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BENEFITS LEADER

Your Guide to Health & Welfare Compliance

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IN THIS ISSUE

2026 BRINGS HIGHER ACA AFFORDABILITY THRESHOLD & PENALTIES

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On July 18, 2025, the IRS issued **Revenue Procedure 2025-25** setting the **2026 Affordable Care Act (ACA) affordability percentage at 9.96%**, the highest level we've seen since the ACA went into effect.

As shown in the table below, the affordability percentage has generally trended upward over the years, with a few exceptions where it dipped. However, 2026 marks the **largest single-year increase in ACA history.**

Plan Year	Affordability %
2015	9.56%
2016	9.66%
2017	9.69%
2018	9.56%
2019	9.86%
2020	9.78%
2021	9.83%
2022	9.61%
2023	9.12%
2024	8.39%
2025	9.02%
2026	9.96%

WHAT DOES THIS MEAN FOR EMPLOYERS?

Under the employer mandate, large employers must offer health coverage that is considered "affordable" and provides minimum value. Starting in 2026, coverage is considered affordable if the employee's required contribution for self-only coverage does not exceed **9.96% of their household income** (or using one of the three safe harbors: Federal Poverty Guideline, Rate of Pay, or W-2)

This updated threshold gives employers a bit more room in designing cost-sharing structures for employee health coverage. On the flip side, we're also seeing higher penalties for non-compliance coming in 2026.

RISING ACA PENALTIES ALSO AHEAD IN 2026

The following week on July 22, 2025, the IRS also released **Revenue Procedure 2025-26**, which outlines substantial increases to the ACA employ-er mandate penalties under **Section 4980H(a)** and **Section 4980H(b)** for 2026. Take a look at the changes below.

Year	Section 4980H(a) Penalty (Failure to offer coverage)	Section 4980H(b) Penalty (Unaffordable/ Inadequate coverage)
2025	$2,900	$4,350
2026	$3,340	$5,010

The rising penalty amounts reflect inflation adjustments and add to the importance of maintaining ACA compliance in both affordability and the offer of coverage. Employers should take these new changes into account when setting contribution levels for 2026 and reviewing their use of affordability safe harbors (Federal Poverty Line, Rate of Pay, or W-2).

PUBLIC LAW NO. 119-21: THE ACT RESHAPING EMPLOYEE BENEFITS

Alina Achim
Marketing & Content Coordinator

From telehealth to student loan help, employee benefits are getting a refresh.

With new legislation taking effect in 2025 and 2026, brokers and employers alike have a lot to consider. Here's a breakdown of some of the key changes that could affect how benefits are offered, used, and taxed in the coming years.

As of January 1, 2025, telehealth is no longer disqualifying for HDHP and HSA eligibility, and plans can continue offering telehealth as before under the Cares Act before this provision sunset on December 31, 2024. Plans can now offer low or no-cost telehealth visits before the deductible is met without affecting HSA contributions. Beginning in 2026, direct primary care fees up to **$150/month for individuals** or **$300/month for families** will also be HSA-qualified, provided they don't include:

- General anesthesia
- Most prescription medications (excluding vaccines)
- Lab tests that are not part of routine primary care

More 2026 updates...

1. **Marketplace Plan Eligibility:** Bronze and Catastrophic plans offered through the Health Insurance Marketplace will qualify as High-Deductible Health Plans (HDHPs).
2. **HSA Compatibility:** This change enables greater access to HSA-eligible plans for employees, particularly those utilizing Individual Coverage Health Reimbursement Arrangements (ICHRAs).
3. **Student loan repayment benefits go permanent:** Employers will be able to contribute up to $5,250 per year tax-free toward employees' student loans, offering long-term support for financial wellness.
4. **Higher Dependent Care limits:** The Dependent Care Assistance Program (DCAP) limit will increase to $7,500 annually. While this is a welcome change for many families, employers should consider the potential impact on non-discrimination testing.
5. **Expanded paid leave tax credit:** Employers that offer up to 12 weeks of paid family and medical leave may qualify for a 25% tax credit. The rules now include part-time employees and those with at least six months of service, even when leave is required by state law.
6. **New savings accounts for children:** Launching in July 2026, these long-term savings accounts will be available for children under age 18. Contributions can be made annually—up to $5,000—from parents, employers, or others, with funds intended for future qualified expenses such as education or a first-time home purchase.
    - A one-time $1,000 federal contribution will be provided for eligible children born between 2025 and 2028
    - Employers may contribute up to $2,500 per child on a tax-free basis (pending further guidance)

NEW LEGISLATION OPENS THE DOOR FOR HSAs & DIRECT PRIMARY CARE

Michelle Barki, RN, Esq.
Senior Legal Counsel

One consideration under P.L. 119-21:

Offering a high-deductible plan coupled with an HSA that would allow Direct Primary Care

Direct Primary Care (DPC) is an innovative healthcare model that's rapidly gaining traction, offering a compelling alternative to traditional fee-for-service medicine. Understanding DPC is critical to providing your employees with a complete and competitive benefits package. It's a powerful tool that can lower costs, improve employee health, and enhance retention. "It has already helped a quarter million people stay healthy and spend less on health care" (Resource: https://mapper.dpcfrontier.com/).

DPC is a **membership-based healthcare model** where patients pay a flat, periodic fee directly to their primary care physician. This fee, typically ranging from **$50 to $150 per month**, covers a comprehensive range of primary care services, including unlimited office visits, same-day or next-day appointments, and direct communication with the doctor. Unlike concierge medicine, DPC **does not bill insurance for primary care services**. This eliminates the administrative burden of insurance paperwork, allowing physicians to focus on patient care. While DPC covers routine primary care, it is not a substitute for health insurance. It does not cover hospitalizations, specialist visits, imaging, or advanced diagnostics, such as MRIs, CT scans, and extensive lab work. While vaccines may be covered, prescription drugs are not covered. Therefore, DPC is typically paired with a high-deductible health plan (HDHP) or a catastrophic plan to cover emergency care, hospitalizations, and specialist visits.

DPC offers significant advantages for both employees and employers. For employees, the benefits are clear: a **stronger doctor-patient relationship, easier access to care, and transparent, predictable costs**. For employers, the advantages translate into potential cost savings and a healthier workforce. By focusing on preventive care and early intervention, DPC can lead to a reduction in emergency room visits and hospital admissions. In addition, easy access to a doctor for quick consultations means less time out of work for employees, which in turn improves productivity. A robust benefits package that includes DPC may also be a key differentiator in a competitive job market, boosting morale and loyalty.

Brokers and employers should be aware of the specific rules regarding DPC and tax-advantaged accounts like Health Savings Accounts (HSAs) and Flexible Spending Accounts (FSAs). For years, the Internal Revenue Service (IRS) considered DPC memberships a "health plan," which could disqualify an individual from

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contributing to an HSA. However, a landmark provision in **Public Law No. 119-21** changes this. Effective January 1, 2026, the following changes will take effect: **DPC membership fees will be considered a qualified medical expense, allowing individuals to use their pre-tax HSA funds to cover them**. Having a DPC arrangement will no longer disqualify an individual from contributing to an HSA, as long as the fee doesn't exceed the specified threshold. (**$150 per month for an individual or $300 per month for a family**). This change is a huge win for DPC, making it a more financially viable option for many consumers and a more attractive offering for employers. It allows for the perfect pairing of DPC membership for routine care and HDHP for catastrophic coverage, with the added benefit of a tax-advantaged savings vehicle.

The shift towards DPC presents a unique opportunity. Direct Primary Care is more than a trend; it's a re-imagining of the primary care experience. For brokers, it’s a powerful new tool to help clients navigate the complex world of healthcare benefits and build a healthier future for their employees.

To find a DPC near you visit https://mapper.dpcfrontier.com/.

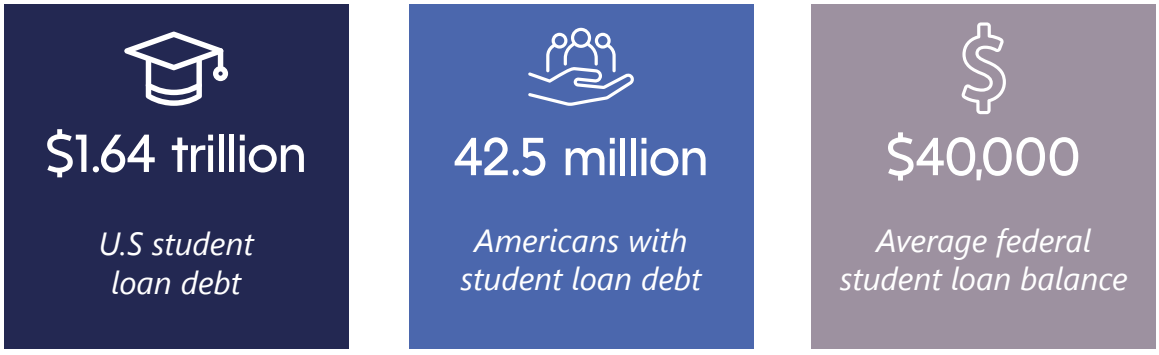
PERMANENT RELIEF, LASTING LOYALTY: THE FUTURE OF STUDENT LOAN REPAYMENT BENEFITS

Michelle Barki, RN, Esq.
Senior Legal Counsel

The future of employee benefits just got a major boost. A powerful provision in the recently enacted **Public Law No. 119-21** has made the **tax-free status of employer-provided student loan repayment assistance permanent**. This isn't just a temporary perk; it's a long-term strategic advantage that offers a compelling solution to two of the most pressing challenges facing businesses today: recruitment and retention.

For over five years, employers have had the ability to offer up to $5,250 annually in tax-free student loan repayment to employees. This benefit was initially established under the CARES Act, which took effect on March 27, 2020. However, the provision was always temporary and was slated to sunset on December 31, 2025. This looming expiration created a major point of hesitation for employers. Companies were reluctant to invest in and roll out a popular benefit that they would inevitably have to take away, fearing the negative impact on employee morale and retention. The uncertainty of the benefit's lifespan made it challenging to integrate into long-term strategic planning, as employers worried about the resentment that would build if they had to remove a valued component of their total compensation package.

Now, with the new Act, this benefit is here to stay and will be indexed to inflation starting in **2026**, making it an even more valuable benefit over time. This permanence provides the certainty needed for companies to confidently integrate it into their core compensation strategy, knowing that it's a sustainable tool for attracting and retaining top talent. Offering a student loan repayment benefit directly addresses one of the most significant financial burdens facing the American workforce.



According to the Federal Reserve Bank of New York's Quarterly Report, total student loan debt in the United States stands at over **$1.64 trillion**. This makes it the **second-largest form of consumer debt** in the country, affecting approximately **42.5 million Americans**. And the debt is not just limited to young graduates. Data from the Education Data Initiative shows that the average federal student loan balance is nearly **$40,000**, and debt levels for professional degrees can exceed **$130,000**. The burden is particularly heavy for those aged 35 to 49, who hold the largest share of the debt. This is why a benefit that provides tangible financial relief is so impactful.

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By helping employees pay down their debt, employers improve their employees' financial well-being and alleviate a significant source of stress. In today's competitive job market, especially for highly skilled and educated roles, traditional benefits like health insurance and 401(k) matching are no longer enough to differentiate a company. By offering a student loan repayment program, employers are directly addressing a critical pain point that others may be ignoring. This benefit immediately stands out in a crowded field of job offers, demonstrating commitment to an employee's financial well-being. The positive impact of this benefit extends far beyond the hiring process. It serves as a powerful tool for employee retention. Employees who feel their employer is genuinely invested in their financial future are more likely to be loyal and committed. Studies show that a significant percentage of employees would be more likely to stay with a company for an extended period if it helped them repay their student loans.

By helping employees reduce their debt, employers not only improve their employees' financial health but also build loyalty and reduce turnover, which can be a substantial cost for any business. Offering this benefit is a true win-win scenario. For employees, it means tangible, tax-free financial relief that can help them pay down their debt faster and save thousands of dollars in interest over the life of their loans. For the employer, the contributions are tax-deductible as a business expense. With the security that this new Act provides, employers can confidently integrate this benefit into their long-term talent strategy, knowing that they are making a meaningful difference in the lives of their employees while gaining a powerful competitive edge.

FIDUCIARY DUTIES & THE RISE OF BENEFITS LITIGATION

Michelle Barki, RN, Esq.
Senior Legal Counsel

In recent years, the landscape of employee benefits has seen a significant increase in class-action lawsuits, particularly those targeting pharmacy benefit managers (PBMs). These cases often allege that PBMs, and the plan sponsors who hire them, have breached their fiduciary duties by mismanaging drug benefits, leading to inflated costs for plan participants.

Now, a new front has opened in this litigation with the case of *Barbich et al. v. Northwestern University et al.* This case, though focused on health insurance, highlights that the same rigorous fiduciary standards applied to retirement plans are now being used to scrutinize the design of an employer's health plan offerings.

Under the Employee Retirement Income Security Act (ERISA), plan sponsors and administrators are held to the highest standard of care as fiduciaries. This means they have a legal and ethical duty to act in the best interest of plan participants and beneficiaries. Fiduciaries who breach these duties may be held personally liable for any losses to the plan.The key fiduciary obligations include:

01

Duty of Undivided Loyalty: Fiduciaries must act solely for the benefit of plan participants. This means they cannot put their own interests or the employer's interests ahead of the plan.

02

Duty of Prudence: Fiduciaries must act with the care, skill, and diligence that a prudent person would use in a similar situation. This is a high standard and requires plan sponsors to engage in a careful and thorough process when selecting and monitoring plan options. This includes evaluating the financial and clinical effectiveness of the options offered.

03

Exclusive Purpose Rule: The plan's assets must be used for the exclusive purpose of providing benefits to participants and paying reasonable plan expenses. This ensures that the plan is not used for other corporate purposes.

04

Duty of Diversification: For investment-based plans, fiduciaries must diversify plan investments to minimize the risk of large losses.

05

Duty to Follow the Plan Documents: Fiduciaries must adhere to the terms of the plan's governing documents, provided those terms are consistent with ERISA.

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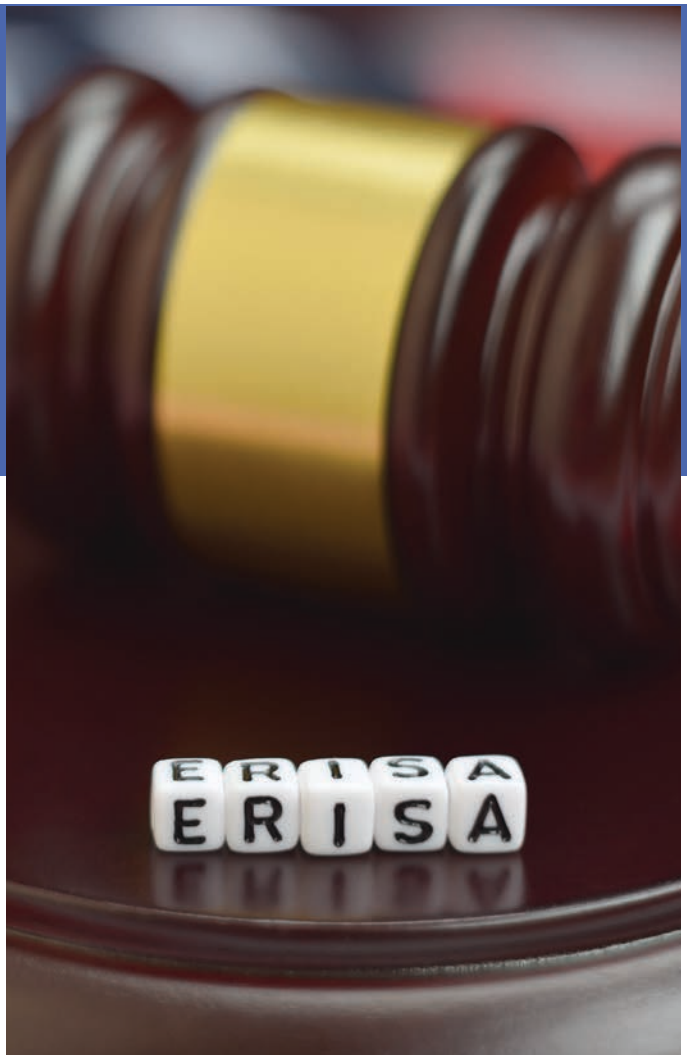
Barbich v. Northwestern University



A recent case that highlights the consequences of a potential breach of a fiduciary's duty is B*arbich et al. v. Northwestern University et al*. This lawsuit serves as a powerful cautionary tale, centering on a dispute over the financial structure of the university's health plan options. The lawsuit alleges that Northwestern, as a plan sponsor, failed in its fiduciary duty by offering plan options that were misleading and not in the best financial interest of its employees. The core of the complaint is that what seemed like a straightforward choice between a low-deductible and a high-deductible health plan was anything but. The plan sponsor's own communications to employees stressed that the low-deductible plan, which had a higher monthly premium contribution, would limit employees' financial exposure more than the alternative, suggesting it was the safer and more protective choice. At the same time, Northwestern also offered a high-deductible health plan (HDHP). While this plan came with a significantly lower monthly premium, its high deductible seemed daunting to many employees.

What employees were not adequately informed of, however, was a critical detail that changed the entire financial equation: Northwestern University made matching contributions to the employees' Health Savings Accounts (HSAs) associated with the HDHP. Meanwhile, the Flexible Spending Account (FSA) available with the low-deductible plan received no employer match. As a result, many employees who chose the low-deductible plan found themselves paying more out of pocket than their colleagues on the HDHP. Even with a lower deductible, they had to cover all of their initial medical expenses from their own funds, with no employer assistance to offset those costs. Conversely, employees on the HDHP had a large portion of their deductible effectively funded from day one by their employer's HSA contribution. This meant that for many, their true out-of-pocket exposure was dramatically less than what the plan's high deductible might have suggested, and was actually the better option if trying to limit financial exposure.

This case, which is at the beginning of the litigation's stages, underscores that a fiduciary's duty goes beyond just offering plan options; it requires ensuring that those options are structured prudently and that communications about them are transparent and not misleading.

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UPCOMING DEADLINES

SEPTEMBER 30, 2025 | Medical Loss Ratio (MLR) Rebates

Employers with fully insured health plans may receive rebates if issuers don't meet the required Medical Loss Ratio (MLR). Rebates are due to plan sponsors by Sept. 30 following the end of the MLR reporting year. If any portion of rebate is considered a plan asset under ERISA, it must be used solely for the benefit of the plan's participants and beneficiaries and be used within three months to avoid trust requirements.

SEPTEMBER 30, 2025 | Distribute a Summary Annual Report (SAR)

Employers required to file Form 5500 must provide participants with a summary of the information in the form, known as a Summary Annual Report (SAR) within nine months after the close of the plan year. For **calendar-year plans**, this deadline is Sept. 30. If an extension to file Form 5500 is granted, the plan administrator must provide the SAR within two months after the extension period ends.

OCTOBER 3, 2025 | Provide 2026 ICHRA Notice

Employers offering individual coverage health reimbursement arrangements (ICHRAs) are required to provide eligible employees with a notice outlining the ICHRA coverage at least 90 days before each plan year. For **calendar-year** ICHRAs, the notice for the 2026 plan year is due by Oct. 3, 2025.

OCTOBER 14, 2025 | Provide Medicare Part D Notices

Employers with group health plans offering prescription drug coverage must inform Medicare Part D-eligible individuals by October 14 each year whether their prescription drug coverage is at least equivalent to Medicare Part D coverage (i.e., whether the coverage is "creditable" or "noncreditable").

OCTOBER 15, 2025 | File Form 5500 (Extended Deadline)

Applies to employers with ERISA-covered welfare benefit plans (**calendar-year**) that requested a one-time automatic extension of 2.5 months via IRS Form 5558 by the original due date of Form 5500.

DECEMBER 15, 2025 | Provide SAR (Extended Deadline)

If an extension to file Form 5500 was granted, the plan administrator must provide the SAR within two months after the extension period ends. For **calendar-year plans**, the extended deadline is Dec. 15, 2025.

DECEMBER 31, 2025 | Submit gag clause attestation

A federal transparency law mandates that health plans and health insurance issuers submit attestations of compliance with the prohibition on gag clauses annually through the Gag Clause Attestation platform. If the issuer of a fully insured health plan provides the attestation, the plan is not required to submit one separately. Self-insured employers may have their TPA handle the filing, but the legal responsibility stays with the health plan.

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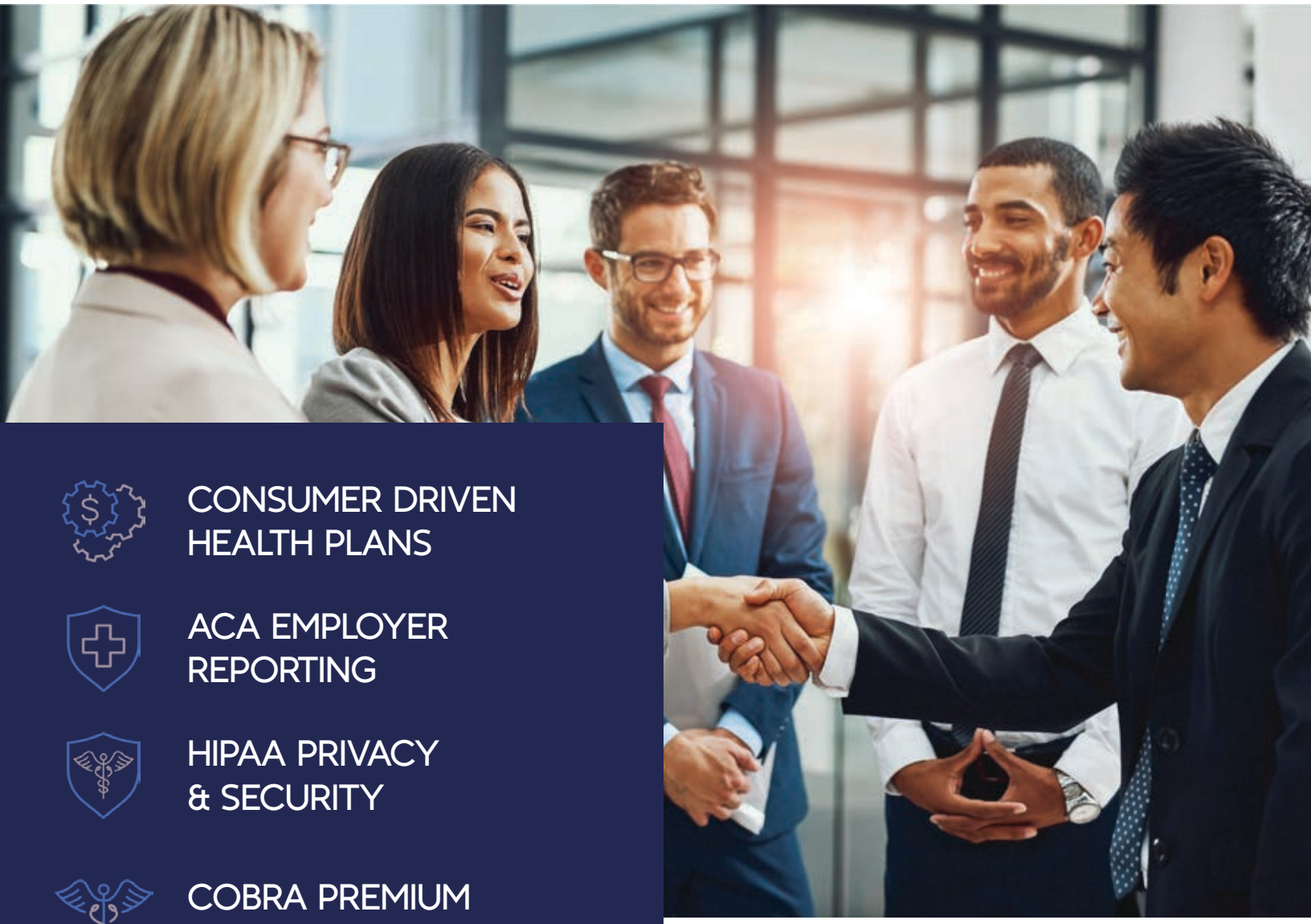

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