Navigating Health Plan Compliance Developments for 2026

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Employers should stay alert to several important compliance developments that will shape the design and administration of health plans in 2026. Notably, in 2026, many organizations subject to the Affordable Care Act's (ACA) reporting requirement will first use the streamlined approach for distributing individual statements. In addition, a number of anticipated regulatory shifts warrant close attention, including potential revisions to federal mental health parity standards and additional flexibility in offering fertility benefits.

As 2026 begins, the compliance environment remains somewhat unsettled due to new regulatory priorities under the Trump administration, ongoing benefits-related litigation and changes in federal staffing. This year, federal agencies will be working to implement the One Big Beautiful Bill Act (OBBBA) while also prioritizing President Donald Trump's broader directives, such as expanding health care transparency.

Employers reviewing their 2026 health plan obligations should take time to assess how these evolving requirements may shape the design and administration of their benefit programs.

Expanded Access to HSAs

On July 4, 2025, a sweeping tax and spending bill, commonly referred to as the OBBBA, was signed into law. Although significantly pared down from its original draft version, the OBBBA includes a broad set of changes for employee benefit plans, most of which take effect in 2026. These changes expand options for existing employee benefit plans and present new benefit-related opportunities for employers to consider for 2026. Significantly, the OBBBA expands access to health savings accounts (HSAs), tax-advantaged medical savings accounts generally available to individuals who are enrolled in high deductible health plans (HDHPs) and do not have other health coverage.

The OBBBA permanently allows employers with HDHPs to provide benefits for **telehealth and other remote care services** before plan deductibles have been met without jeopardizing HSA eligibility. A pandemic-related relief measure temporarily allowed HDHPs to waive the deductible for telehealth services without impacting HSA eligibility; however, this bipartisan-supported relief expired at the end of the 2024 plan year. The OBBBA retroactively extended this relief, effective for plan years beginning after Jan. 1, 2025, and made it permanent. Employers with HDHPs should review their health plan's coverage of telehealth services and assess if changes should be made, considering the OBBBA's permanent extension. Any changes to telehealth coverage should be communicated to plan participants.

Effective Jan. 1, 2026, the OBBBA further expands access to HSAs by allowing individuals with **direct primary care (DPC) arrangements** to make HSA contributions if their monthly fees are $150 or less ($300 or less for family coverage). These dollar limits will be adjusted for inflation each year. A DPC arrangement is a subscription-based health care delivery model where an individual is charged a fixed periodic fee for access to medical care consisting solely of primary care services. In addition, the OBBBA treats DPC fees as a medical care expense that can be paid for using HSA funds. Given this change, employers with HDHPs may wish to explore integrating DPC arrangements into their benefits packages.

Simplified ACA Reporting

At the end of 2024, Congress passed legislation that eased ACA reporting requirements for employers. The ACA requires applicable large employers (ALEs) and non-ALEs with self-insured health plans to provide information to the IRS about the health plan coverage they offer (or do not offer) to their employees while providing related statements to individuals. Yet, with the new legislation, employers that take certain steps no longer need to automatically distribute these individual statements, unless an individual specifically requests one. In late February 2025, the IRS released guidance on this relief, leaving employers only a brief period to apply the change for statements due in March 2025. Because of the limited time frame, **many employers are expected to begin using this relief starting in 2026**.

For this relief to apply in 2026, an employer must post a clear and conspicuous notice on its website by **March 2, 2026**, stating that employees may receive a copy of their statement upon request. The notice must include an email address, a physical address to which a request may be sent, and a telephone number to contact the employer. This website notice must remain posted through **Oct. 15, 2026**. In general, employers must fulfill requests within **30 days** of receiving them.

Crossroads for Mental Health Parity Rules

In May 2025, federal agencies announced they would not enforce a 2024 final rule that expanded parity requirements for mental health and substance use disorder (MH/SUD) benefits. This decision stems from a lawsuit filed by an employer trade group challenging the rule's validity. The case has been put on hold while the Trump administration reviews the rule and considers whether to revise or repeal it. Many of the final rule's provisions were originally set to take effect in 2026. At the same time, the Trump administration is taking a broader look at its overall approach to enforcing mental health parity.

As background, the Mental Health Parity and Addiction Equity Act (MHPAEA) requires parity between a group health plan's medical/surgical (M/S) benefits and MH/SUD benefits. Notably, MHPAEA requires health plans and health insurance issuers to conduct comparative analyses of nonquantitative treatment limitations (NQTLs), which include a variety of strategies that generally limit the scope or duration of benefits, such as prior authorization requirements. The 2024 final rule primarily focused on stricter parity requirements for NQTLs. Under the final rule, health plans and issuers would be required to collect and review outcomes data and take reasonable steps to fix any significant differences in access between MH/SUD and M/S benefits. They would also need to make sure their comparative analyses of NQTLs include specific, detailed elements to show compliance.

Due to the nonenforcement policy, employer-sponsored health plans are not required to comply with the 2024 final rule. However, employers should make sure their health plans **continue to comply with MHPAEA's statutory requirements, including the comparative analysis requirement for NQTLs**. Employers should reach out to the health plan's issuer or third-party administrator (TPA) to confirm that comparative analyses of NQTLs are updated, if necessary, for the plan year beginning in 2026. Employers should also stay alert for any changes to the 2024 final rule.

Ongoing Health Plan Litigation

In 2026, employers should also keep an eye on litigation involving several important health plan compliance issues. While a recent U.S. Supreme Court ruling limited the ability of federal courts to issue nationwide injunctions of government policies, federal courts still have the authority to block regulatory actions that are unlawful, arbitrary or beyond an agency's authority. In addition, a Supreme Court ruling from 2023 ended the long-standing deference given to federal agencies' interpretations of the law, making it more likely that federal rulemaking will be successfully challenged in the courts.

In 2026, ALEs should keep an eye on a case now before the U.S. Court of Appeals for the 5th Circuit that **could affect how "pay-or-play" penalties under the ACA are assessed**. In April 2025, a federal District Court in Texas ruled that the IRS cannot assess these penalties unless the U.S. Department of Health and Human Services (HHS) first issues a certification to the employer. Currently, the IRS relies on Letter 226-J to notify employers of potential liability without any prior certification from HHS. The 5th Circuit's upcoming decision may impact how pay-or-play penalties are enforced going forward.

Employers should also be aware of the **growing number of fiduciary lawsuits tied to health plans**. Most private-sector employers must follow the fiduciary duty standards set by the Employee Retirement Income Security Act (ERISA) when managing their employee benefit plans. These standards require fiduciaries to prudently select and monitor plan service providers. Recent litigation has underscored how important it is for employers to meet these obligations when managing group health plans. These cases have mainly focused on prescription drug benefits and the selection of pharmacy benefit managers. More recently, however, several class-action lawsuits have been filed involving voluntary benefit programs, such as accident, critical illness and hospital indemnity insurance. These lawsuits allege fiduciary breaches related to costs and excessive premiums. In 2026, employers should review their fiduciary compliance to limit potential liability, including documenting the process for selecting and monitoring health plan service providers.

In addition, employers should be aware of a **recent surge of class-action lawsuits involving health plan premium surcharges related to tobacco use**. When a health plan imposes a surcharge (or provides a reward) based on a health-related standard (such as not using tobacco or meeting an exercise goal), it must comply with the Health Insurance Portability and Accountability Act's (HIPAA) nondiscrimination requirements. These lawsuits generally allege that health plans failed to meet these requirements by not offering a reasonable alternative standard to avoid the surcharge, by only applying the premium reduction on a prospective basis after completing the alternative standard, and by not describing the availability of the alternative standard in all plan materials. With this heightened scrutiny, employers should make sure any surcharge or reward tied to a health-related standard is offered through a wellness program that fully meets HIPAA's nondiscrimination requirements, including clear communication to participants about the availability of a reasonable alternative standard.

Increased Health Care Transparency

The Trump administration is expected to **continue focusing on health care transparency** in 2026. Early into his second term, Trump released an executive order highlighting transparency as a key part of efforts to improve Americans' health and provide consumers with more meaningful price information. The order directed federal agencies to take specific steps to advance transparency, such as making price information more easily comparable and strengthening enforcement policies.

For 2026, employers should review their compliance with applicable health plan transparency requirements. Most employers depend on their issuers, TPAs or other service providers to handle these obligations because they do not have the information needed for transparency disclosures. To stay compliant, employers should confirm that written agreements with issuers, TPAs or other service providers clearly spell out responsibility for compliance. They should also monitor those service providers to confirm their plans' compliance with applicable legal requirements. For added protection, cautious employers may want to request regular reporting from service providers to verify transparency compliance. Employers should also stay alert to regulatory and legislative developments that could impact health plan transparency. For instance, federal agencies have indicated that they intend to release guidance on machine-readable files for covered prescription drugs and set a deadline for making those files publicly accessible.

HIPAA Privacy and Cybersecurity Updates

Employers with self-insured health plans, as well as those with fully insured health plans that have access to protected health information (PHI), may need to update their administrative policies and privacy notices in light of recent HIPAA developments. In June 2025, a federal District Court in Texas **invalidated a final rule that had expanded HIPAA's privacy protections for reproductive health care**. That rule barred health plans and other regulated entities from using or disclosing PHI related to lawful reproductive health care in certain situations. The court's decision eliminated these protections nationwide, and the Trump administration chose not to appeal, effectively ending HIPAA's special privacy safeguards for reproductive health care for now. While HIPAA's general privacy protections remain in place, employers should review their HIPAA policies and privacy notices and remove any provisions tied to reproductive health care protections.

In addition, employers that maintain HIPAA privacy notices for their health plans should **update them for special privacy protections for patient records regarding substance use disorder treatment provided by a federally assisted treatment program (that is, a Part 2 program)**. The deadline for updating privacy notices for the additional privacy protections for Part 2 program records is Feb. 16, 2026. Employers with self-insured health plans should also distribute their updated privacy notices by this deadline. Note that while self-insured health plans must maintain and provide their own privacy notices, fully insured health plans are not required to maintain or provide privacy notices unless the plan sponsor has access to PHI. In that case, fully insured health plans that have access to PHI must maintain a privacy notice and provide it upon request. It is unclear if HHS will update its model notices to incorporate the new requirements before the compliance deadline.

Employers that handle PHI should also monitor developments related to HIPAA cybersecurity. In early 2025, at the end of the Biden administration, HHS proposed significant updates to the HIPAA Security Rule to strengthen cybersecurity protections for electronic PHI (ePHI). According to HHS, the proposed rule would modernize existing standards to better respond to the growing cybersecurity threats facing the health care industry. It remains uncertain whether the Trump administration will finalize these changes in 2026, although cybersecurity generally has bipartisan support. Employers with self-insured health plans and those with fully insured health plans that have access to ePHI should monitor developments and be prepared to improve safeguards for ePHI if the changes are finalized.

More Flexibility for Fertility Benefits

The market for employer-provided fertility benefits is entering a period of expansion, driven largely by regulatory guidance and strong evidence that these benefits are important for employee attraction and retention. Increasing access to and reducing costs for infertility treatment has been a stated priority of the Trump administration. In February 2025, an executive order directed agencies to develop policy recommendations to expand in vitro fertilization (IVF) access and reduce out-of-pocket and health plan costs for IVF treatment. Following that directive, in October 2025, the U.S. Department of Labor, HHS and the Treasury jointly issued guidance outlining the following three primary options for offering stand-alone fertility benefit packages outside of traditional group health plans:

1. **Fertility benefits as an independent, noncoordinated excepted benefit**—Employers may provide fertility benefits through a separate, fully insured policy if there is no coordination between the fertility benefit and exclusions under any other group health plan maintained by the same employer, and the benefits are payable regardless of coverage under other plans;
2. **Excepted benefit health reimbursement arrangement (EBHRA)**—Employers can reimburse employees for out-of-pocket fertility expenses through an EBHRA, provided the arrangement complies with applicable regulatory requirements; and
3. **Employee assistance program (EAP)**— Employers may offer fertility-related coaching and navigator services through an EAP that qualifies as a limited excepted benefit. To qualify, the EAP cannot be coordinated with benefits under another group health plan, cannot require employee premiums or contributions for participation, and cannot impose cost sharing.

Looking ahead, the agencies stated that they intend to propose rulemaking to provide additional ways for certain fertility benefits to be offered outside of traditional group health plan coverage. At the same time, state-level mandates continue to expand. California recently joined more than 20 other states with fertility benefit mandates. In 2026, employers should assess whether their current health plans meet applicable state mandates, particularly in states like California, where new requirements are taking effect. Employers with self-funded plans that are not subject to state mandates should consider their options for offering fertility benefits to remain competitive. Monitoring forthcoming federal rulemaking can help identify cost-effective strategies for offering fertility benefits outside traditional group health plans.

LINKS AND RESOURCES

- OBBBA's text and implementation guidance (IRS Notice 2026-5)
- Guidance on ACA simplified reporting (IRS Notice 2025-15)
- FAQs about offering fertility benefits outside of group health plan coverage
- Trump administration's nonenforcement policy regarding a 2014 final rule on mental health parity

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