a program of study that will qualify the employee for a new trade or business

# Qualified Educational Assistance Program (§127)

**Full Details:** How the One Big Beautiful Bill Affects Employee Benefits

## IRC §127 Permits Tax-Free Educational Assistance

- Allows employers to cover the cost of educational expenses for an employee tax-free
- Did not include student loan repayments prior to CARES Act
- Capped at $5,250 per calendar year ***(new in OBBB: indexed as of 2027)***

## Tax-Free Student Loan Repayment Now Permanently Available

- The CARES Act permitted employers to offer an educational assistance program to reimburse student loans tax-free in 2020
- The CAA extended the availability of this tax-free student-loan repayment assistance option through the end of 2025
- ***The OBBB made the availability of this tax-free student-loan repayment assistance permanent***
- Employer payment can be made to the employee or directly to the lender
- For principal or interest on a “qualifying education loan” incurred by the employee
- Capped at the same standard $5,250 limit under §127, and includes any other forms of assistance (tuition, books, fees, etc.)

## What Could Make Tax-Advantaged Employer Student Loan Repayment Even Better?

- For the feature to become even more useful, Congress could allow employee pre-tax contributions (e.g., through the cafeteria plan) to count toward the limit
- Fortuantley they finally did index the $5,250 limit for inflation in the OBBB given that fixed amount dates back to 1979!

# Trump Accounts: The Basics

**Full Details:** Trump Accounts as an Employee Benefit

**Trump Accounts ("TAs") were added by the One Big Beautiful Bill ("OBBB") as a new way to save for children on a tax-advantaged basis prior to reaching age 18. They become available on July 4, 2026.**

## The Purpose
Providing Newborns with a Stake in U.S. Business

**Background**

- Originally part of a stand-alone bill that referred to the approach as "Invest America" accounts
- Intended to expand financial literacy and participation in the American stock market

**Basics**

- No distributions prior to age 18
- Must be invested in S&P 500 or U.S. broad market fund

**General Rules**

- TAs function similarly to Individual Retirement Accounts (IRAs) whereby investments grow tax-deferred
- Gains are taxed as ordinary income upon distribution
- $5,000 (indexed) annual contribution limit to age 18

## The Federal Government Role
$1,000 Contribution Upon Birth

**Federal Government Contribution: Pilot Program 2025 – 2028**

- OBBB includes $1,000 gift contribution to TAs for babies born from 2025-2028
- If initial rollout goes well, the pilot could be made permanent, increased, etc.

**States and Charities**

- Any of the 50 states, D.C., or Indian tribal governments can contribute to TAs
- Tax-exempt §501(c)(3) charities can also contribute to qualified classes
- Michael and Susan Dell have pledged to donate $6.25 billion to TAs for kids

**Parent Contributions**

- Parents can also contribute to TAs for their children, up to the $5,000 max
- Children who were born prior to 2025 but are under age 18 will not receive the $1,000 gift contribution from the federal government, but parents may still choose to open a TA on behalf of the child for the tax-advantaged growth
- Competing options include 529 college savings plans and custodial accounts

# Trump Accounts: The New Employee Benefit Option

**Full Details:** Trump Accounts as an Employee Benefit

**Trump Accounts ("TAs") were added by the One Big Beautiful Bill ("OBBB") as a new way to save for children on a tax-advantaged basis prior to reaching age 18. They become available on July 4, 2026.**

## The Tax Advantage
$2,500 Tax-Free Annual Employer Contributions

**How It Works**

- Starting July 4, 2026, employers can contribute up to $2,500 (indexed) per employee tax-free each calendar year to the TAs of employees' dependents
- The annual tax-free limit is per employee (not per child)

**Initial Interest from Prominent Employers**

- Dell, Altimeter Capital, Arm Holdings, ServiceNow, Uber, Goldman Sachs, Robinhood, and Salesforce all expressed interest prior to the OBBB passing
- Dell pledged to match $1,000 federal government amount

**What About Employee Contributions?**

- Initial guidance states Section 125 cafeteria plan contributions will be permitted, regulations to clarify

## The Compliance Rules
Similar to Dependent Care FSA Requirements

**Counts Toward $5,000 Annual Contribution Limit**

- Employer contributions appear to count toward the $5,000 annual limit
- Different from the $1,000 government contribution (doesn't count toward limit)

**Written Plan Document**

- Must have a separate written plan for the exclusive purpose of providing TA benefit to employee's dependents
- Not an ERISA benefit, so not included in wrap document or Form 5500
- Must provide reasonable notice of TA benefit to employees (summary docs)

**Nondiscrimination**

- The same §129 nondiscrimination rules as apply to dependent care FSAs
- Cannot discriminate in favor of HCEs in terms of eligibility or benefits
- HCEs are generally $160k+ in prior year and officers/more-than-5% owners

02

# The ACA Employer Mandate

& The Associated ACA Reporting Requirements

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# The ACA's Employer Mandate §4980H Penalties

**Full Details:** The ACA Affordability Determination in 2026

## §4980H(a)—The "A Penalty" Aka: The "Sledgehammer Penalty"

- **Failure to offer MEC to at least 95% of all full-time employees (and their children to age 26)**
- The A Penalty is triggered by at least one such full-time employee who is not offered MEC enrolling in subsidized exchange coverage
  - **2026 A Penalty liability is $3,340 annualized ($278.33/month) multiplied by all full-time employees**
    - **30 full-time employee reduction from multiplier**

## §4980H(b)—The "B Penalty" Aka: The "Tack Hammer Penalty"

- Applies where the employer is not subject to the A penalty
- **Failure to:**
  1. **Offer coverage that's affordable;**
  2. **Offer coverage that provides MV; or**
  3. **Offer MEC to a full-time employee (where employer offers at a sufficient percentage to avoid A Penalty liability)**
- The B Penalty is triggered by any such full-time employee enrolling in subsidized exchange coverage
- 2026 B Penalty liability is $5,010 annualized ($417.50/month) multiplied by each such full-time employee who enrolls in subsidized exchange coverage
- Note that although the B Penalty amount is higher ($5,010 vs. $3,340), the multiplier is generally much lower (only those full-time employees not offered affordable/minimum value coverage who enroll in subsidized exchange coverage)

# The ACA's Employer Mandate §4980H Penalties

**Full Details:** The ACA Affordability Determination in 2026

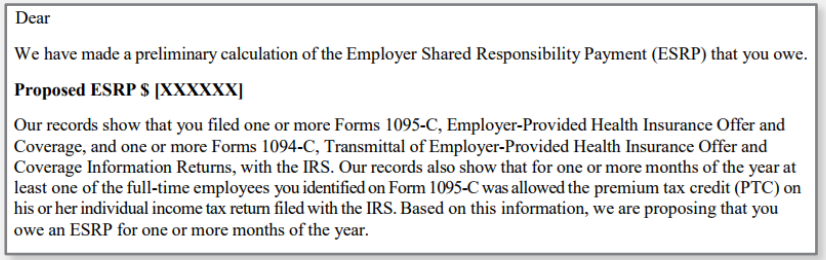
| §4980H(a)—The "A Penalty"<br>Aka: The "Sledgehammer Penalty" | §4980H(b)—The "B Penalty"<br>Aka: The "Tack Hammer Penalty" |
|---|---|
| **Simplified Version** | **Simplified Version** |
| • To avoid the "A Penalty" **must offer MEC to at least 95% of full-time employees and their children to age 26**<br>• **2026 A Penalty liability is $3,340 annualized ($278.33/month)** multiplied by all full-time employees (reduced by first 30) | • To avoid the "B Penalty", the offer of MEC must:<br>  • **Be affordable; and**<br>  • **Provide minimum value (MV)**<br>• **2026 B Penalty liability is $5,010 annualized ($417.50/month)** multiplied by each such full-time employee who enrolls in subsidized exchange coverage |

# ACA Employer Mandate Penalties are Real

**Full Details:** Responding to IRS Letter 226J

## IRS Letter 226J

- Applicable Large Employers (ALEs) have been receiving ACA employer mandate penalty assessments since late 2017
- ALEs continue to be informed of prior year penalty assessments
- Many penalties are the result of ACA reporting errors on the Forms 1094-C and 1095-C
- Explanation of reporting errors and corrected codes usually removes penalties
- Keep relevant data because Letters 226J are generally for two years prior
- Review full alert for details on how to respond to Letter 226J



Dear

We have made a preliminary calculation of the Employer Shared Responsibility Payment (ESRP) that you owe.

**Proposed ESRP $ [XXXXXX]**

Our records show that you filed one or more Forms 1095-C, Employer-Provided Health Insurance Offer and Coverage, and one or more Forms 1094-C, Transmittal of Employer-Provided Health Insurance Offer and Coverage Information Returns, with the IRS. Our records also show that for one or more months of the year at least one of the full-time employees you identified on Form 1095-C was allowed the premium tax credit (PTC) on his or her individual income tax return filed with the IRS. Based on this information, we are proposing that you owe an ESRP for one or more months of the year.

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# 2026 Affordability Safe Harbors: 9.96%

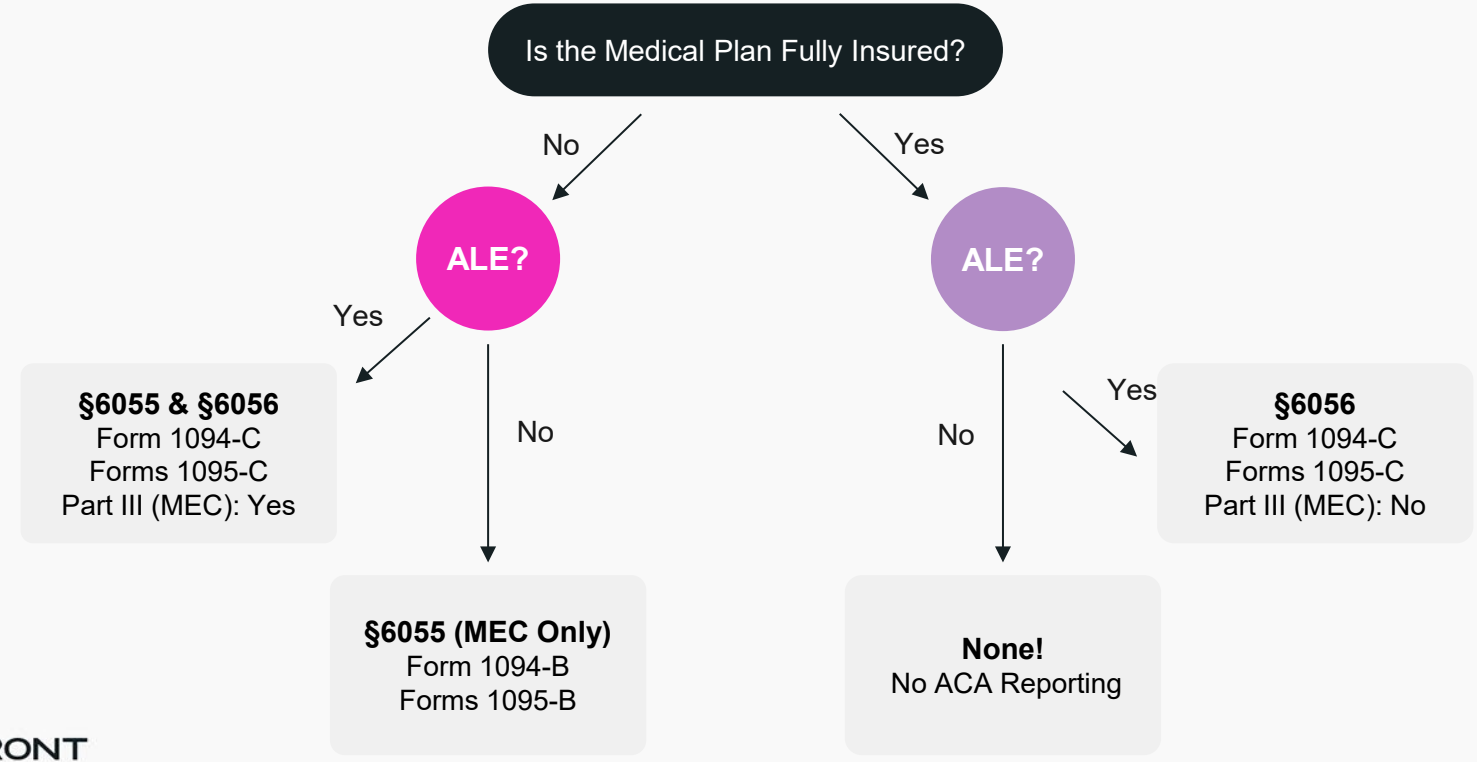
The employer mandate affordability safe harbors are indexed to a metric based on the rate of premium growth over the rate of CPI growth for the preceding year. For 2026, the applicable percentage increases **to 9.96%** (up from 9.02% in 2025).

**Full Details Available Here:** The ACA Affordability Determination in 2026

- **2026 Federal Poverty Line Safe Harbor:** 9.96% of the Federal Poverty Line
  - Prior-Year Federal Poverty Line (Contiguous 48 States): $15,650
  - 2026 Monthly Employee-Share of Premium for Lowest-Cost (Minimum Value) Plan Limit: **$129.89**
  - *Action Item: Always use this approach where the employer offers plan option at a cost that does not exceed $129.89/month*
- **2026 Rate of Pay Safe Harbor:** 9.96% of Rate of Pay
  - Hourly Employees: 9.96% of Employee's Hourly Rate of Pay x 130 Hours (regardless of actual hours of service)
  - Salaried Employees: 9.96% of Employee's Monthly Salary
  - *Action Item: Use this approach where the employer's cheapest (minimum value) plan option costs employees more than $129.89/month*
- **2026 Form W-2 Safe Harbor *(Not Recommended)*:** 9.96% of Box 1 Wages
  - *Disadvantage #1*: Retrospective Determination—Form W-2 safe harbor provides no predictability because Box 1 unknown until January of following year (i.e., employer will not know until January 2027 whether it met the Form W-2 safe harbor for 2026)
  - *Disadvantage #2:* Disregarded Compensation—Box 1 does not include many forms of compensation, including 401(k) deferrals and Section 125 salary reductions for health and welfare plan coverage
  - *Disadvantage #3:* Fixed Premium—The employee-share of the premium must remain consistent as an amount or percentage for the full plan year, which means employers cannot make mid-year adjustments to address lower-than-anticipated Box 1 amounts

# ACA Reporting: Which Employers Must Report?

**Full Details:** The ACA Reporting Requirements in 2026

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# ACA Reporting Penalties

**Full Details:** The ACA Reporting Requirements in 2026

## Same Penalties Apply as for Forms W-2 (Penalty Amounts for Forms Furnished/Filed in 2026)

General penalty is **$680** for each incorrect return (**$340** for return furnished to individual, **$340** for return filed with the IRS).

- Total fine not to exceed $4,098,500.
- Penalty reduced to **$60** if the corrected return is filed **within 30 days** after the required filing date—total fine max reduced to $683,000.
- Penalty reduced to **$130** if corrected by **August 1** of the year in which the filing due—total fine max reduced to $2,049,000.

## Special Good Faith Efforts Applied in Previous Years–No Longer Available

For the Forms 1094-C and 1095-C filed in previous years, a “good faith efforts” standard applied.

- The IRS would not impose the penalties described above if the employer could show that it made “good faith effort” to comply with the information reporting requirements.
- Applied to incorrect or incomplete information (including SSNs).
- IRS has confirmed the end of good faith transition relief confirmed in new final regulations
- Reasonable cause penalty relief is still available in some circumstances
- More details: ACA Reporting Penalties

# ACA Reporting Penalties: Filing Failures

**Full Details:** ACA Reporting Penalties

## No Filing: IRS Letter 5699

- Employers that fail to file their ACA reporting forms will receive an IRS Letter 5699
- Letter asks the employer several questions related to why the forms have not been filed
- Questions are generally inquiring as to whether the employer was an ALE and what the status is of their filing
- Employer has 30 days to respond
- Failure to respond will result in IRS Letter 5698 and eventually referral to IRS examiner to pursue penalties for failure to file/furnish

## Late/Incorrect Filing: IRS Notice 972CG

- Employers that do not timely file the ACA reporting forms will receive an IRS Notice 972CG informing them of the proposed penalties being imposed
- Employers have 45 days to respond to the Notice 972CG
- If employer agrees, they can simply respond with the payment
- Those disagreeing will state the reason the penalties (in full or in part) should not apply
- Employers that do not timely respond will receive a follow-up "Notice of Penalty Charge" bill that includes additional interest

## Reasonable Cause Relief: IRS Publication 1586

- "Reasonable cause" relief is available to potentially reduce or eliminate ACA reporting penalties
- Employer must show:
  1. No willful neglect;
  2. That it acted in a responsible manner both before and after the failure occurred; and
  3. There were significant mitigating factors or events beyond its control
- Full description of the standard in Treas. Reg. §301.6724-1
- Summary of the standard in IRS Publication 1586

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# ACA Reporting Deadlines

## Extension Stays, No More Good Faith Safe Harbor

**Full Details:** The ACA Reporting Requirements in 2026

### Extended Deadline Is Here to Stay

***New Furnishing Relief Available!**

- The IRS finalized regulations to make the 30-day extension permanent*
- 30-day extension applies only to the deadline for providing the forms to individuals*
- Deadlines to file with the IRS remain standard
- In prior years the IRS also provided the good faith enforcement safe harbor to avoid penalties for incorrect or incomplete information (generally $340 per return)
- In prior years, IRS allowed employers filing fewer than 250 returns to file by paper
- **Remember:** No good-faith safe harbor available anymore—standard penalty scheme applies for incorrect information
- **Remember:** No option to file by paper anymore—going forward all employers must file electronically

**2026 ACA Reporting Deadlines for ALEs**

| Forms | Type of Distribution | Due Date |
|---|---|---|
| 2025 Forms 1095-C | *Furnish to Individuals** | **March 2, 2026** |
| 2025 Forms 1094-C (+Copies of Forms 1095-C) | *Electronically File with IRS* | **March 31, 2026** |

# Due Dates: 30-Day Extension to Furnish, No Longer Option to File by Paper

**Full Details:** The ACA Reporting Requirements in 2026

| Form 1095-C: To Employees | Forms 1094-C and 1095-C to the IRS: Electronic Only |
|---|---|
| ***New Furnishing Relief Available!***<br>• Must be furnished by **March 2, 2026**<br>• Standard deadline is January 31, but the new IRS final regulations make the 30-day extension from previous years permanently available going forward (great news!)<br>• Unfortunate downside is they have also confirmed that the good faith enforcement safe harbor for incorrect/incomplete forms is no longer available<br>• Note: The 30-day extension makes the deadline March 2 for a non-leap year, March 1 on a leap year | • Must be filed electronically by **March 31, 2026**<br>• Employers must file electronically if filing 10 or more returns (including ACA reporting, Form W-2, and 1099, etc.) starting in 2024—includes virtually all employers<br>• Previous ability to file by paper where under 250 ACA form return threshold is now eliminated<br>• More details: IRS Requires Electronic ACA Filing in 2024<br>• Note: The filing deadline is extended on years when it falls on a weekend |

# New ACA Reporting and ER Mandate Relief

**Full Details:** The ACA Reporting Requirements in 2026

## Form 1095-C Furnishing Relief:
*Paperwork Burden Reduction Act* Passed End of 2024

**ALEs No Longer Have to Furnish Forms 1095-C**

- Instead, ALEs simply have to make the forms available upon request

Two requirements for employers to take advantage of this "alternative manner of furnishing statements":

1. *Notice of Availability:* Provide employees with clear, conspicuous, and accessible notice that they may request a copy of the Form 1095-C; and
2. *Provision Upon Request:* If the employee requests a copy, the employer must provide a copy by the later of a) January 31, or b) 30 days after the date of the request

- See next slide for details such as how to provide the notice of availability

## Employer Mandate Penalty Relief:
*Employer Reporting Improvement Act* Passed End of 2024

**Additional Time to Respond to IRS Letter 226J**

- New law provides employers with 90 days to respond to proposed ACA employer mandate penalty assessment in IRS Letter 226J
- Extends the period from the standard 30-day window that the IRS made available previously
- Employers can use additional time to respond to proposed assessment with information and documentation showing that the assessment should be reduced or eliminated (e.g., because of an ACA reporting error)

**Statute of Limitations for Employer Mandate Penalties**

- New law provides a six-year statute of limitations for any ACA employer mandate penalty assessment
- Previously the IRS took the position that there was no statute of limitations that applied in this context

# The New PBRA Alternative Manner of Furnishing Forms 1095-C

**Full Details:** The ACA Reporting Requirements in 2026

**Clear Notice:**
Website Posting by Due Date

- Employer must provide a clear and conspicuous notice
- Must be in a location on its website that is reasonably accessible to all employees
- State that employees may receive a copy of the Form 1095-C upon request
- Notice must post to the website by the due date for furnishing the Form 1095-C, which is 30 days after January 31
- Deadline to post this notice is March 2, 2026 for 2025 Forms 1095-C

**Website Notice Details:**
Template Language

- Must be written in plan, non-technical terms
- Using font size large enough and any visual clues or graphical features to call viewer's attention

Example:

- Statement on website reading "Tax Information"
- Links to secondary page that includes a statement in capital letters "IMPORTANT HEALTH COVERAGE TAX DOCUMENTS"
- Explains how to request copy of the Form 1095-C

**Responding to Requests:**
Applicable Timeframes

- Notice must remain available on the website through October 15
- For 2025 Forms 1095-C, notice on website must remain posted until October 15, 2026
- If employee requests the Form 1095-C, employer must provide it by the later of:
  1. January 31; or
  2. 30 days after the date of the request
- Employer may provide requested Form 1095-C by paper (hand delivery/mail) or electronically with affirmative consent

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03

# The CAA

## Reaching Full Implementation

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# CAA Effective Dates Timeline

**February 10, 2021**

- **Mental Health Parity Comparative Analysis Documentation**

**First Plan Year on or After January 1, 2022**

- **Primary Care Provider Designation**
  - Expanded to non-grandfathered plans
- **Preventing Surprise Medical Bills: Emergency Services (No Surprises Act)**
- **Preventing Surprise Medical Bills: Non-Emergency Services (No Surprises Act)**
- **Ending Surprise Air Ambulance Bills (No Surprises Act)**
  - Reporting requirement delayed pending final regulations
- **Continuity of Care (No Surprises Act)**
  - Good faith, reasonable interpretation of the CAA provisions until regulations issued
- **Medical ID Card Cost-Sharing**
  - Good faith, reasonable interpretation of requirements until the Departments issue regulations

**July 1, 2022**

- **Machine-Readable In-Network Rates and Out-of-Network Allowed Amounts with Detailed Pricing Information**
  - Delayed from first plan year beginning on or after January 1, 2022

# CAA Effective Dates Timeline

**December 27, 2022**

- **Annual Reporting on Pharmacy Benefits and Drug Costs**
  - Departments issued FAQ guidance on December 23, 2022 providing a grace period for first submission through January 31, 2023, and announcing a good faith efforts standard for enforcement of initial report (now annually required by 6/1)

**First Plan Year on or After January 1, 2023**

- **Price Comparison Tool for First 500 Shoppable Items/Services**
  - ACA regulations and CAA have nearly identical provisions, ACA provision delayed from 1/1/22
- The New CAA Surprise Billing Notice (Version 2)
  - For employers that maintain a public website for their group health plan

**December 31, 2023**

- **Gag Clause Prohibition Compliance Attestation**
  - Covers the period from date of CAA enactment (December 27, 2020) through the date of the attestation

**First Plan Year on or After January 1, 2024**

- **Price Comparison Tool for Remaining Shoppable Items/Services**
  - In addition to first 500 required by first plan year on or after 1/1/23

# CAA Prescription Drug Data Collection Reporting (RxDC)

**Full Details:** RxDC Reporting Considerations for Employers

| Annual Reporting on Rx Benefits and Drug Costs | Reports Due Annually by June 1 for Prior Year |
|---|---|
| • **Reporting is designed "as a means to promote competition and bring down overall health care costs" by collecting:**<br>  • General information regarding the plan or coverage;<br>  • Enrollment and premium information, including average monthly premiums paid by employees versus employers;<br>  • Total health care spending, broken down by type of cost (hospital care; primary care; specialty care; prescription drugs; and other medical costs, including wellness services), including prescription drug spending by enrollees versus employers and issuers;<br>  • The 50 most frequently dispensed brand prescription drugs;<br>  • The 50 costliest prescription drugs by total annual spending;<br>  • The 50 prescription drugs with the greatest increase in plan or coverage expenditures from the previous year;<br>  • Prescription drug rebates, fees, and other remuneration paid by drug manufacturers to the plan or issuer in each therapeutic class of drugs, as well as for each of the 25 drugs that yielded the highest amount of rebates; and<br>  • The impact of prescription drug rebates, fees, and other remuneration on premiums and out-of-pocket costs. | • FAQ guidance issued 12/23/22 extended grace period for initial 2020/2021 reporting from 12/27/22 through 1/31/23<br>  • Guidance also announced a good faith effort standard for enforcement for this initial reporting submission<br>• Going forward the due date is June 1 annually to report on prior calendar year<br>  • June 1, 2025 reported on 2024 calendar year<br>  • June 1, 2026 reports on 2025 calendar year<br>  • No good faith efforts standards or extensions apply<br>• Employers rely on their insurance carrier or TPA/PBM to submit the Prescription Drug Data Collection (RxDC) Report<br>  • For self-insured plans, the obligation lies with the employer, but the rules permit (and expect) employers to delegate to TPA/PBM<br>• Full details: RxDC Reporting Considerations for Employers |

# CAA Mental Health Parity Comparative Analysis

**Full Details:** The CAA Mental Health Parity Comparative Analysis Requirement

## MHPAEA Overview

- The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) generally provides that financial requirements (such as coinsurance and copays) and treatment limitations (such as visit limits) imposed on mental health or substance use disorder (MH/SUD) benefits cannot be more restrictive than the predominant financial requirements and treatment limitations that apply to substantially all medical/surgical benefits within its set classification
- Group health plans and insurance carriers may not impose non-quantitative treatment limitations (NQTL) with respect to MH/SUD benefits in any classification unless, under the terms of the plan as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the NQTL to MH/SUD benefits in the classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation to medical/surgical benefits in the same classification

## CAA Imposes New MHPAEA Documentation Requirement

- CAA expands upon the MHPAEA by requiring group health plans and insurance carriers that offer both medical/surgical benefits and MH/SUD benefits, and that impose NQTLs on MH/SUD benefits, to perform and document a comparative analysis of the design and application of the NQTLs.

## Comparative Analysis Disclosure

- The CAA requires group health plans and insurance carriers that offer both medical/surgical benefits and MH/SUD benefits, and that impose NQTLs on MH/SUD benefits, to make their comparative analysis of the design and application of NQTLs available to the Departments (DOL/HHS/IRS) or applicable state authorities
- July 2023 Tri-Agency MHPAEA Report to Congress reported EBSA issued 25 letters requesting comparative analyses for 69 NQTLs from Nov. 2021 – July 2022
- Newly finalized regulations require plan sponsors to certify they have engaged in a prudent process to select/monitor the preparer of the comparative analysis
  - See next slide for more details…

# The MHPAEA Employer Certification *(Delayed)*

**Full Details:** The Mental Health Parity Employer Certification Requirement

**The Departments issued a lengthy set of new regulations in 2024 to address many aspects of the CAA MHPAEA comparative analysis requirement. These have been delayed at least 18 months after lawsuit challenging rules—unclear if/when a certification will be required.**

- *The Departments delayed enforcement (originally effective 2025) pending litigation and reconsideration of the rule. It may eventually be removed.*

| The Certification Requirement: | What the DOL Expects of Employers: | Enforcement Process: |
|---|---|---|
| **Employer as fiduciary must certify:**<br>• They have engaged in a prudent process to select the service provider(s) to perform and document a comparative analysis in accordance with applicable law<br>• The analysis is based on the imposition of any nonquantitative treatement limitations (NQTL) that apply to mental health and substance use disorder benefit (MH/SUD) under the plan<br>• They have satisfied their duty to monitor the service provider(s) per the standard ERISA duty of prudence with respect to the performance and documentation of the comparative analysis | **DOL expects employers as fiduciary to:**<br>• Review the comparative analysis prepared by or on behalf of the plan with respect to an NQTL applicable to mental health and substance use disorder benefits and medical/surgical benefits<br>• Ask questions about the analysis and discuss it with service providers, as necessary, to understand the findings and conclusions documented in the analysis<br>• Ensure that the service provider provides assurance that the comparative analysis complies with the requirements of MHPAEA | **1) Available Upon Request**<br>• The plan must provide the comparative analysis to the relevant department (DOL/IRS/HHS) within 10 business days of the relevant department's request<br>• The plan has 45 calendar days to correct issues if determined to be noncompliant<br>**2) Notify Employees**<br>• If the plan receives a final determination of noncompliance, it has 7 business days to notify all enrolled employees<br>• Header: "Attention! The Department of [X] has determined that [plan name] is not in compliance with the MHPAEA!" |

# CAA Gag Clause Prohibition Compliance Attestation

**Full Details:** The CAA Gag Clause Prohibition Attestation Requirement

## Prohibited Gag Clauses Under CAA

To increase transparency by removing gag clauses on price and quality information, CAA prohibits plans from entering into agreements with health care providers, network, TPA, or other service providers that have restrictions on releasing certain information:

1. Provider-specific cost or qualify of care information or data through a consumer engagement tool or any other means;
2. Electronic de-identified claims and encounter information or data for individuals upon request and consistent with HIPAA, GINA, and the ADA;
3. The ability to share information or data in 1) and 2) above (or to direct information be shared) with a HIPAA business associate, consistent with HIPAA, GINA, and the ADA.

## CAA Imposes Gag Clause Prohibition Compliance Attestation Requirement (GCPCA)

- The CAA includes an annual attestation requirement for plans to certify their compliance with the gag clause prohibition. This is referred to as the annual Gag Clause Prohibition Compliance Attestation, or “GCPCA”.

## Satisfying the GCPCA

- For fully insured plans, the employer and carrier are both responsible, but FAQ gudiance confirms both will be treated as satisfying if carrier submits
- For self-insured plans, the employer may satisfy the attestation requirement by entering into a written agreement with the TPA to complete
- Attestation is due by December 31 annually (first was due in 2023), completed at the Gag Clause Prohibition Compliance Attestation website
- Full details: The CAA Gag Clause Prohibition Attestation Requirement

04

# The Trump Administration

## Potential Employee Benefits Priorities in 2026

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# Trump Administration: Potential 2026 EB Priorities

**Full Details:** What Employee Benefits Provisions Did *NOT* Make the Final OBBB?

**The best indication of potential legislative action in 2026 is the significant number of items that were removed from the OBBB last-minute.**

- *Everything remains status quo unless and until any of the potential policy goals discussed are actually enacted/promulgated/implemented.*

## HSA Expansions:

**Initial House-passed version of the OBBB was far more ambitious in HSA expansion:**

- Medicare Part A not disqualifying coverage;
- On-site medical clinics not disqualifying coverage;
- HSA distributions for gym memberships up to $500/year;
- Both spouses can make catch-up contribution to the same HSA;
- Distributions from health FSA/HRA into an HSA;
- Distributions for expenses incurred in the 60-day period after enrollment in an HDHP;
- Spouse enrollment in a general purpose health FSA not disqualifying coverage; and
- Increase to the employee HSA contribution limit by $4,300 individual/ $8,550 family coverage

## ICHRA Codification:

**Initial House-passed version of the OBBB made significant ICHRA improvements:**

- Rebranding ICHRAs to be known as “Custom Health Option and Individual Care Expense Arrangements,” or “CHOICE Arrangements”;
- Codifying the current ICHRA regulations (with modifications) into statute;
- Adding a new requirement to include the ICHRA amount available on the employee’s Form W-2;
- Allowing employees to pay their share of the premium on a pre-tax basis through the Section 125 cafeteria plan even if it the policy is purchased on the Exchange; and
- The creation of an employer tax credit for offering an ICHRA.

## Other Potential Priorities:

**1) PBM Reform**

- The government funding bill at the end of 2024 initially included a sweeping federal PBM reform package
- Would have given the industry 30 months (until 2028) to come into compliance
- Was ultimately scrapped last-minute, but remains a priority in Congress to address

**2) Revisit Association Health Plans**

- Regulations from first Trump administration were overturned in court and rescinded by Biden administration
- Association Health Plans Act introduced in 2025 revives the effort legislatively

# 2026 Wildcard Predictions

Remember 2017? We had AHCA in the House, then BCRA in the Senate. When that failed, the Senate then turned the Graham-Cassidy bill—but it was one vote short. That bill may still hold some clues…

**Full Details:** Potential Employee Benefits Changes in Second Trump Term

## Uncle Sam HSA Funding?

- President Trump's Truth Social post advocated that "Republicans should give money DIRECTLY to your personal HEALTH SAVINGS ACCOUNTS"
- GOP is considering an approach to redirect some of the ACA premium tax credits funds to HSAs for certain individuals

## HSA Distributions for Premiums

- Current law permits tax-free HSA distributions to pay premiums only in limited circumstances (COBRA, federal unemployment, post-age 65, long-term care, DPC)
- Opening the use of HSAs for premiums would be a major paradigm-shift and justify the much higher contribution levels

## Double the Contribution Limits

- Increase the contributions limits for everyone to roughly match the current out-of-pocket maximum limits
- Would increase the contribution limits to $8,500 individual, $17,000 family

# A Post-ICHRA Landscape?

## Employer HSA Contributions Could Become the New Defined Contribution Alternative

**Full Details:** HSAs to Lead the Way After the ACA

- **Could legislation in second Trump term make HSA contributions a more attractive alternative to the ICHRA?**
  - The Graham-Cassidy bill represented the GOP's last gasp of an effort for an ACA repeal/replace bill in 2017
  - It's no longer under consideration of course, but it shows some sense of a possible GOP direction in the second Trump term
  - The prior bill would have doubled the HSA contribution limit (to over $17,000 for family coverage), permitted tax-free HSA distributions for premiums, and repealed the ACA employer mandate to offer group coverage
  - » HSAs have key ownership and investment employee advantages over HRAs

- **What It Could Mean**
  - If these HSA changes ever became law, employers would likely consider HSA contributions as the defined contribution holy grail (even more than ICHRA!)
  - » Employers could simply deposit a set sum in employees' HSA upon verification of HDHP enrollment, with no other administrative or compliance burdens—and employees would probably love it!

05

# Other News

# The Health FSA Contribution & Carryover Limits

**Full Details:** 2026 Health FSA Limit Increased to $3,400

## Salary Contribution Limit:
$3,400 for Plan Years Beginning On or After 1/1/2026

**ACA Original $2,500 Limit Indexed for Inflation**

- Adjusts in $50 increments based on a complex cost-of-living calculation tied to the chained and standard consumer price index increases for the preceding year
- The cost-of-living increases in 2025 were sufficient to boost the 2026 limit by two $50 increments ($100 total)
- *Health FSA Salary Reduction Contribution Limit for Plan Years Beginning On or After January 1, 2026:* ***$3,400***

**Employer Health FSA Contributions:**

- Employer contributions do not count toward the $3,400 salary reduction contribution limit
- Maximum is generally $500/year (can be higher if structured as a dollar-for-dollar match)
- Total max generally $3,400 (EE) + $500 (ER) = $3,900

## Carryover Limit:
$680 for PY Starting in 2026 to PY Starting in 2027

**IRS Indexes the Carryover Limit**

- Executive Order 13877 in June 2019 directed the IRS to increase the $500 carryover limit
- The IRS announced in Notice 2020-33 that it was increasing the carryover limit to an amount equal to 20% of the maximum health FSA salary reduction contribution
- *Carryover Limit from a Plan Year Starting in 2025 to a Plan Year Starting in 2026:* ***$660***
- *Carryover Limit from a Plan Year Starting in 2026 to a Plan Year Starting in 2027:* ***$680***

# HSA and HDHP 2026 Limits

The annual statutory maximum HSA contribution limits are for all contributions combined (employer and employee). These amounts are subject to cost-of-living adjustments each year based on chained CPI (modified by TCJA).

**Full Details:** 2026 HSA Contribution Limits

| | 2025 | **2026** |
|---|---|---|
| **Annual Contribution Limit** | Individual Coverage: $4,300<br>Family Coverage: $8,550<br>Age 55+ Catch-Up: $1,000 | **Individual Coverage: $4,400**<br>**Family Coverage: $8,750**<br>**Age 55+ Catch-Up: $1,000** |
| **Minimum Annual Deductible** | Individual Coverage: $1,650<br>Family Coverage: $3,300 | **Individual Coverage: $1,700**<br>**Family Coverage: $3,400** |
| **Annual Out-of-Pocket Maximum** | Individual Coverage: $8,300<br>Family Coverage: $16,600 | **Individual Coverage: $8,500**<br>**Family Coverage: $17,000** |

# 2026 Employee Benefit Limits

**Full Details:** 2026 Health and Welfare Employee Benefit Amounts

| Employee Benefit Limit | 2025 | 2026 |
|---|---|---|
| **HSA Individual** | $4,300 | **$4,400** |
| **HSA Family** | $8,550 | **$8,750** |
| **HSA Catch-Up (55+)** | $1,000 | **$1,000** |
| **HDHP Maximum Out-of-Pocket** | $8,300 / $16,600 | **$8,500 / $17,000** |
| **HDHP Minimum Deductible** | $1,650 / $3,300 | **$1,700 / $3,400** |
| **Health FSA Salary Reduction Contribution** | $3,300 | **$3,400** |
| **Health FSA Carryover to Following Year** | $660 | **$680** |
| **Dependent Care FSA** | $5,000 ($2,500 married filing separately) | **$7,500 ($3,750 married filing separately)** |
| **Highly Compensated Employee** | $155,000 | **$160,000** |
| **Mass Transit/Vanpooling** | $325/month | **$340/month** |
| **Qualified Parking** | $325/month | **$340/month** |
| **401(k) Elective Deferral** | $23,500 | **$24,500** |
| **401(k) Catch-Up (50+)** | $7,500 | **$8,000** |
| **FICA Wage Base (SS Only)** | $176,100 | **$184,500** |
| **ACA Employer Mandate Penalties** | A Penalty: $2,900, B Penalty: $4,350 | **A Penalty: $3,340, B Penalty: $5,010** |
| **ACA Employer Mandate Affordability** | 9.02% | **9.96%** |
| **ACA Federal Poverty Level Safe Harbor** | $113.20/month | **$129.89/month** |
| **Adoption Assistance** | $17,280 | **$17,670** |

# PCORI Fee for Self-Insured Plans

**Full Details:** ACA PCORI Fee Due in July via IRS Form 720

**Congress Extended the PCORI Fee for Another Decade (to 2029)**

- 2019 was to be the final year the Patient Centered Outcomes Research Institute (PCORI) fees were required
- Major industry groups (AHIP, BCBSA, ERIC, NRF, US Chamber) pushed for 10-year extension to 2029
- That legislation was ultimately incorporated into the same massive “Further Consolidated Appropriations Act, 2020”
- Employers with self-insured medical plans (including level funded plans) need to file and pay for the PCORI fee!
- **Only employers with a self-insured major medical plan (including level funded plans) and/or HRA (special HRA rules apply) must file for and pay the PCORI fee (the insurance carrier files/pays for fully insured plans)**

| PCORI Fees | July 31, 2025 Form 720 PCORI Filing | July 31, 2026 Form 720 PCORI Filing |
|---|---|---|
| **Plan Year Ends January 1–September 30** | Applicable Rate:<br>• $3.22 per covered individual | Applicable Rate:<br>• $3.47 per covered individual |
| **Plan Year Ends October 1–December 31 (Including Calendar Plan Years)** | Applicable Rate:<br>• $3.47 per covered individual | Applicable Rate:<br>• **$3.84 per covered individual** |

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# The J&J Prescription Drug Case Makes Waves

**Full Details:** The J&J Case Practical Considerations (ERISA Fiduciary Duties); (ERISA Trust Rules)

## ERISA Fundamentals Revisited

### The Allegation: Excessive Prescription Drug Costs

- The class plaintiff in *Lewandowski v. Johnson & Johnson, et. al.* principally allege that the company breached its fiduciary duty by mismanaging the health plan's Rx benefits
  - Argument is that cost employees millions in the forms of higher Rx payments, higher premiums, higher cost-sharing, and lower wages or limited wage growth
- Class plaintiff alleges that J&J breached its fiduciary duty of prudence by failing to engage in a prudent and reasoned decision-making process to lower the cost of drugs

### Key Points to Keep in Mind

- The J&J plaintiff did not prevail, and it is unclear whether these novel breach of fiduciary duty theories can be successful—so try to avoid knee-jerk overreactions
- The J&J plan is very large and *funded by a trust*, which allows the plaintiff to establish a clear connection between the employer's fiduciary duties and the trust funds held as plan assets
- This area of law remains unsettled with the J&J (and similar Wells Fargo/JPMorgan) litigation, so employers should be cautious considering any radical changes to plan governance
  - *Best practice:* **Return to the basics** of proven ERISA compliance methods/strategies while monitoring developments for any outcomes that may drive new best practices going forward

## Fiduciary Committee Considerations

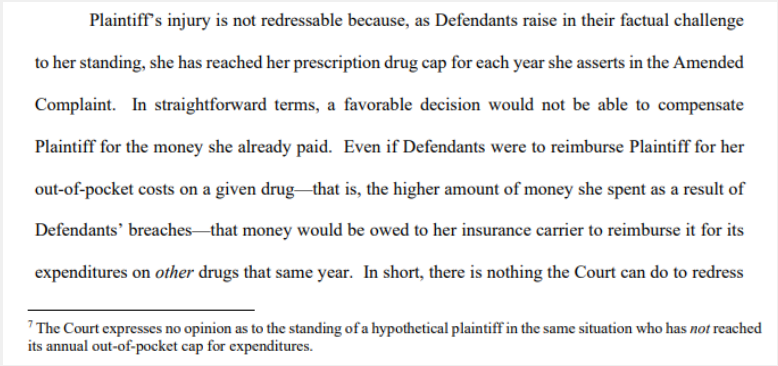
- J&J's plan had a fiduciary benefits committee but was still the target of this case
- The individuals serving on the committee were a clear target as defendants, with the CHRO and VPs of HR personally named
- H&W Plan committees are rare because of the time/cost
- Trump Administration may seek reduced plan burdens
- For more details: The Pros and Cons of a Health and Welfare Plan Fiduciary Committee

# What to Make of the Court's J&J Decisions?

**Full Details:** Newfront ERISA Fiduciary Library

## Court (Twice) Grants J&J Motion to Dismiss on Procedural Grounds

**Lewandoski v. Johnson & Johnson *et. al.*, D.N.J., No 3:24-cv-00671:**



Plaintiff's injury is not redressable because, as Defendants raise in their factual challenge to her standing, she has reached her prescription drug cap for each year she asserts in the Amended Complaint. In straightforward terms, a favorable decision would not be able to compensate Plaintiff for the money she already paid. Even if Defendants were to reimburse Plaintiff for her out-of-pocket costs on a given drug—that is, the higher amount of money she spent as a result of Defendants' breaches—that money would be owed to her insurance carrier to reimburse it for its expenditures on *other* drugs that same year. In short, there is nothing the Court can do to redress

[7] The Court expresses no opinion as to the standing of a hypothetical plaintiff in the same situation who has *not* reached its annual out-of-pocket cap for expenditures.

## Implications?

- An initial win for employers, shows difficulty for employees to bring this type of claim
- Key quote (second dismissal): *"Put simply, it is too speculative that the allegedly excessive fees the Plan paid to its PBM 'had any effect at all' on Plaintiffs' contribution rates and out-of-pocket costs for prescriptions."*
- Wells Fargo case came to similar conclusion, will any of these be able to address the merits? Not clear at this point
- Continue to monitor whether any of these can get standing and survive motion to dismiss

## Plaintiff Lacked Standing:

- Found that any higher prescription drug costs than appropriate still would not have caused plaintiff to pay more in cost-sharing (because already reached the plan's OOPM)
- Also found it speculative whether the higher prescription drug costs might have caused plaintiff to pay higher premium

## Only Document Request Piece Remains:

- The court granted the motion to dismiss on the core complaints
- Second court decision again affirmed that J&J motion to dismiss
- However, it denied the (much smaller) motion with respect to failure to timely provide requested ERISA documents

# Court Case Removes Reproductive Health Rules

## However, the Substance Use Disorder Provisions Remain in Effect

**Full Details:** Purl v. United States HHS, No. 2:24-CV-228-Z, 2025 U.S. Dist. (N.D. Tex. June 18, 2025)

In sum, HIPAA confers authority to promulgate regulations protecting "individually identifiable health information." 42 U.S.C. § 1320d-2 note. But it confers no authority to distinguish between types of health information to accomplish *political* ends like protecting access to abortion and gender-transition procedures. Thus, HHS lacks the authority to issue regulations that enact heightened protections for information about politically favored procedures. "[T]he people and their elected representatives" remain free to enact their preferred protections for such procedures. *Dobbs*, 597 U.S. at 292. And HIPAA and its regulations cannot preempt any state laws that enact "more stringent" protections. *See* Pub. L. No. 104-191, § 264, 110 Stat. 1936, 2033–34 (1996).

But until the people speak through their representatives, agencies must fall silent on issues of abortion or other matters of great political significance. Thus, HHS lacked the authority to promulgate the 2024 Rule.

The court decision vacated the portion of the rules related to reproductive health, but severed that portion and preserved the other piece related to the Part 2 Rule for substance use disorder protections:

Fed. Reg. at 33048. The remainder of the changes to Section 164.520 in 89 Fed. Reg. 32976 are not "directly related" to the 2024 Rule's unlawful provisions. 89 Fed. Reg. at 33048. Thus, HHS intended them to sever.

Accordingly, 45 C.F.R. Section 164.520 is severed and not vacated *except* 45 C.F.R. Section 164.520(b)(1)(ii)(F), (G), and (H), which are vacated because HHS did not intend they remain.

# The Part 2 Rule: Substance Use Disorder Protections Notice of Privacy Practices Update Required

**Full Details:** The Part 2 Substance Use Disorder Rules

## The Action Item

*Notice of Privacy Practices (NPP) Update by 2/16/26*

- Originally the new Part 2 rules were largely addressed with the reproductive health rules that required a new attestation and NPP updates
- After the court decision, only the Part 2 SUD piece remains
- Requires NPP update by February 16, 2026 to reflect new SUD rights (but no longer includes reproductive health)

## What's New With Part 2?

- The CARES Act required the Part 2 rules to be more aligned with the HIPAA rules
- Final Part 2 rules issued February 8, 2024 completed that alignment
- Authority to enforce Part 2 rules was formally delegated to HHS OCR as of August 27, 2025
- Was initially in combination with reproductive health rules, *but a court vacated the reproductive health components*

## What is the Part 2 Rule?

- Protects the records of the identity, diagnosis, prognosis, or treatment of any patient in connection with any federal program or activity relating to substance use disorder (SUD)
- Includes education, prevention, training, treatment, rehabilitation, or research
- Designed to address concerns that discrimination and fear of prosecution might deter treatment for SUD

# The New California IVF Mandate

**Full Details:** California Imposes New IVF Insurance Mandate

## California Mandates IVF Coverage:
Effective in 2026

**Prior Law (Pre-2026)**

- No mandate for health insurance policies to cover infertility treatment, including IVF
- Carriers had to offer employers the option to add infertility treatment as a rider, but IVF excluded from the requirement

**New SB 729 Requirements**

*Large Group Policies (100+ Employees)*

- **Must cover** the diagnosis and treatment of infertility and fertility services, including at least three cycles of IVF

*Small Group Policies (1-100 Employees)*

- Must **offer** employers **the option to cover** the diagnosis and treatment of infertility and fertility services (does not have to include IVF)

**Not Applicable to Self-Insured Plans (Incl. Level Funded)**

- ERISA preempts state insurance mandates for self-insured plans

## The Details:
Important Considerations and Open Questions

**Broad Definition of Infertility**

- Includes inability to reproduce either as an individual or with their partner without medical intervention
- Governor Newsom's signing statement states this is "inclusive of LGBTQ+ families"
- Not clear whether this meets §213(d) definition of infertility

**No IVF Requirement for Small Group**

- The policy option to include infertility is not required to cover IVF—only required to offer option to include coverage for the diagnosis and treatment of infertility
- Be wary because state legislators have misconstrued this

**Original Effective Date Was Delayed**

- AB 116 pushed the effective date back from 7/1/25 to policies issued/amended/renewed on or after 1/1/26
- Guidance expected by 1/1/27 from DOI and DMHC

# The New California PBM Law

**Full Details:** California Enacts Sweeping PBM Reform

## PBM Spread Pricing Ban:
Effective in 2026

- PBMs cannot use spread pricing in California for new contracts as of January 1, 2026
- Spread pricing allows the PBM to bill the plan a higher amount than it reimburses the dispensing pharmacy and keep the "spread"
- This approach has been much-maligned as opaque because the plan sponsor does not have access to the true pharmacy cost or PBM margin, creating the potential for misaligned incentives

*Pass-Through Pricing Mandated*

- PBMs must use pass-through pricing where the plan pays exactly what the pharmacy is reimbursed (or the PBM's acquisition/cost basis) plus an explicit administrative fee

*Self-Insured Plans*

- Likely to be challenged on ERISA preemption grounds based on 2023 *PCMA v. Mulready* 10th Circuit decision

## The Other Terms:
New Fiduciary Standard

*Fiduciary Duty*

- Similar to the employer's obligation under ERISA, PBMs have a fiduciary duty to their clients to be fair and truthful, act in the client's best interests, avoid conflicts of interest, and act with prudence

*Rebates Returned to Plan*

- The PBM must direct 100% of all prescription drug rebates received to the plan for the sole purpose of offsetting cost-sharing or reducing premiums

*PBM Contract Terms*

- Any existing PBM contract language authorizing spread pricing must be removed at the next amendment/renewal starting in 2026—in all cases, such spread pricing terms are void by operation of law on and after January 1, 2029

*PBM Licensure*

- PBMs must be licensed to do business in CA as of 2027

# Medicare Part D: What's New?

The IRA made significant changes to Medicare Part D coverage, including an out-of-pocket maximum capping enrollee costs at $2,000 (indexed, $2,100 in 2026).

**Full Details:** IRA Changes Affect Notice of Creditable Coverage Considerations

- The creditable status determination can be a pain point
- **Ideally the plan's insurance carrier or TPA will perform the assessment and inform the employer of creditable status!**
- Where the carrier/TPA refuses to perform the analysis, the employer will need to determine creditable status independently
- The change to the simplified determination approach in 2027 could lead to more plans not satisfying the creditable standard

## 2027 Creditable Status

*More Difficult 72% Standard*

- The existing simplified approach to determining creditable status requires (among other conditions) that the plan is designed to pay on average at least **60%** of participants' prescription drug expenses
- CMS guidance states that starting in 2027, it will likely increase to **72%**

### What if Plan Loses Creditable Status for 2027?

- Upon receipt of non-creditable notice, employee should **a)** enroll in a different creditable plan option made available, **or b)** enroll in Part D *(also requires Part A enrollment)* to avoid late penalties

## Simplified Determination

*Approach Changes in 2027*

**Two Different Approaches**

1. Simplified Determination
2. Actuarial Determination

### Simplified Movies to 72%

- CMS initially threatened to remove the simplified option as of 2025, then again as of 2026
- CMS has now decided that it will keep the simplified method as an available option—but with changes
- Starting in 2027, plans must use the "revised" simplified method that increases the threshold to 72% of participants' Rx drug expenses

# Required SBC Language Translations

SBCs Must be Provided In a **“Culturally and Linguistically Appropriate Manner”**

**Full Details:** Providing SBCs to Employees

## The SBC Language Requirements

- Employers must satisfy the following standards for the SBC:
  - Oral language services (e.g., phone customer service hotline) that includes answering questions in the non-English language
  - Upon request, the plan must provide the SBC translated in the non-English language
  - Must include a prominently displayed statement in SBC in the non-English language of how to access these language services
- SBC template includes access taglines in non-English languages on page four of the SBC (“Language Access Services”)

## When the SBC Language Services Requirement Applies

- **SBC language services required (including translations upon request) where provided to an employee/dependent in county where at least 10% of the the population residing in the county is literate only in the same non-English language**
  - Departments use survey and census information to periodically update which counties qualify
  - Most recent Culturally and Linguistically Appropriate Services County Data (CLAS County Data) is from 2023

## New 2023 CLAS County Data Applies Going Forward

- **Applies to SBCs for Plan Years beginning on or after January 1, 2025**

**Where to Access 2023 CLAS County Data:**
**https://www.dol.gov/sites/dolgov/files/ebsa/laws-and-regulations/laws/affordable-care-act/for-employers-and-advisers/clas-county-data-2023.pdf**

**Where to Access SBC Translations:**
**https://www.cms.gov/marketplace/resources/forms-reports-other**

NEWFRONT

# Required SBC Language Translations

## SBCs Must be Provided In a **"Culturally and Linguistically Appropriate Manner"**

**Full Details:** Providing SBCs to Employees

### Which Languages Qualify? (*New for 2025)

- **Spanish**
  - 216 Counties in AZ, AK, CA, CO, FL, GA, ID, IA, KS, MN, NE, NM, NY, NC, OK, OR, PR, TX, VA, WA
- **Tagalog (includes Filipino)**
  - 10 Counties in AK, Northern Mariana Islands
- **Samoan***
  - 3 Counties in American Samoa
- **Chamorro***
  - 3 Counties in Northern Mariana Islands
- **Pennsylvania Dutch (Includes Yiddish/West Germanic)***
  - 2 Counties in IN, OH
- **Chinese (includes Mandarin and Cantonese)**
  - 1 County in CA
- **Navajo**
  - 1 County in AZ
  - *Note:* Navajo oral translation also available (mp3 format)
- **Carolinian***
  - 1 County in Northern Mariana Islands

### New 2023 CLAS County Data Applies Going Forward

- **Applies to SBCs for Plan Years beginning on or after January 1, 2025**

**Where to Access 2023 CLAS County Data:**
**https://www.dol.gov/sites/dolgov/files/ebsa/laws-and-regulations/laws/affordable-care-act/for-employers-and-advisers/clas-county-data-2023.pdf**

**Where to Access SBC Translations:**
**https://www.cms.gov/marketplace/resources/forms-reports-other**

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# Required SBC Language Translations

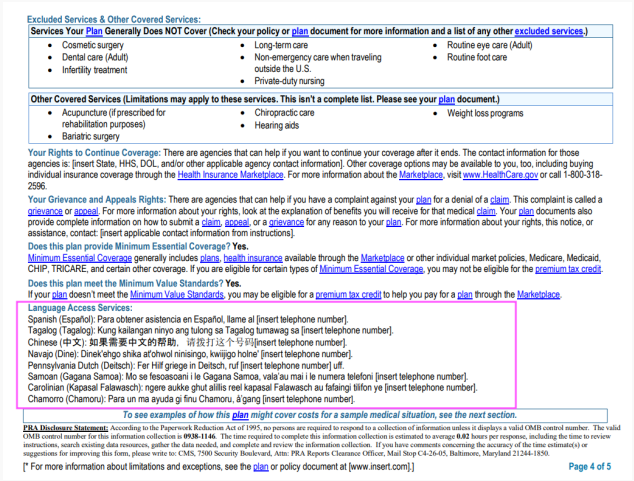
SBCs Must be Provided In a **“Culturally and Linguistically Appropriate Manner”**

**Full Details:** Providing SBCs to Employees

## Updated Templates to Include New Languages

**Forms**

- Summary of Benefits and Coverage (SBC) Template
  - English Standard Format (DOCX)
  - English Accessible Format (PDF)
  - Carolinian Standard Format (DOCX)
  - Carolinian Accessible Format (PDF)
  - Chamorro Standard Format (DOCX)
  - Chamorro Accessible Format (PDF)
  - Chinese Standard Format (DOCX)
  - Chinese Accessible Format (PDF)
  - Navajo Standard Format (DOCX)
  - Navajo Accessible Format (PDF)
  - Navajo Oral Translation
  - Pennsylvania Dutch Standard Format (DOCX)
  - Pennsylvania Dutch Accessible Format (PDF)
  - Samoan Standard Format (DOCX)
  - Samoan Accessible Format (PDF)
  - Spanish Standard Format (DOCX)
  - Spanish Accessible Format (PDF)
  - Tagalog Standard Format (DOCX)
  - Tagalog Accessible Format (PDF)



**Excluded Services & Other Covered Services:**

**Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)**

- Cosmetic surgery
- Dental care (Adult)
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care

**Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)**

- Acupuncture (if prescribed for rehabilitation purposes)
- Bariatric surgery
- Chiropractic care
- Hearing aids
- Weight loss programs

**Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: [insert State, HHS, DOL, and/or other applicable agency contact information]. Other coverage options may be available to you, too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

**Your Grievance and Appeals Rights:** There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: [insert applicable contact information from instructions].

**Does this plan provide Minimum Essential Coverage? Yes.**

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

**Does this plan meet the Minimum Value Standards? Yes.**

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

**Language Access Services:**

Spanish (Español): Para obtener asistencia en Español, llame al [insert telephone number].
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa [insert telephone number].
Chinese (中文): 如果需要中文的帮助，请拨打这个号码[insert telephone number].
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' [insert telephone number].
Pennsylvania Dutch (Deitsch): Fer Hilf griege in Deitsch, ruf [insert telephone number] uff.
Samoan (Gagana Samoa): Mo se fesoasoani i le Gagana Samoa, vala'au mai i le numera telefoni [insert telephone number].
Carolinian (Kapasal Falawasch): ngere aukke ghut alillis reel kapasal Falawasch au fafaingi tilifon ye [insert telephone number].
Chamorro (Chamoru): Para un ma ayuda gi finu Chamoru, à'gang [insert telephone number].

*To see examples of how this plan might cover costs for a sample medical situation, see the next section.*

**PRA Disclosure Statement:** According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-1146**. The time required to complete this information collection is estimated to average **0.02** hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

[* For more information about limitations and exceptions, see the plan or policy document at [www.insert.com].]

Page 4 of 5

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**Where to Access SBC Translations:**
**https://www.cms.gov/marketplace/resources/forms-reports-other**

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# Will SBC Enforcement Finally Ramp Up?

**Full Details:** Providing SBCs to Employees

## The Neverending Story: Good Faith Enforcement Safe Harbor

### SBC Penalty Provisions

- An employer that willfully fails to provide SBCs in accordance with the SBC rules is subject to a penalty of up to $1,443 (indexed) per failure
  - Failure with respect to each employee or dependent constitutes a separate offense
  - If the employee has a family of four, the penalty could be up to $5,772!
- Failures may also trigger the standard $100/day ACA excise tax liability under IRC §4980D
- Failures may also be considered a breach of fiduciary duty under ERISA

### Temporary Good Faith Standard Appears to Still Apply

- Since SBCs took effect in 2012, Tri-Agencies (DOL/IRS/HHS) have stated that they "will not impose penalties on plans and issuers that are working diligently and in good faith to provide the required SBC content in an appearance that is consistent with the [SBC rules]"
- Tri-Agencies reiterated in 2014 that this good faith enforcement safe harbor from potential penalties applies "until further guidance is provided"
- Although it raised eyebrows that the good faith standard went unaddressed in the most recent 2015 SBC regulations, no further guidance has wound down this long-lasting safe harbor

### Will the IRS Finally Enforce the SBC Rules?

- During the Obama Administration when the good faith standard began, SBCs were new and therefore it made sense to have a transitional period
- Given the long runway now (over a decade) for employers to adjust, it seems appropriate to consider an end to the penalty relief soon
- As we enter a new era of SBC templates/translations, it may be time to wind down the relief and begin enforcement

# Fully Insured Nondiscrimination Rules Delayed Until…?

**Full Details:** What's Left to be Implemented Under the ACA?

## ACA Added Fully Insured Nondiscrimination Rules

- The ACA provides that insured group health plans will be subject to rules "similar to" the nondiscrimination requirements that have long applied to self-insured plans under Internal Revenue Code §105(h)
- These rules technically were scheduled to apply at the same time as the first wave of market reforms (first plan year on or after September 23, 2010)
- **However, the IRS issued Notice 2011-1 at the end of 2010 confirming that employers are not required to comply until the Departments issue regulations or other administrative guidance to implement the rules**

## Will the Trump Administration Finally Implement/Enforce?

- The Notice states that any such guidance will not apply until plan years beginning a specified period after issuance
  - For example, they may not apply until the first plan year beginning on or after six months following the regulatory issue date
- One of the few employer-side ACA items that may have actually been affected by Trump's ACA executive order
- Will Treasury/IRS now take up these rules under a Trump administration? They seem to have largely slipped off the radar
- If they do implement the rules, we should still have plenty of time before they take effect to revise any problematic plan structures

06

# COBRA High Five

Celebrating COBRA's 40th Birthday!

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# Part I: Independent Election Rights

**COBRA qualified beneficiaries have independent election rights. Each qualified beneficiary can elect and maintain COBRA coverage independently.**

**Full Details:** COBRA High Five Part I: Indepndent Election Rights

| Independent Election Rights | Coverage Requirements |
|---|---|
| **Individuals Who Can Be Qualified Beneficiaries:**<br>*Employees*<br>*Spouses*<br>• As defined by federal law<br>• Includes same-sex and opposite-sex spouses<br>• Does not include domestic partners<br>*Children*<br>• Determined by eligible child definition under the plan<br>*Children born to or adopted by covered employee during COBRA coverage* | **Must Be Covered Upon Qualifying Event:**<br>• Mere eligibility for the plan is not sufficient to be a qualified beneficiary<br>• Individuals not covered by the plan will not have independent COBRA rights upon any of the triggering events<br>**Non-Qualified Beneficiaries (including Domestic Partners):**<br>• Can still be added as a dependent<br>• However, will have no independent election/coverage rights<br>  • Those not covered at time of qualifying event can be added at open enrollment<br>  • Will lose COBRA coverage if covered employee dies or drops COBRA |

# Part II: The Notices of Unavailability and Termination of Coverage

**Full Details:** COBRA High Five Part II: The Notices of Unavailability and Termination of Coverage

| | |
|---|---|
| **The Notice of Unavailability of Continuation Coverage** | • **Applies Where:** Plan denies a request for continuation coverage by individuals not entitled to COBRA or not entitled to a requested extension<br>• **Who Must Receive:** Any individual denied a request for COBRA continuation coverage or an extension of such continuation coverage<br>• **Content:** Explain to the individual why they are not entitled to the requested COBRA continuation coverage or an extension of such continuation coverage<br>• **Deadline to Provide:** Within 14 days after the request is received |
| **The Notice of Termination of Continuation Coverage** | • **Applies Where:** Qualified beneficiary's right to COBRA will end prior to expiration of the maximum coverage period<br>• **Who Must Receive:** The qualified beneficiary losing COBRA<br>• **Content:** The reason COBRA is terminating early, the date of termination, and any rights to other alternative coverage (e.g., Exchange)<br>• **Deadline to Provide:** As soon as practicable following determination of termination |
| **Examples** | • **Notice of Unavailability:** No qualifying event, not a qualified beneficiary, failure to timely elect, not entitled to extension based on disability or second qualifying event<br>• **Notice of Termination:** Failure to timely pay premium, enrollment in another group health plan or Medicare, loss of disability status for extension, fraud or similar conduct |

# Part III: The COBRA Premium Grace Period and Shortfalls

**Full Details:** COBRA High Five Part III: The COBRA Premium Grace Period and Shortfalls

## The Grace Periods: *Initial and Ongoing Monthly*

**The Initial Premium Payment (45 Days):**

- Due within 45 days of the COBRA election

**Ongoing Monthly Payments (30-Day Grace Period):**

- Due within 30 days after the monthly premium due date
- Means there is a 30-day grace period following each deadline
- Ensure plan lists deadline as actual due date (not the 30-day grace period deadline) to avoid inadvertent extensions

**Example:**

- July 1 due date for Michael's COBRA ongoing monthly premium
- Michael makes payment on July 26
- Payment is timely b/c made before end of 30-day grace period

## Premium Shortfalls: *Insignificant and Significant*

**Significant Shortall**

- Plan can terminate coverage for failure to timely pay

**Insignificant Shortfall**

- Payment shortfall is no greater than the lesser of:
  1. $50; or
  2. 10% of the full premium amount required for the month

Plan has two options for how to address a shortfall:

1. ***Accept the Short Payment:*** Deem the payment received to be a full payment of the required COBRA premium; or
2. ***Notice of Deficiency:*** Send the qualified beneficiary a notice of the shortfall and provide a "reasonable period" (at least 30 days) to pay the balance owed

# Part IV: Coverage During the Election and Premium Period (Prior to COBRA Taking Effect)

**Full Details:** COBRA High Five Part IV: Coverage During the Election and Premium Period

## COBRA Generally Provides Continuous, Seamless Coverage

- In other words, almost always a timely COBRA election and payment provides coverage retroactive to the instant active coverage terminated
- Two exceptions where COBRA can include a gap in coverage between the period of active coverage COBRA (removal of spouse in anticipation of divorce, failure to return from FMLA)

Plan Options by Type:

**1 HMO**

1. Require prior timely election/payment
2. Require subsequent timely election/payment
3. Charge for services

&

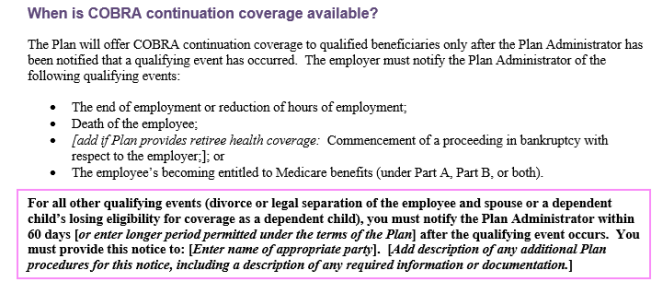
**2 PPO**

1. Continue providing coverage pre-payment
2. Terminate and retroactively reinstate coverage upon payment

# Part V: Required Notice From Employees/Dependents

**Full Details:** COBRA High Five Part V: Qualifying Event Notices from Empoyees and Dependents

## The Model COBRA Initial Notice Informs Employees/Dependents:



**When is COBRA continuation coverage available?**

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee;
- *[add if Plan provides retiree health coverage:* Commencement of a proceeding in bankruptcy with respect to the employer;]; or
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

**For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days [*or enter longer period permitted under the terms of the Plan*] after the qualifying event occurs. You must provide this notice to: [*Enter name of appropriate party*]. [*Add description of any additional Plan procedures for this notice, including a description of any required information or documentation.*]**

## Which Events Require Notice?

- Divorce or Legal Separation from Employee (causing spouse to lose plan eligibility)
- Loss of Eligible Dependent Status (e.g., child reaching age 26)
- Disability Extension

## The Employee/Dependent Notice Requirement:

*Divorce/Legal Separation/Loss of Eligible Dependent Status*

- Employee or dependent is responsible for notifying the plan **within 60 days** of the event

*Disability Extension*

- Qualified beneficiary must notify the plan **within 60 days** of the SSA disability determination

## Consequences of Failure to Provide Timely Notice:

- Oftentimes the employee or dependent is not aware of the requirement to provide notice to the employer/plan
- Failure to provide timely notice can cause the employee or dependent to lose their COBRA rights under the plan
- Employers considering exceptions need to ensure carrier/stop-loss approval and consider the ERISA plan precedent concerns

WRAP-UP

# Takeaways

# Year in Review – Top Six Summary

**Remember:** This is just a short thumbnail sketch of the boundless issues we face in employee benefits compliance for health and welfare plans. For all the latest alerts, guides, and FAQs throughout the year: https://www.newfront.com/blog/category/compliance

## 1 The OBBB Adds New EB Features and Options

- First-dollar telehealth access does not affect HSA eligibility
- DPC coverage does not affect HSA eligibility
- DPC premium an eligible HSA expense
- Dependent care FSA limit bump to $7,500
- Tax-free student loan reimbursement made permanent
- Trump Accounts provide child savings opportunities

**Key New Point for 2026**

- OBBB offers multiple new changes for employers to consider

## 2 ACA Employer Mandate & Reporting

- The §4980H employer mandate penalties continue be enforced—make sure to offer affordable coverage to all full-time employees to avoid potential liability
- The affordability threshold increases in 2026 to 9.96%, automatic pass by offering coverage at or below $129.89/month

**Key New Point for 2026**

- Distribution of Forms 1095-C to all full-time employees is no longer required—can instead be available upon request

## 3 CAA Reaches Full Implementation

- Employers with fully insured plans can largely rely on their insurance carrier to address most of the CAA requirements
- Employers with self-insured plans (including level funded) need to coordinate with the TPA to determine what aspects they will assume on the plan's behalf

**Key New Point for 2026**

- The new MHPAEA employer fiduciary certification rule has been delayed at least 18 months

## 4 Potential Trump Administration Priorities

- The OBBB House bill had many more HSA expansions that may still be on the table
- The OBBB House bill also had major improvements for ICHRA that could be a lingering priority
- Federal PBM reform almost passed in the funding bill at the end of 2024 and is still a talking point
- Association health plan expansion could also receive attention

**Key New Point for 2026**

- Republicans still have the trifecta and therefore can use reconciliation again

## 5 The Other News

- The J&J and other related cases put a spotlight on fiduciary duties and PBM issues
- HIPAA Notice of Privacy Practices needs substance use disorder update by 2/16/26
- California imposes new PBM reform and IVF mandates in 2026
- The Medicare Part D creditable coverage determination becomes more difficult for 2027
- New SBC templates for updated languages

**Key New Point for 2026**

- The employee benefits news arena continues to move fast, expect many new developments

## 6 COBRA Turns 40!

- Qualified beneficiaries each have independent election rights
- Provide notice when COBRA not available or terminates early
- Grace periods apply for initial and subsequent monthly premiums
- COBRA provides continuous, seamless coverage during the election/payment period
- Employees and dependents must provide notice for certain events

**Key New Point for 2026**

- As COBRA reaches its 40th birthday, a reminder to continue prioritizing compliance—even for the tricky rules

# Content Disclaimer

Employee Benefits Year in Review

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# Thank You

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