Brown & Brown

EMPLOYEE BENEFITS

2026 Compliance Guide

December 2025

From the Brown & Brown Regulatory and Legislative Strategy Group

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Affordable Care Act (ACA)

The following are certain disclosures, notices and reporting currently required for group health plans under the ACA. This is not an exhaustive list of ACA requirements, nor does it include past requirements that are no longer applicable, or future requirements that are not yet effective.

Summary of Benefits and Coverage (SBC)

Group health plans (other than excepted benefits and retiree plans) are required to furnish an SBC for each benefit option. The SBC is a uniform explanation of benefits that is required in addition to other ERISA disclosure requirements (i.e., SPDs). Regulations specify language and format that must be used. The DOL issued final SBC regulations and instructions in April 2016. The rules apply to all SBCs created on or after April 1, 2017.

More recently, the DOL released a new SBC template that is required to be used with respect to all plan years beginning on or after January 1, 2021. Current and revised SBC templates can be found on the DOL website.

SBCs must be distributed:

1. At initial enrollment;
2. Annually at re-enrollment;
3. Within 90 days after enrollment resulting from a special enrollment right; and
4. Within seven (7) business days of an employee/beneficiary request.

Notice of mid-year material modifications to an SBC must be provided at least 60 days ***prior to*** the effective date of the change.

Model Notice to Employees of Coverage Options ("Marketplace/ Exchange" Notice)

The notice must broadly describe the existence of the Health Insurance Marketplace and the ramifications if an employee purchases individual coverage on the Marketplace instead of enrolling in the employer's coverage. The notice must be provided to new employees within 14 days of the employee's start date. This includes employees who are not eligible for the employer's health benefits.

Grandfathered Health Plan Disclosure – Grandfathered Health Plans Only

Grandfathered health plans must include language (in any plan materials describing the plan's benefits), indicating that the plan believes it is a grandfathered health plan under the health care reform law. The language must provide contact information for plan participants to ask questions and make complaints.

Internal Appeals and External Review Requirements – Non-Grandfathered Health Plans Only

Plans must ensure their internal appeals process satisfies the procedural requirements imposed by the ACA, and an external review process must also be made available to plan participants. Model notices have been issued for claim denials/external review decisions, and specific language regarding the updated appeals processes also is required to be included in plan documents and SPDs. Employers should confirm that their health plan's appeals procedures comply with these requirements.

Selecting a Benchmark Plan

The final market reform rules require self-insured and large group insured plans to select one of the three Federal Employees Health Benefit Program (FEHBP) options or a state benchmark plan to define essential health benefits (EHBs) for the purposes of ensuring the plan imposes no annual or lifetime dollar limits on any EHBs offered under the health plan. This requirement applies to benefits provided in- or out of-network.

Patient Protection Disclosure – Non-Grandfathered Health Plans Only

Health plans that require the designation of a primary care physician (PCP) by a plan participant must provide a notice of patient protections under health care reform whenever the plan or issuer provides a participant with a summary plan description or other similar description of benefits under the plan or health insurance coverage.

NOTE: Plans that do not require/allow PCP designations are not required to provide this notice. In general, most Preferred Provider Organizations (PPOs) do not require PCP designation; however, we are seeing some carriers request or assign PCPs on PPOs for provider payment under accountable care contracts. We recommend confirming if this notice applies to your plans.

Medical Loss Ratio (MLR) Reporting

Health insurers of fully insured plans (including grandfathered plans) are required to report to HHS each year the percentage of their premium revenue that the insurer spent on 1) clinical services for enrollees, 2) "activities that improve health care quality," and 3) all other non- claims costs, excluding federal and state taxes and licensing or regulatory fees. Insurers in the small group market must spend at least 80% and insurers in the large group market must spend at least 85% of their premium revenues (excluding federal and state taxes and licensing and regulatory fees) on clinical services and quality improvement activities. Insurers that fail to do so will have to rebate the difference to their enrollees. Under the HHS rule, rebates must be paid by September 30 of the year following the year for which the MLR data is reported. In the case of an employer group health plan, rebates must be paid to the policyholder (that is, the employer). Insurers must also report to their enrollees how the rebate was calculated.

The employer is often required to return a portion of the rebate to, or use a portion of the rebate for the benefit of, the plan participants as opposed to simply retaining the entire rebate. More information regarding these requirements is available here. If an employer receives an MLR rebate, it should review its obligations with legal counsel.

EMPLOYER FAQ →

Rescission of Health Plan Coverage

Group health plans may not retroactively rescind coverage except when a plan participant commits fraud or intentional misrepresentation of a material fact related to such coverage. A rescission includes any retroactive termination or retroactive cancellation of coverage, except for a termination or cancellation due to a failure to timely pay premiums.

Therefore, if an employee is enrolled in the plan and makes the required contributions, then the employee's coverage may not be rescinded if it is later discovered that the employee was mistakenly enrolled and not eligible to participate in such coverage. If a mistake was made and there was no fraud or intentional misrepresentation of a material fact, then the employee's coverage may be canceled prospectively, but not retroactively. In cases where a rescission is permitted, the plan must provide the covered person with at least 30 days of advance written notice of the rescission.

Patient Centered Outcomes Research Institute Fee (PCORI)

Imposed on issuers of insurance policies and sponsors of self-insured health plans starting with the first plan year ending after September 30, 2012. While originally set to sunset with plan years ending on or after October 1, 2019, the 2020 SECURE Act extended the PCORI fee for an additional ten years.

The PCORI fee (as indexed for inflation) will continue to apply to all plan years ending before October 1, 2029. The applicable dollar amount that must be used to calculate the fee imposed by sections 4375 and 4376 for policy years and plan years that end on or after October 1, 2024, and before October 1, 2025, is $3.47. The fee for plan years ending on or after October 1, 2025 and before October 1, 2026 is $3.84 per covered member. The fee is reported and paid once per year on IRS Form 720 no later than July 31 of the calendar year immediately following the last day of the plan year for which the fee is owed. For fully insured plans, the carrier will make the payment on the employer's behalf. If a health plan is self-insured or has an HRA integrated with a fully insured plan, the health plan sponsor/employer is responsible for making the payment directly to the IRS. Employers/plan sponsors that sponsor a fully insured plan and an HRA can use the "one life per participant" rule - meaning spouses and dependents need not be counted in the PCORI fee calculation.

**The PCORI fee is inflation-adjusted annually based on the Centers for Medicare and Medicaid Services (CMS) annual increase in national health expenditures.*

Employer Shared Responsibility ("Play or Pay")

Applicable Large Employers (ALEs) subject to the ACA's Employer Shared Responsibility requirement are those employers with 50 or more full-time and full-time equivalent employees on average during the preceding calendar year. ALE status is determined by counting all employees in a controlled group or affiliated service group. Under this provision, employers are subject to penalties if they do not offer health coverage (minimum essential coverage (MEC)) to substantially all of their full-time employees and their dependents, and at least one full-time employee receives a premium tax credit and purchases coverage on the Marketplace (public Exchange). "Full-time employee" is defined as a common-law employee who is employed an average of at least 30 hours of service per week (or at least 130 hours of service per calendar month) determined using the monthly measurement method or the look-back measurement method.

- "Substantially all" is defined as offering MEC to at least 95% of all full-time employees in the applicable month.
- "Dependents" is defined to include only natural/adopted children to the end of the month they attain age 26, but does not include spouses.

If the applicable threshold is not met, and at least one full-time employee (who may or may not have been offered coverage) receives a premium tax credit and purchases coverage on the Marketplace (public Exchange), the employer is subject to a penalty per common-law full-time employee that works for the employer, with the penalty waived for the first 30 full-time employees. The thresholds and corresponding penalties are evaluated on a monthly basis. For 2025, the penalty is $241.67 per month (1/12 of $2,900) x the number of full-time employees (minus 30) x the number of months in which the threshold is not met. The penalty is indexed each year for inflation, and the 2026 adjusted amount increases to $278.33 per employee per month (1/12 of $3,340).

Rather than evaluating eligibility on a monthly basis, the IRS has outlined an alternative look-back measurement method that can be used by employers with a large population of part-time and/or "variable hour employees" (an employee whose hours of service per week cannot be reasonably determined to be full-time at date of hire). This allows employers to avoid the penalty if they provide prospective eligibility to employees who met the definition of full-time in the retrospective measurement period.

Even if an ALE offers "substantially all" of its full-time employees MEC, the employer may still be subject to a penalty if the coverage isn't offered to a full-time employee who then receives a premium tax credit and purchases coverage on the public Marketplace/Exchange, or the coverage offered to full-time employees is inadequate (less than 60% minimum value) or unaffordable (employee-only coverage costs more than 9.02% (in 2025) of household income). The affordability safe harbor percentage increases to 9.96% in 2026. For 2025, the penalty is $362.50 (1/12 of $4,350) x the number of full-time employees who receive a premium tax credit or cost sharing assistance per month. For 2026, the inflation-adjusted penalty will be $417.50 (1/12 of $5,010) x the number of full-time employees who receive a premium tax credit or cost sharing assistance per month.

The IRS recognizes that employers do not know employees' household incomes and have therefore issued three affordability safe harbors (Federal Poverty Line, Rate of Pay and W-2) that are generally based only on the earnings of the employee. NOTE: If an employer offers an opt-out payment for employees who waive coverage, the amount of the payment may be required to be included in the affordability calculation unless it was in place by December 16, 2015 or it is conditioned on the employee providing reasonable evidence of enrollment by the employee and their expected tax family in minimum essential coverage that is not individual market coverage.

Large Employer Reporting

Applicable Large Employers and other entities are required to annually report (regarding the prior calendar year) health coverage information to assist the IRS in administering premium tax credits and making employer penalty determinations. The reports (due after the year ends) must include information related to full-time employee status and coverage information for each month of the calendar year.

There are two reporting requirements:

1. **Code Section 6055 reporting:** Requires various reporting entities (including employers and insurance carriers) to report information on each individual with minimum essential coverage. The IRS intended to use the information to enforce the individual mandate, but that mandate has since been effectively repealed because the penalty has been reduced to $0. However, these reports may still be useful in states that have adopted a state-based individual mandate. The forms used for filing returns are 1094-B (transmittal form) and 1095-B (individual statement). Reporting for Applicable Large Employers that are self-funded plan sponsors can be satisfied by submitting the 1094-C and 1095-C forms (referenced below); however, in this situation an employer may still issue the B forms for reporting on enrolled non-employees. A provider of minimum essential coverage will be treated as having satisfied the Section 6055 requirements if the form is made available through the provider's website and certain conditions are met as further described in the Instructions for Forms 1094-B and 1095-B.
2. **Code Section 6056 reporting:** Requires Applicable Large Employers that are subject to the Employer Shared Responsibility (Play or Pay) penalties to report information on the coverage offered to full-time employees. The IRS will use the information to enforce the play or pay penalties. The forms used for filing returns are 1094-C (transmittal form) and 1095-C (individual statement). Self-funded employers that are also Applicable Large Employers will be permitted to satisfy both Code Section 6055 and Code Section 6056 reporting requirements by submitting a combined information return. There are also simplified Section 6056 reporting alternatives that may apply to certain employers/groups of employees. In concept, the reports are similar to Form W-2 reporting – for example, an aggregate filing must be made to the IRS, and an individual statement must be provided to applicable employees.

Employee statements must be furnished no later than the first business day that occurs 30 days on or after January 31 following the end of the calendar year being reported (i.e., 2025 employee statements must be furnished to employees by March 2, 2026). In the alternative, effective for reporting years beginning in 2024 and beyond, IRS guidance in Notice 2025-15 confirms that employers may satisfy their Form 1095-C delivery obligations to full-time employees by posting a "clear, conspicuous, and accessible notice" on their website that notifies full-time employees of their ability to request their Form 1095-C in paper form from the employer.

The notice needs to include an email address, a physical mailing address where full-time employees/covered individuals can send requests for a copy of their Form 1095-B or Form 1095-C, and a phone number for full-time employees/covered individuals to call with questions. The notice should be written in simple, everyday language and use a font size that is large enough—possibly with visual cues or graphics—clearly stating that these are tax statements related to health coverage. For instance, the entity's website could feature a statement on the main page, or a link labeled "Tax Information" that leads to another page with a bold, all-caps heading like "IMPORTANT HEALTH COVERAGE TAX DOCUMENTS." This page would explain how full-time employees/covered individuals can request a copy of their Form 1095-B or Form 1095-C, and, if the entity is an ALE with a self-insured health plan reporting under specific rules, the page would also explain how non-full-time employees or non-employees enrolled in the plan can request their Form 1095-C, while listing the entity's email, mailing address, and phone number.

Employers must post the "clear, conspicuous, and accessible notice" on or before the annual furnishing deadline for Forms 1095-B and 1095-C (e.g., March 2, 2026, for the 2025 reporting year) and keep the notice posted until October 15 of the applicable furnishing year (i.e., the year following the applicable reporting year).

If an individual requests a paper copy of the Form 1095-B or Form 1095-C, the employer is required to provide a paper copy to the requester by the later of January 31 of the year following the reporting year or 30 days following the request, whichever is later.

The IRS filing is due no later than the first business day on or after February 28 (if filed by mail) or March 31 (if filed electronically) following the end of the calendar year being reported (i.e., 2025 filings are due March 2, 2026 (if filed by mail) or March 31, 2026 (if filed electronically)). Employers issuing ten or more information returns (including W-2, 1099, 1095-C, and others) must file electronically via the AIR system. See Instructions for Forms 1094-C and 1095-C.

Reporting is subject to the general reporting penalty provisions under section 6721 (failure to file correct information returns) and section 6722 (failure to furnish correct payee statement). The current penalty for failure to file an IRS return or provide individuals statements is up to $340 per return with a calendar year maximum penalty of up to $4,098,500.

W-2 Reporting

Employers providing applicable employer-sponsored group health plan coverage are required to report the aggregate cost of applicable employer-sponsored group health plan coverage in Box 12 of an employee's Form W-2 with code "DD." Employers who issued fewer than 250 Form W-2s in the preceding calendar year are not subject to the reporting requirement until further guidance is issued.

Section 1557 Nondiscrimination

Section 1557 of the Affordable Care Act (ACA) prohibits covered entities from discriminating in health programs on the basis of race, color, national origin, age, disability or sex. On May 6, 2024, HHS issued amended final regulations on Section 1557, with the final regulations becoming effective on January 1, 2025.

These rules apply to "covered entities," which include health programs or activities that receive HHS funding, health programs or activities administered by HHS (such as the Medicare Part D program), and the health insurance Marketplace. From a group health plan perspective, the Section 1557 requirements would only apply to group health plans that receive federal financial assistance, such as plans that receive retiree drug subsidy payments or Employer Group Waiver Plans (EGWPs). Covered entities must take "reasonable steps" to provide an annual notice of nondiscrimination and a notice of the availability of language assistance services and auxiliary aids (at no cost) to participants, beneficiaries, enrollees, and applicants. The information must be provided in English and the top 15 non-English languages spoken by people in the state where the covered entity operates and must be posted on the covered entity's website. HHS provides sample notices on their website.

Accommodations must be provided by the covered entity to ensure that any services available telephonically are accessible to those with disabilities and limited English proficiency. In addition, covered entities must implement policies and training, and a "Section 1557 Coordinator" must be designated to ensure compliance with the Section 1557 requirements.

In the opening days of 2025, President Trump signed an executive order titled "Defending Women From Gender Ideology Extremism and Restoring Biological Truth to the Federal Government." This Executive Order firmly establishes the Trump Administration's position that "sex" means an individual's unchangeable biological status as male or female, explicitly excluding gender identity from that definition. The Executive Order also directed federal agencies to apply this definition when upholding laws related to sex-based protections and rights and promptly rescind all guidance documents inconsistent with this Executive Order. As a result, employers should be aware that various government agency website links to Section 1557 guidance may not be operational as government agencies attempt to comply with the Executive Order's directives.

Additionally, there is ongoing litigation regarding significant portions of the Section 1557 2024 final regulations and whether Section 1557 applies to group health plans. Employers that are covered entities should consult with counsel to determine their obligations under Section 1557.

ERISA Reporting and Disclosure

Form 5500

Must be filed with the Department of Labor within seven (7) months after the end of the plan year. May be extended to 9½ months by filing Form 5558 by the last day of the seventh month after the end of the plan year. (Exception – Form 5500 is not required for fully insured and unfunded plans covering fewer than 100 employees as of the first day of the plan year).

Summary Annual Reports (SARs)

Must be distributed to participants within nine (9) months following the end of the plan year or two (2) months after the due date for the Form 5500 filing (including any extensions). Doesn't apply to plans exempt from Form 5500 filing.

Summary Plan Description (SPD)

Must be distributed:

- Within 30 days of written request by a participant or beneficiary;
- Within 90 days of enrollment for new participants;
- Every five (5) years if material modifications are made during that period; or
- Every ten (10) years if no amendments occur.

SPD content must explain the plan's benefits, claim review procedures and the participant's ERISA rights.

Summary of Material Modifications (SMM)

Generally, must be distributed to employees within 210 days following the end of a plan year in which a material change to the plan occurred.

However, in the case of a material reduction in group health plan covered services, the SMM must be distributed to employees within 60 days following adoption of the reduction. Further, note that for mid-year modifications affecting the information in the Summary of Benefits and Coverage (SBC), the new SBC must be provided 60 days prior to the effective date of the change.

Plan Documents

Must be furnished to participants and beneficiaries within 30 days of written request, and copies must be available for examination. This participant right also includes SPDs, SMMs, Forms 5500, trust agreements and other instruments under which the plan is operated.

Qualified Medical Child Support Order (QMCSO)

Rules require that a plan must issue notice to the employee upon receipt of an QMCSO that outlines procedures for qualification. Notice must also be sent when the plan determines whether the QMCSO is qualified. The SPD must include the procedures or inform participants of the right to receive a copy of the procedures.

ERISA Fiduciary Duties

All private plans (except church, governmental plans, and some Indian tribal plans) are subject to ERISA. Every ERISA plan must designate one or more named fiduciary/fiduciaries (often the plan administrator) of the health and welfare benefit plan. A fiduciary may be designated by the plan, or an individual may become a fiduciary by the nature of their role. ERISA imposes a variety of responsibilities on these health and welfare plan fiduciaries. Primary fiduciary duties related to a health benefit plan include (1) acting in the best interest of the plan participants and beneficiaries (duty of loyalty); (2) using plan assets for the exclusive purpose of providing plan benefits and defraying reasonable plan administration expenses (exclusive benefit rule); (3) acting with the care, skill, and diligence that a prudent person acting in a similar capacity would use (prudent expert rule), including when selecting vendors and monitoring their performance; and (4) administering the plan in accordance with its terms. Fiduciaries should ensure that proper documentation is in place for the plan (e.g., plan document, SPD, etc.) and should implement, follow, and document any processes that a fiduciary would abide by to carry out their fiduciary duties. Plan sponsors should consult with legal counsel to confirm they are complying with the fiduciary duties applicable to their health and welfare plans under ERISA.

ERISA Electronic Disclosure Requirements

Most ERISA SPDs, notices and disclosures can be provided electronically if the DOL safe harbor requirements are met. Electronic disclosure includes providing documents via email or posting on a website.
In general, the safe harbor is met if a plan administrator:

- Uses “appropriate and necessary” means to ensure that the electronic disclosure/delivery results in actual receipt by the employee;
- Meets all other distribution requirements (e.g., timing and format); and
- Provides a notice to employees of the significance of the document and where it is located (for example, attaching the document to the email or providing a link to the employer’s website where the document is located), and that a paper copy is available upon request at no charge. This notice must be provided each time the document is required to be distributed and electronic disclosure is used.

For individuals who work with a computer as a regular part of their job, the above requirements are sufficient. This applies to individuals who have the ability to access the documents at a location where he/she is expected to perform his/her job duties and has computer access as an integral part of his/her job.

There are additional requirements for employers that wish to use electronic disclosure for participants who do not work with a computer as a regular part of their job. In these instances, individuals must affirmatively consent to the electronic disclosure and provide the email address they would like used. The consent must be made in a way that demonstrates the individual’s ability to access the electronic format used (such as replying to an email sent to that address). Prior to requesting consent, the employer must let individuals know about the type of documents that will be provided in this manner, how they can access them, the right to request a paper copy without charge and the right to withdraw consent or update information and the process to do so. It is likely that most employers have both populations: those who work with a computer as a regular part of their job for whom electronic disclosures suffice, and those who do not work with a computer as a regular part of their job for whom paper documents may still be the easiest method of distribution. Like all compliance topics outlined in this document, legal counsel should confirm your ability to rely on the ERISA Electronic Disclosure safe harbor.

Consolidated Omnibus Budget and Reconciliation Act (COBRA)

COBRA generally requires all group health plans to provide covered employees and dependents an opportunity to continue coverage under the plan when such coverage would be lost as a result of a particular qualifying event (which are specified in the statute). COBRA imposes a variety of notice requirements on group health plans.

General Notice

Group health plans must give each employee and each spouse of an employee who becomes covered under the plan a general notice describing COBRA rights. The general notice must be provided to a plan participant within the first 90 days of coverage. Group health plans can satisfy this requirement by furnishing the notice to plan participants (e.g., employees and spouses), or by including the general notice in the plan's SPD (provided the SPD is distributed to both the employee and the spouse within the applicable time limit). The DOL updated its model COBRA general notice in January 2023 to include a new expiration date of January 31, 2026. As of the time of this publication, the DOL has not yet updated its model COBRA general notice for beyond January 31, 2026. Employers may generally continue to use the current model COBRA general notice until the DOL issues an updated version with a new expiration date.

Election Notice

Group health plans must also send a COBRA election notice to qualified beneficiaries following a qualifying event. For certain qualifying events (termination of employment, reduction of hours and death of an employee), the employer has 30 days to notify the plan administrator and the plan administrator has 14 days to send the notice to qualified beneficiaries (44 days if the employer is also the plan administrator*). For other qualifying events (divorce, legal separation and a child ceasing to be eligible), the covered employee or other qualified beneficiary has 60 days to notify the plan administrator, and the plan administrator has 14 days to send the notice.

The DOL updated its model COBRA election notice in January 2023 to include a new expiration date of January 31, 2026. As of the time of this publication, the DOL has not yet updated its model COBRA election notice for beyond January 31, 2026. Employers may generally continue to use the current model COBRA election notice until the DOL issues an updated version with a new expiration date.

**The plan administrator is not the same as the COBRA administrator.*

Notice of Unavailability

Group health plans must send a notice of unavailability of COBRA coverage if the plan administrator determines that an individual is not eligible for COBRA coverage. This notice must be furnished within 14 days of the administrator's receipt of the coverage election notice furnished by the covered employee or other qualified beneficiary for qualifying events that include divorce, legal separation or a child ceasing to be eligible.

Notice of Early Termination

Group health plans must send a notice of early termination of COBRA coverage to qualified beneficiaries if COBRA coverage terminates earlier than the maximum period of coverage. The notice must be provided by the plan or COBRA administrator as soon as practicable after the decision to terminate COBRA coverage is made.

COBRA Notice of Insufficient Payment

If a COBRA premium payment is insufficient by an "insignificant amount," a notice must be provided of the insufficient payment. (In addition, a reasonable period of time, such as 30 days, must be given to pay the insufficient amount).

Health Insurance Portability and Accountability Act (HIPAA)

Special Enrollment Rights

Special enrollment is available under group health plans (other than excepted benefits) in the following situations:

- A loss of eligibility for group health coverage or health insurance coverage;
- The acquisition of a new spouse or dependent by marriage, birth, adoption or placement for adoption; and
- Becoming eligible or ceasing to be eligible for Medicaid or CHIP coverage and/or for Medicaid or CHIP premium assistance subsidies.

Plans must notify eligible employees of their special enrollment rights upon their initial eligibility to enroll in the plan.

Privacy and Security Requirements

Covered entities and business associates must create and implement policies and procedures to comply with the privacy and security rule's standards, implementation specifications and other requirements. Policies and procedures may be changed at any time, but the changes must be documented.

Notice of Privacy Practices

A HIPAA Notice of Privacy Practices must be provided to participants and beneficiaries upon enrollment and when there are material changes to the notice, generally within 60 days of the material change. Every three years, the notice must be re-issued, or participants must be notified that a Notice of Privacy Practices is available and how to obtain it.

On April 26, 2024, the Office for Civil Rights at the Department of Health & Human Services published its "Final Rule to Support Reproductive Health Care Privacy" ("Reproductive Health Care Rule"). The final rule, which was originally effective December 23, 2024, adopted a "purpose-based prohibition" on the disclosure and use of reproductive healthcare-related information of covered individuals under HIPAA.

However, on June 18, 2025, the U.S. District Court for the Northern District of Texas in Purl v. United States Department of Health and Human Services, vacated most of the Reproductive Health Care Rule published in April 2024. The District Court's order vacating the majority of the Reproductive Health Care Rule applies nationwide with immediate effect. Plan sponsors who updated their HIPAA policies and procedures, business associate agreements, or other HIPAA-related documents to reflect the Reproductive Health Care Rule should consult legal counsel about whether changes to these documents are required to remain compliant with the District Court's decision.

A separate section of the Reproductive Health Care Rule relates to modifications to HIPAA Notices of Privacy Practices (NPPs) related to substance use disorder (SUD) patient records. In February 2024, HHS issued a separate rule, the 2024 Confidentiality of Substance Use Disorder (SUD) Patient Records Final Rule, that included changes to the HIPAA NPP requirements for substance use disorder patient records. However, HHS did not finalize those changes until the April 2024 Reproductive Health Care Rule, where HHS indicated they were aligning the compliance dates for the changes to the NPP for both rules "so that covered entities regulated under both rules can implement all changes to their NPPs at the same time. Covered entities are expected to be in compliance with the modifications to 45 CFR 164.520 on February 16, 2026." The parties and the District Court agreed that the SUD changes to the NPP requirements were separate issues from the reproductive health issues; therefore, the NPP requirement related to SUD records was not vacated by the Court and the deadline to amend NPPs to address SUD records remains **February 16, 2026**.

Nondiscrimination Requirements

Group health plans (other than excepted benefits) may not discriminate with respect to eligibility, benefits and contributions on the basis of health status-related factors.

Other Laws

Children's Health Insurance Program Reauthorization Act (CHIPRA)

Since 2009, special enrollment rights to immediately enroll in an employer's health plan arise if an individual becomes eligible for a state premium assistance subsidy under Medicaid or CHIP. The subsidy helps low-income individuals pay for employer coverage, transferring them from government-sponsored health programs to employer health plans. CHIPRA imposes a notice requirement on employers who maintain health plans with participants residing in one of the states providing a premium assistance subsidy. The notice must be provided annually to all employees residing in each premium assistance subsidy state, including employees not enrolled in the plan. Model notice language, which is periodically updated, is available on the DOL website and includes contact information for each state offering a premium assistance subsidy. Before distributing the notice each year, you should check the DOL website for any updates to the model. (The DOL typically updates the notice each January 31 and July 31.)

Mental Health and Substance Use Disorder Parity

The Mental Health Parity Act of 1996 prohibits group health plans from having lower annual or aggregate lifetime dollar limits for mental health benefits than for medical/surgical benefits. The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) broadened the "parity" requirements by making them applicable to substance use disorder benefits and by mandating parity for financial requirements and treatment limitations.

The MHPAEA rules generally apply to all group health plans except HIPAA excepted benefits and plans sponsored by an employer that averaged 50 or fewer employees during the prior calendar year (100 or fewer employees for non-federal governmental employers in states that define a small employer as 100 or fewer employees). Self-insured non-federal governmental plans previously had the ability to opt out of complying with this law.

However, these plans can make no new elections to opt out of compliance with the MHPAEA effective December 29, 2022. Governmental plans may not renew opt out elections expiring on or after June 27, 2023, subject to a limited exception for plans subject to multiple collective bargaining agreements.

Under the MHPAEA rules, the plan may not impose a financial requirement (deductible, copay, etc.) or quantitative treatment limitation on a mental health/substance abuse benefit in a classification that is more restrictive than the predominant requirement or limitation applied to substantially all medical/surgical benefits in the same classification. Plans must be tested for compliance with the parity law. While not required to be done annually, it should be done when there is a change to plan design (e.g., to a cost sharing or utilization management provision) that affects a financial or treatment limitation within a defined classification or sub-classification.

Plans also may not impose nonquantitative treatment limits (NQTLs) for mental health/substance abuse benefits unless certain conditions are met. Group health plans must complete a comparative analysis that demonstrates that the processes, strategies, evidentiary standards or other factors used to apply any NQTL to the plan's mental health and substance use disorder benefits are comparable to, and applied no more stringently than, the processes, strategies, evidentiary standards and other factors used to apply NQTLs to medical or surgical benefits.

On September 23, 2024, the Departments published final rules that aimed to provide more clearly defined standards to ensure that group health plans, health insurance carriers, and other stakeholders do not apply more stringent NQTLs on access to mental health (MH) and substance use disorder (SUD) benefits as compared to medical/surgical (M/S) benefits within a health plan or policy. The final rules also established additional content requirements for the NQTLs. These comparative analyses must be provided to the DOL and participants/beneficiaries upon request.

However, on May 15, 2025, the Departments released a statement suspending their enforcement of the 2024 MHPAEA Final Rules while they reconsider those rules, including whether to rescind or modify them. Some of the suspended 2024 MHPAEA Final Rules include:

- The ERISA fiduciary certification of engaging in a prudent process of selecting a vendor to perform the NQTL comparative analysis
- The "meaningful benefits standard" for plans that offer coverage based upon a specific condition

The suspension of the 2024 MHPAEA Final Rules is related to the lawsuit that the ERISA Industry Committee (ERIC) filed against the federal government in 2024.

Although the 2024 MHPAEA Final Rules are currently suspended, the statutory rules, the 2013 MHPAEA Final Rules, and the CAA, 2021 amendments made to MHPAEA (see MHPAEA FAQ Part 45), are still in effect and plan sponsors are still subject to these rules. So, the statutory requirement for the performance of an NQTL comparative analysis still exists, and therefore the Departments, participants and beneficiaries may still request a plan's NQTL comparative analysis.

Employers must consult with legal counsel as to whether they should continue pursuing NQTL comparative analysis assistance from third-party vendors, and what the framework for those new comparative analyses should look like.

Michelle's Law

Michelle's Law requires group health plans to continue coverage for dependent college students who take a medically necessary leave of absence or switch to part-time student status due to a serious illness or injury. The leave must be medically necessary, begin while the child is suffering from illness or injury and cause the child to lose coverage. Coverage must extend for one year after the first day of leave. This requirement applies only if a group health plan requires student status for children age 26 or older.

Since the ACA requires coverage for all dependent children up to age 26, regardless of student status, Michelle's Law typically no longer impacts group health plans.

Newborns' and Mothers' Health Protection Act

The Act and its regulations provide that health plans and insurance issuers may not restrict a mother's or newborn's benefits for a hospital length of stay that is connected to childbirth to less than 48 hours following a vaginal delivery or 96 hours following a delivery by cesarean section.

However, the attending provider (who may be a physician or nurse midwife) may decide, after consulting with the mother, to discharge the mother or newborn child earlier. Notice of this law must be included in the SPD.

Women's Health and Cancer Rights Act (WHCRA)

WHCRA requires group health plans to cover reconstructive surgery following a mastectomy. Notices about this law must be provided upon enrollment and annually thereafter.

No Surprises Act and Related Transparency Requirements

The No Surprises Act, which was passed as part of the Consolidated Appropriations Act, 2021, imposes various transparency and surprise medical billing requirements on group health plans. The No Surprises Act builds on the health plan transparency requirements contained in the Affordable Care Act, which were addressed in final regulations released in October 2020. These requirements have been implemented in stages over several years. The following is a list of key provisions within the No Surprises Act/Transparency in Coverage rules:

- Surprise medical bill rules
- Health plan ID card changes
- Prohibition on gag clauses
- Provider directory requirements
- Continuity of care requirements
- Publicly available machine-readable files containing:
  - Payments to and billed charges from out-of-network providers
  - In-network provider rates for covered items and services
  - In-network rates and historical net prices for all covered prescription drugs by plan at the pharmacy-location level (further guidance anticipated)
- Prescription drug cost (RxDC) reporting
- Requirement to make price comparison information available to participants
- Gag Clause Prohibition Compliance Attestation (GCPCA) rules
- Advance EOB requirements (not yet effective)

Additional information regarding these requirements is available in our prior articles:

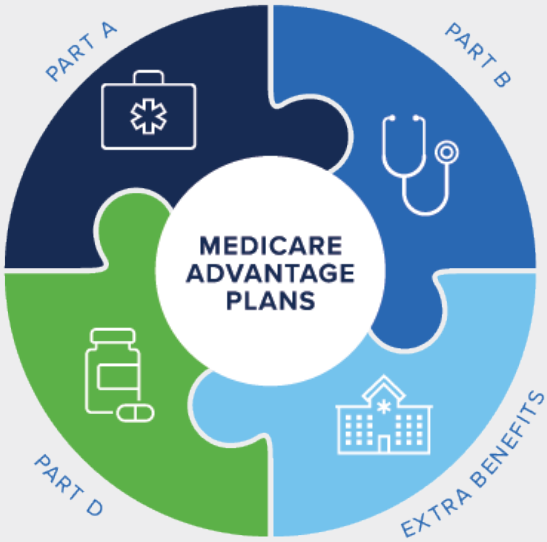
- Requirements for the Surprise Billing Under the No Surprises Act
- Guidance on Health Plan Transparency Rules Delays Some Compliance Dates
- Health Care Cost Transparency Reporting for Group Health Plans
- Departments Issue Further FAQ Guidance on the No Surprises Act and Transparency in Coverage Final Rules
- Gag Clause Prohibition Compliance Attestation

Medicare Requirements

Medicare Part D Creditable Coverage Notice

Employer-sponsored group health plans that provide prescription drug coverage must notify Medicare-eligible plan participants whether the plan's drug coverage is creditable or non-creditable. The notice must be provided to Medicare beneficiaries receiving active or retiree coverage under an employer group health plan, as well as Medicare beneficiaries who are covered as spouses or dependents under an employee's or former employee's group health plan coverage. The notice must be provided prior to the participant's effective date of coverage, prior to an individual's initial enrollment period in Part D*, by October 15 of each year, upon a change in creditable coverage status and upon request.

**An annual notice to all participants by October 15 will satisfy this requirement.*



Determining Creditable Coverage Status

There are three methods for determining whether prescription drug coverage is creditable for purposes of the Medicare Part D Creditable Coverage Notice:

1. Simplified Determination Method

2. Revised Simplified Determination Method

3. Actuarial Determination Method

If an employer's plan does not meet the criteria under either the Simplified Determination Method or the Revised Simplified Determination Method, the plan must use the Actuarial Determination Method to assess creditable coverage status.

Simplified Determination Method to Determine Creditable Coverage Status

The current Simplified Determination method may be utilized for plan years beginning in calendar year 2025 and in 2026 (pending future guidance on whether the current Simplified Determination could continue to be utilized by plan sponsors in later calendar years). The Revised Simplified Determination method may be used for all plan years beginning in calendar year 2026 (i.e., beginning January 1, 2026) and thereafter under guidance issued as of April 2025.

Revised Simplified Determination Method to Determine Creditable Coverage Status

For plan years beginning in **calendar year 2026 and beyond**, employer/union health plans that do not apply for the retiree drug subsidy (RDS) or participate in an Employer Group Waiver Program (EGWP) may use the Revised Simplified Determination method to assess whether their prescription drug plan is creditable under the rules. The Revised Simplified Determination method states that a plan will be deemed to "provide prescription drug coverage with an actuarial value that equals or exceeds the actuarial value of DS Part D coverage if it meets all the following standards:

- Provides reasonable coverage for brand name and generic prescription drugs and biological products;
- Provides reasonable access to retail pharmacies; and
- Is designed to pay on average at least 72 percent of participants' prescription drug expenses."

The new Revised Simplified Determination method parameters contained in the Calendar Year 2026 Final Instructions remove many of the antiquated parameters within the previous Simplified Determination method, such as references to annual and lifetime benefit maximums (and different deductibles), which no longer apply since the inception of the Affordable Care Act.

Plan Sponsor's Medicare Part D Creditable Coverage Disclosure

Online disclosure is due to CMS no later than 60 days after the beginning of the plan year. This requirement applies to sponsors of group health plans that provide prescription drug coverage to Medicare Part D eligible individuals.

Application for Retiree Drug Subsidy (RDS)

Plan sponsors must apply for the retiree drug subsidy annually by submitting a valid application and a valid retiree list to CMS no later than 90 days prior to the beginning of the plan year. (Requests for extension must be approved by CMS.)

Reconciliation for Retiree Drug Subsidy (RDS)

Plan sponsors taking the subsidy are required to report the total gross covered retiree plan related prescription drug costs and actual cost adjustments annually to CMS by the last day of the fifteenth month following the end of the plan year.

Medicare Mandatory Reporting Requirements

Insurers, third party administrators and administrators of self-insured and self-administered group health plans must collect specific information from plan participants and report this information to CMS.

Other Compliance Requirements

Compulsory Short-Term Disability

Laws require employers to provide coverage for non-work-related short-term disability benefits for employees in five states – California, Hawaii, New Jersey, New York and Rhode Island; and one U.S. territory - Puerto Rico.

State Paid Family Leave Laws (PFL)

Many states have enacted laws and regulations that impact employees in their state. For example California, Colorado, Connecticut, Delaware, Massachusetts, Minnesota, New Hampshire, New Jersey, New York, Oregon, Rhode Island, Vermont (voluntary paid) and Washington, plus the District of Columbia currently require covered employers to provide job-protected, paid family leave (except Vermont) for various reasons including (but not limited to) bonding with a new child, caring for a loved one with a serious health condition or helping relieve family pressures when someone is deployed on active military service.

Certain states have also enacted PFL laws that will go into effect on the following various dates: Maine (benefits start May 1, 2026) and Maryland (delayed so contributions start January 1, 2027 and benefits start January 1, 2028).

Other states are in the process of considering similar legislation. Employers are therefore advised to consult with legal counsel to ensure compliance with the various state specific laws which impact their operations.

Family and Medical Leave Act (FMLA)

FMLA entitles eligible employees of covered employers to take unpaid, job-protected leave for certain reasons. General employer requirements:

- Allow eligible employees to take up to 12 weeks of unpaid leave during a 12-month period for certain statutory reasons, or up to 26 weeks in a single 12-month period to care for a service member or an injured/ill veteran
- Continue the employee's group health benefits and any employer contributions while on leave
- Restore the employee to the same or equivalent job and reinstate benefits upon return from leave
- Not take any adverse action against an employee for taking FMLA leave; and
- Provide employees with:
  - A general notice about the FMLA (through a poster and/or an employee handbook upon hire);
  - An eligibility notice;
  - A rights and responsibilities notice; and
  - A designation notice.

Employers are responsible for designating any leave taken as FMLA leave and for notifying an employee of the designation. Note that additional state leave laws may apply.

The Uniformed Services Employment and Reemployment Rights Act (USERRA)

Requires employers to provide certain re-employment and benefits rights to employees who take a leave of absence for service in the military. The maximum period of coverage under the election to continue employer-sponsored health care benefits while on active duty is 24 months. Upon resumption of employment, the employee is entitled to their most recent employment status, pay and benefits.

Internal Revenue Code – General Requirements

Cafeteria Plans

In order to enable employees to make pre-tax salary reduction contributions for health and welfare benefits including flexible spending account (FSA) contributions, an employer must establish a Section 125 plan (aka a cafeteria plan). The terms of a cafeteria plan must be set forth in a written plan document. Participants must make elections prior to the first day of the plan year. If the cafeteria plan document allows, mid-year election changes can be made in accordance with IRS regulations.

Self-Insured Group Health Plans

The terms of a self-insured group health plan must be set forth in a written plan document as required under IRS regulations.

Health Care and Dependent Care Flexible Spending Account (FSA) Limits

The Internal Revenue Code defines eligible FSA expenses and annual maximums (employers can set lower maximums). The maximum salary reduction contribution to a health care FSA for plan years beginning in 2026 is $3,400 (increased from $3,300 in 2025).

A health care FSA can include either a carryover provision or a grace period of up to 2 1/2 months, but cannot include both provisions. Health care FSA plans that include a carryover feature may allow participants to carryover up to $660 of funds from a plan beginning in 2025 to the 2026 plan year. A plan year starting on or after January 1, 2026, may allow participants to carryover up to $680 in unused funds to the following plan year.

For the first time in nearly 40 years, the contribution limit for dependent care assistance programs (DCAP), which are also known as dependent care FSAs, has been updated. The One Big Beautiful Bill Act (OBBBA) passed in July 2025 increased the amount of dependent care benefits that are excludable from income to $7,500 (up from $5,000) for single filers, heads of household, and married couples filing jointly, and $3,750 (up from $2,500) for married individuals filing separately. This increased limit applies for taxable years beginning on or after January 1, 2026. The DCAP limit is not adjusted annually for inflation. Employers adopting an increased contribution limit will likely need to update their DCAP plan document to reflect the increased amount.

Domestic Partner Benefits – Imputed Income

The general rules for excluding from income the value of health care benefits provided for employees, their legal spouses and their dependent children generally do not apply to domestic partners and their dependent children (unless they qualify as the employee's tax dependent – which is rare). The value of coverage for a domestic partner and his or her children may be subject to federal, FICA, state, local and any other applicable payroll taxes.

NOTE: The June 2015 Supreme Court ruling in Obergefell v. Hodges requires all states to license and recognize same-sex marriages. As a result, employers no longer need to impute federal or state income tax on benefits for same-sex spouses. However, imputed income still applies to domestic partners who are not legally married, unless the domestic partner is a tax dependent.

Heroes Earnings Assistance & Relief Tax Act

Cafeteria plans may permit distribution of unused healthcare FSA account balances when reservists are called to active duty for 180 days or more.

Life Insurance Plans

IRC Section 79 requires employers to impute income for the fair-market value of employer-sponsored group-term life insurance benefits in excess of $50,000. Voluntary/ Supplemental life insurance rates that straddle Table I (which are found in Table 2-2 of IRS Publication 15-b) and/or supplemental life insurance that is paid for by the employee on a pre-tax basis may also be subject to imputed income.

Disability Plans

If the cost of coverage under a disability plan is fully or partially subsidized by the employer without imputing income to the employee for the cost of such coverage, or the disability plan is paid for by employees on a pre-tax basis, upon disability of the employee, the disability payments made under the plan to the employee will be subject to federal/state income taxation (in proportion to the employer subsidy or pre-tax share).

IRC Nondiscrimination Requirements

Until further guidance is issued, Brown & Brown recommends that most nondiscrimination tests be performed at least annually.*

*Section 125** – Cafeteria Plans*

Cafeteria plans sponsored by non-governmental employers (that allow employees the ability to contribute to benefits on a pre-tax basis) are subject to three nondiscrimination tests: Eligibility Test, Benefits and Contributions Test and Key Employee Concentration Test. The nondiscrimination tests are designed to prevent the plan from favoring highly compensated and key employees to an impermissible degree. The tests apply with respect to any health and welfare benefits offered by the employer to which employees make pre-tax salary reduction contributions. In some cases, benefits offered through a Section 125 plan are also subject to separate nondiscrimination requirements under the tax code provision that applies to that specific benefit as further discussed below.

Section 105(h) – Self-Funded Health Plans

Self-funded health plans (including health care FSAs and HRAs) are subject to two nondiscrimination tests: Eligibility Test and Benefits Test. Per the Affordable Care Act (ACA), this testing was to also apply to fully insured plans. However, the compliance date has been delayed until regulations or other guidance is issued and it appears the IRS has no plans to do so for the foreseeable future.

Section 129 – Dependent Care Assistance Plans

Dependent care assistance plans (including dependent care FSAs) are subject to four nondiscrimination tests: Eligibility Test, Benefits Test, 55% Average Benefits Test, and 5% or More Owner Concentration Test.

In addition, Brown & Brown recommends that the 55% Average Benefits Test under Section 129 be performed as early in the year as possible in case adjustments are necessary for highly compensated/key employees.

When an employer is evaluating whether to increase its DCAP contribution limit to the new 2026 threshold (i.e., $7,500), an employer should carefully assess its current employee participation and also the past results of its IRC Section 129 nondiscrimination testing. Increasing the contribution limit up to the increased maximum contribution amount could create compliance challenges if highly-compensated employees (HCEs) increase their DCAP contributions in an amount greater (in aggregate) than non-highly-compensated employees (non-HCEs) DCAP contribution amounts (in aggregate). A common issue is failure of the 55% Average Benefits Test, which requires that the average DCAP benefits received by non-HCEs be at least 55% of the average benefits received by HCEs.

Section 79 – Life Insurance Plans

The Section 79 tax exclusion for employer-sponsored group-term life coverage (up to $50,000) is only available to key employees only if the group-term life insurance plan is non-discriminatory under IRC Section 79. Group-term life insurance plans are subject to two nondiscrimination tests under Section 79(d): Eligibility Test and Benefits Test.

**IRS regulations do not specify when or how often nondiscrimination testing should be performed.*

***Cafeteria plan regulations are proposed; final regulations are pending.*

Wellness Program Requirements

HIPAA Wellness Requirements

Wellness programs that require individuals to meet a standard related to a health factor (activity-based or outcome-based) in order to obtain a reward or avoid a penalty under a group health plan are subject to a variety of requirements under HIPAA, including limits on the amount of reward/penalty, requirements regarding earning the reward/avoiding the penalty through alternative means, and certain notice requirements.

Americans with Disabilities Act (ADA)

ADA regulations effective the first day of the plan year beginning on or after January 1, 2017, require employers who offer wellness programs that collect employee health information (e.g., via health risk assessments, biometric screenings) in exchange for an incentive to comply with certain requirements to ensure the wellness program is voluntary. Key requirements include a limitation on the amount of incentive that may be provided and a requirement to provide a notice to employees informing them of what information will be collected, how it will be used, who will receive it and what will be done to keep it confidential. The EEOC has issued a sample notice.

A federal court ordered the portion of the ADA wellness rules addressing the maximum size of the incentive that may be provided under a program subject to the ADA to be vacated as of January 1, 2019.

The EEOC is in the process of developing new regulations. In the interim, it appears the notice portion of the rules continues to apply, but it is unclear what size incentive can be provided.

Employers with wellness programs that collect medical information should consult with counsel to discuss compliance with the ADA.

Genetic Information Nondiscrimination Act (GINA)

GINA restricts the ability of health plans (including wellness programs that are part of or tied to health plans) and employers to collect and use genetic information, including family health histories (which generally includes information about a spouse or child's health conditions).

Regulation issued under GINA Title II allowed limited collection of information about a spouse's current health conditions as part of a wellness program, but that portion of the regulation was vacated (along with parts of the ADA wellness regulations) and the regulations under GINA Title I do not specifically allow the collection of information about a spouse's current health conditions.

Employers with wellness programs that include health risk assessments should consult with counsel to discuss compliance with GINA.

General Notice Timeline

Generally, all new employees should receive:

- CHIPRA Notice
- Notice of Exchange

Notices eligible employees should receive when enrollment is offered or upon enrollment:

- COBRA General Notice (Spouse must also receive)
- HIPAA Notice of Privacy Practices
- HIPAA Notice of Special Enrollment Rights
- Medicare Part D Creditable Coverage or Non-Creditable Coverage
- Summary of Benefits and Coverage (SBC)
- Summary Plan Description (SPD)
- Women's Health and Cancer Rights Act (WHCRA) Enrollment Notice
- Fixed Indemnity Notice (if applicable)

Notices participants should receive on an annual basis:

- HIPAA Notice of Privacy Practices (once every three (3) years)
- Medicare Part D Creditable Coverage or Non-Creditable Coverage
- Summary of Benefits and Coverage (SBC)
- SPD or Summary of Material Modification
- Summary Annual Report (SAR) for ERISA plans subject to filing Form 5500 (e.g., plans with 100 or more participants on the first day of the plan year and plans funded through a trust)
- Women's Health and Cancer Rights Act (WHCRA)
- Other potential notice requirements:
  - Patient Protection Disclosure (with SPD or similar benefit description)
  - Notice of Grandfathered Status (with materials describing benefits)
  - Wellness Program Disclosure (in all materials describing terms of wellness program and/or before collection of medical information)

Notices that all employees should receive on an annual basis:

- CHIPRA Notice

Potential notices a terminated employee may receive:

- COBRA Election Notice
- Conversion/Portability Notice (fully insured benefits)

Other:

- Balance Billing Notice (must be posted on a public website and provided with any Explanation of Benefits issued with respect to an item or service to which the surprise medical bill requirements apply)

General reporting requirements:

- Form 5500 (ERISA plans covering 100 or more participants on the first day of the plan year and funded plans regardless of number of participants)
- W-2 Reporting (i.e., aggregate cost of employer sponsored coverage, imputed income for life insurance, imputed income for domestic partner coverage, dependent care assistance benefits)
- Medicare Part D Creditable Coverage Disclosure Notice to CMS
- Section 6055 and 6056 reporting (to the IRS and to covered individuals)
- PCORI Fee
  - Medical plans that are self-funded (if fully insured the carrier reports and pays)
  - Self-funded prescription drug plans
  - Some dental or vision plans
  - Health Reimbursement Arrangements (HRAs) (Special Rules)
  - Retiree-only health plans
  - Some FSAs

Due Dates & Links

Benefit Notice	Due Date	Link
ACA		
Summary of Benefits and Coverage (SBC)	With open enrollment materials (or at least 30 days prior to the start of the plan year if enrollment is automatic), with initial application materials (or if the plan does not distribute written application materials for enrollment, no later than the first date on which the participant is eligible to enroll in coverage), within 90 days of special enrollment, no later than seven (7) business days following a request	Model SBCs and instructions, as well as final regulatory guidance, are available on the DOL's website at: SBC's and Instructions Link
Marketplace (Public Exchange) Notice	Within 14 days of date of hire	If you offer a health plan: Marketplace Notice If you do not offer a health plan: Marketplace Notice
Grandfathered Health Plan Disclosure – Grandfathered Health Plans Only	In any materials describing benefits available under the plan	Model notice is available on the DOL's website: Grandfathered Health Plan Disclosure Link
Patient Protection Disclosure – Non-Grandfathered Health Plans Only	Whenever a SPD or similar description of benefits is distributed (only applies to HMO/POS)	Patient Protection Model Notice
Internal Appeals and External Review Requirements – Non-Grandfathered Health Plans Only	Language required in SPD	Model notice is available on the DOL's website: Internal Appeals and External Review Requirements Link
COBRA		
General Notice	Within the first 90 Days of Coverage	Click on "COBRA Model General Notice" General Notice Link
Election Notice	Employer has 30 days to notify the plan administrator and the administrator has 14 days to send the notice (44 days total if the employer is also the administrator)	Click on "COBRA Model Election Notice" Election Notice Link

Benefit Notice	Due Date	Link
HIPAA Notices		
HIPAA Notice of Special Enrollment Rights	At or before initial enrollment period	Notice of Special Enrollment Rights can be found here. (page 138)
Notice of Privacy Practices	Upon Enrollment and within 60 days of material change, every three (3) years participants must be provided a new notice or notified that a notice of privacy practices is available	Notice of Privacy Practices Link
Other Law Notices		
Fixed Indemnity Notice	For plan years beginning on or after January 1, 2025*, a hospital/fixed indemnity plan will qualify as a HIPAA excepted benefit only if a hospital/fixed indemnity notice is prominently display on the first page of any "marketing, application, and enrollment materials that are provided to participants at or before the time participants are given the opportunity to enroll" (or reenroll) in that coverage. The notice must be in at least 14-point font and must be on the first page of any applicable paper or electronic materials (subject to the ERISA safe harbor for electronic distribution). These materials likely include benefit guides, enrollment packets, and online enrollment systems. A model notice is included in the final regulations that is titled: Short-Term, Limited-Duration Insurance and Independent, Non-coordinated Excepted Benefits Coverage. *On December 4, 2024, the U.S. District Court for the Eastern District of Texas issued a final judgment in the Manhattan Life Insurance and Annuity Co. et al. v. U.S. Department of Health and Human Services et al. case, vacating (i.e., striking down) the provision in the final regulations requiring hospital/fixed indemnity plans to provide a written notice in order to qualify as a HIPAA excepted benefit. Also President Trump released Executive Order "Initial Rescissions of Harmful Executive Orders and Actions" (January 2025 Executive Order), which rescinded the Executive Order related to the creation of the fixed indemnity notice obligation that was originally released under the former Biden Administration. Despite these circumstances, we have preserved the fixed indemnity notice as a required disclosure document for now due to uncertainty around the applicability of both of these actions. Please review our article about the fixed indemnity notice requirement, here.*	See Short-Term, Limited-Duration Insurance and Independent, Non-coordinated Excepted Benefits Coverage Final Rules, and the Fixed Indemnity Notice on page 23389 of those Final Rules, here: Fixed Indemnity Notice Requirements

Benefit Notice	Due Date	Link
Other Law Notices		
No Surprises Act (NSA)	Group health plans and health insurance issuers must post notice on plan website and include notice of rights and protections on EOBs	Balance Billing Model Notice
Children's Health Insurance Program Reauthorization Act (CHIPRA)	At enrollment and annually	CHIP Model Notice - United States Department of Labor
Newborns' and Mothers' Health Protection Act	Must be included in the SPD	Newborns' and Mothers' Health Protection Act Link (page 140)
Women's Health and Cancer Rights Act (WHCRA) Notices	At enrollment and annually	WHCRA Model Notices can be found here. (page 141)
Medicare Notices		
Medicare Part D Notice of Creditable (or Non-Creditable) Coverage	Prior to October 15 each year, prior to an individual's initial enrollment period in Part D, prior to an individual's effective date of coverage under the employer's plan, upon change in creditable coverage status and upon request	Model Notice for Creditable Coverage Link Model Notice for Non-Creditable Coverage Link
Wellness Notices		
EEOC Notice	At enrollment and annually if applicable	EEOC Notice Link

How Brown & Brown Can Help

Connect with your Brown & Brown service team to learn more about how we can help find solutions to fit your unique needs.

Brown & Brown

Find Your Solution at BBrown.com

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