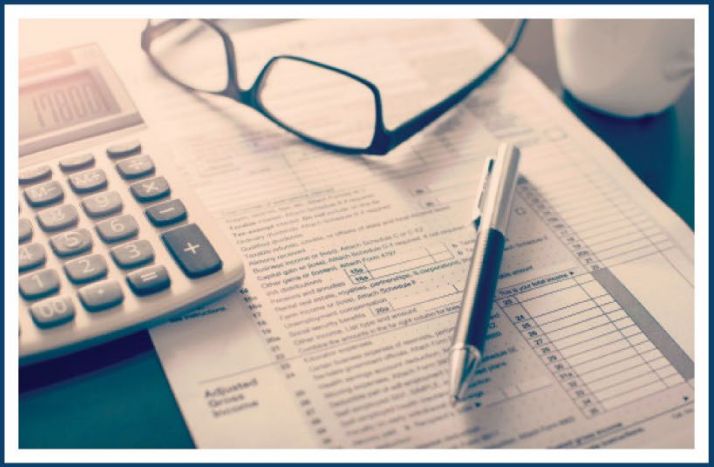
OPEN ENROLLMENT CHECKLIST 2026



2026 Open Enrollment Checklist

To prepare for open enrollment, employers that sponsor health plans should be aware of compliance changes affecting the design and administration of their plans for plan years beginning on or after Jan. 1, 2026. These changes include limits adjusted for inflation each year, such as the Affordable Care Act's (ACA) affordability percentage and cost-sharing limits for high deductible health plans (HDHPs). Employers should review their health plan's design to confirm that it has been updated, as necessary, for these changes.

In addition, any changes to a health plan's benefits for the 2026 plan year should be communicated to plan participants through an updated Summary Plan Description (SPD) or a Summary of Material Modifications (SMM).

Health plan sponsors should also confirm that their open enrollment materials contain certain required participant notices, such as the summary of benefits and coverage (SBC), when applicable. Some participant notices must also be provided annually or upon initial enrollment. Employers should consider including these notices in their open enrollment materials to minimize costs and streamline administration.

PLAN DESIGN CHANGES

ACA Affordability Standard

The ACA requires ALEs to offer affordable, minimum-value health coverage to their full-time employees (and dependents) or risk paying a penalty to the IRS. This employer mandate is also known as the "pay-or-play" rules. An ALE is an employer with at least 50 full-time employees, including full-time equivalent employees, during the preceding calendar year.

An ALE's health coverage is considered affordable if the employee's required contribution for the lowest cost self-only coverage that provides minimum value does not exceed 9.5% (as adjusted) of the employee's household income for the taxable year. For plan years beginning in 2025, the adjusted affordability percentage is 9.02%. On July 18, 2025, the IRS announced that the affordability percentage will increase to **9.96% for plan years beginning in 2026**. This is a significant increase from the affordability percentage for 2025 and the highest this percentage has ever been. As a result, employers may be able to increase employees' health coverage contributions for 2026 while still meeting the adjusted affordability percentage.

ALEs should take the following step for the 2026 plan year:

- Confirm that at least one of the health plans offered to full-time employees satisfies the ACA's affordability standard (9.96%). Because an employer generally will not know an employee's household income, the IRS has provided three optional safe harbors that ALEs may use to determine affordability based on information that is available to them: the Form W-2 safe harbor, the rate-of-pay safe harbor and the federal poverty line safe harbor.

Out-of-Pocket Maximum Limits

The ACA requires non-grandfathered health plans and health insurance issuers to comply with annual limits on total enrollee cost sharing for essential health benefits (EHB). This type of cost-sharing limit is commonly referred to as an out-of-pocket maximum (OOPM). **The OOPMs for EHB for plan years beginning on or after Jan. 1, 2026, are $10,600 for self-only coverage and $21,200 for family coverage**.

The ACA's OOPM for self-only coverage applies to each individual, regardless of whether the individual is enrolled in self-only coverage or family coverage. **This requires health plans and issuers to embed an individual OOPM in family coverage if the family OOPM is greater than the ACA's OOPM for self-only coverage ($10,600 for 2026 plan years).**

Also, to be compatible with HSA contributions, **HDHPs must comply with lower limits on OOPMs**.

With these requirements in mind, employers should take the following steps:

- Review the health plan's OOPMs to ensure they comply with the ACA's limits for the 2026 plan year;
- Determine if the health plan's OOPM for family coverage is greater than the ACA's OOPM for self-only coverage ($10,600 for 2026 plan years). If it is greater, make sure the health plan embeds an individual OOPM for family coverage that is not more than $10,600; and
- If the health plan is an HDHP, confirm that it complies with the lower limits on OOPMs. **For the 2026 plan year, the OOPMs for HDHPs are $8,500 for self-only coverage and $17,000 for family coverage.**

Preventive Care Benefits

The ACA requires non-grandfathered health plans and issuers to cover a set of recommended preventive services without imposing cost-sharing requirements, such as deductibles, copayments or coinsurance, when in-network providers provide the services. The recommended preventive care services covered by these requirements are:

- Evidence-based items or services with an A or B rating in recommendations of the U.S. Preventive Services Task Force;
- Immunizations for routine use in children, adolescents and adults recommended by the Advisory Committee on Immunization Practices;
- Evidence-informed preventive care and screenings in guidelines supported by the Health Resources and Services Administration (HRSA) for infants, children and adolescents; and
- Other evidence-informed preventive care and screenings in HRSA-supported guidelines for women.

Health plans and issuers are required to adjust their first-dollar coverage of preventive care services based on the latest preventive care recommendations. In general, coverage must be provided for a newly recommended preventive health service or item for plan years beginning on or after the one-year anniversary of when the recommendation was issued. For example, **for plan years beginning after Dec. 30, 2025, health plans and issuers must expand their first-dollar coverage for preventive care for women to include additional breast cancer imaging or testing that may be required to complete the initial mammography screening process**. In addition, health plans and issuers must cover **patient navigation services** for breast and cervical cancer screening without cost sharing.

Before the beginning of the 2026 plan year, employers should take the following step:

- Confirm the health plan covers the latest recommended preventive care services without imposing any cost sharing when the care is provided by in-network providers.

Health FSA Contributions

The ACA imposes a dollar limit on employees' pre-tax contributions to a health FSA. This limit is indexed each year for cost-of-living adjustments. An employer may set their own dollar limit on employees' contributions to a health FSA as long as the employer's limit does not exceed the ACA's maximum limit in effect for the plan year**. For plan years beginning in 2026, the health FSA limit has been increased to $3,400 and FSA carryover limit increases to $680.**

- Confirm that health FSAs will not allow employees to make pre-tax contributions in excess of the 2026 limit.
- Communicate the health FSA limit to employees as part of the open enrollment process.

HDHP and HSA Limits

The IRS limits for HSA contributions and HDHP cost sharing (minimum deductible and OOPM) increase for 2026. The HSA contribution limits will increase effective Jan. 1, 2026, while the HDHP cost-sharing limits will increase effective for plan years beginning on or after Jan. 1, 2026. Looking ahead, employers should take these steps:

- Check whether HDHP cost-sharing limits need to be adjusted for the 2026 limits; and
- Communicate HSA contribution limits for 2026 to employees as part of the enrollment process.

The following table contains the HDHP and HSA limits for 2026 compared to 2025. It also includes the catch-up contribution limit that applies to HSA-eligible individuals age 55 and older, which is not adjusted for inflation and stays the same from year to year.

Type of Limit		2025	2026	Change
HSA Contribution Limits	Self-only	$4,300	$4,400	**Up $100**
	Family	$8,550	$8,750	**Up $200**
HSA Catch-up Contributions	Age 55 and older	$1,000	$1,000	**No change**
HDHP Minimum Deductibles	Self-only	$1,650	$1,700	**Up $50**
	Family	$3,300	$3,400	**Up $100**
HDHP OOPM *(deductibles, copayments and other amounts but not premiums)*	Self-only	$8,300	$8,500	**Up $200**
	Family	$16,600	$17,000	**Up $400**

HDHPs: Permanent Extension of Telehealth Option

To be eligible for HSA contributions, an individual must be covered under an HDHP and have no other impermissible coverage. Historically, individuals who were covered by telehealth programs that provided free or reduced-cost benefits before the HDHP was satisfied were not eligible for HSA contributions.

A pandemic-related relief measure temporarily allowed HDHPs to waive the deductible for telehealth services without impacting HSA eligibility. This relief expired at the end of the 2024 plan year. However, the One Big Beautiful Bill Act **permanently extends the ability of HDHPs to provide benefits for telehealth and other remote care services before plan deductibles have been met without jeopardizing HSA eligibility**. Due to the permanent extension, HDHPs may waive the deductible for any telehealth or other remote care services for plan years beginning in 2025 and beyond without causing participants to lose HSA eligibility. This provision is optional; HDHPs can apply any telehealth services, other than preventive care, toward the deductible.

Due to this change, employers with HDHPs should take these steps:

- Determine whether the HDHPs will waive the deductible for telehealth services for the plan year beginning in 2026; and
- Notify plan participants of any cost-sharing changes for telehealth services through an updated SPD or SMM.

Mental Health Parity—Required Comparative Analysis for NQTLs

The Mental Health Parity and Addiction Equity Act (MHPAEA) requires parity between a health plan's medical/surgical benefits and its mental health or substance use disorder (MH/SUD) benefits. These parity requirements apply to financial requirements and treatment limits for MH/SUD benefits. In addition, any nonquantitative treatment limitations (NQTLs) placed on MH/SUD benefits must comply with MHPAEA's parity requirements. For example, NQTLs include prior authorization, step therapy protocols, network adequacy and medical necessity criteria.

MHPAEA requires health plans and issuers to conduct comparative analyses of the NQTLs used for medical/surgical benefits compared to MH/SUD benefits. This analysis must contain a detailed, written and reasoned explanation of the specific plan terms and practices at issue and include the basis for the plan's or issuer's conclusion that the NQTLs comply with MHPAEA. **Plans and issuers must make their comparative analyses available to specific federal agencies or applicable state authorities as well as participants upon request**. In 2024, federal agencies released a final rule under MHPAEA that would have imposed stricter standards for comparative analyses for the plan year beginning in 2026. However, enforcement of this final rule has been put on hold by the Trump administration. Although the final rule's requirements are not being enforced, MHPAEA's statutory requirement to conduct comparative analyses remains in effect.

Considering this information, employers should take the following step:

- Reach out to the health plan's issuer or third-party administrator (TPA) to confirm that comparative analyses of NQTLs will be updated, if necessary, for the plan year beginning in 2026.

Prescription Drug Benefits – Creditable Coverage Determination

The Inflation Reduction Act of 2022 (IRA) includes several cost-reduction provisions affecting Medicare Part D plans, which may impact the creditable coverage status of employer-sponsored prescription drug coverage for 2025 and 2026.

Employers that provide prescription drug coverage to individuals who are eligible for Medicare Part D must inform these individuals and the Centers for Medicare and Medicaid Services (CMS) whether their prescription drug coverage is creditable, meaning that the employer's prescription drug coverage is at least as good as Medicare Part D coverage.

In its Final Part D Redesign Program Instructions, **CMS has revised one of the methods for determining whether coverage is creditable (the "simplified determination" method)** to better reflect actuarial equivalence with the richer Part D benefit under the IRA. CMS will continue to permit use of the existing simplified determination methodology, without modification, for calendar year 2025 for group health plan sponsors who are not applying for the retiree drug subsidy (RDS).

For calendar year 2026 only, non-RDS group health plans are **permitted to use either the existing simplified determination methodology or the revised simplified determination methodology to determine whether their prescription drug coverage is creditable.** Under the revised simplified determination methodology, the group health plan coverage must be designed to pay, on average, at least 72% of participants' prescription drug expenses (versus 60% under the existing methodology) to be considered creditable coverage.

Under existing CMS guidance, there are a few different ways for an employer to determine whether its prescription drug coverage is creditable:

- As a first step, employers with insured prescription drug plans should ask their carriers whether they have determined whether the plan's coverage is creditable.

- For self-insured plans, or where the carrier for an insured plan has not made a determination about whether the plan is creditable, employers may use a simplified determination—as long as the coverage meets certain design requirements. If it doesn't, the employer must use an actuarial determination method.

ACA EMPLOYER MANDATE REQUIREMENTS

Applicable Large Employer Status (ALE)

Under the ACA's employer penalty rules, applicable large employers (ALEs) that do not offer health coverage to their full-time employees (and dependent children) that is affordable and provides minimum value will be subject to penalties if any full-time employee receives a government subsidy for health coverage through an Exchange.

To qualify as an ALE, an employer must employ, on average, **at least 50 full-time employees, including full-time equivalent employees (FTEs)**, on business days during the preceding calendar year. All employers that employ at least 50 full-time employees, including FTEs, are subject to the ACA's pay or play rules.

- Determine your ALE status for 2026.
- Calculate the number of full-time employees for all 12 calendar months of 2025. A full-time employee is an employee who is employed on average for at least 30 hours of service per week.
- Calculate the number of FTEs for all 12 calendar months of 2025 by calculating the aggregate number of hours of service (but not more than 120 hours of service for any employee) for all employees who were not full-time employees for that month and dividing the total hours of service by 120.
- Add the number of full-time employees and FTEs (including fractions) calculated above for all 12 calendar months of 2025.
- Add up the monthly numbers from the preceding step and divide the sum by 12. Disregard fractions.
- If your result is 50 or more, you are likely an ALE for 2026.

Identify Full-time Employees

All full-time employees must be offered affordable minimum value coverage. A full-time employee is an employee who was employed on average at least 30 hours of service per week. The final regulations generally treat 130 hours of service in a calendar month as the monthly equivalent of 30 hours of service per week. The IRS has provided two methods for determining full-time employee status—the **monthly measurement method** and the **look-back measurement method.**

- Determine which method you are going to use to determine full-time status
- Monthly measurement method involves a month-to-month analysis where full-time employees are identified based on their hours of service for each month. This method is not based on averaging hours of service over a prior measurement method. Month-to-month measuring may cause practical difficulties for employers, particularly if there are employees with varying hours or employment schedules, and could result in employees moving in and out of employer coverage on a monthly basis.

- Look-back measurement method allows an employer to determine full-time status based on average hours worked by an employee in a prior period. This method involves a measurement period for counting/averaging hours of service, an administrative period that allows time for enrollment and disenrollment, and a stability period when coverage may need to be provided, depending on an employee's average hours of service during the measurement period.

Offer of Coverage

An ALE may be liable for a penalty under the pay or play rules if it does not offer coverage to "substantially all" **(95%)** full-time employees (and dependents) and any one of its full-time employees receives a premium tax credit or cost-sharing reduction for coverage purchased through an Exchange. Employees who are offered health coverage that is **affordable** and provides **minimum value** are generally not eligible for these Exchange subsidies.

- Offer minimum essential coverage to all full-time employees
- Ensure that at least one of those plans provides minimum value (**60%** actuarial value)
- Ensure that the minimum value plan offered is affordable to all full-time employees by ensuring that the employee contribution for the lowest cost single minimum value plan does not exceed **9.96%** of an employee's earnings based on the employee's W-2 wages, the employee's rate of pay, or the federal poverty level for a single individual.

Reporting of Coverage

The ACA requires ALEs to report information to the IRS and to employees regarding the employer- sponsored health coverage on Form 1095-C. The IRS will use the information that ALEs report to verify employer-sponsored coverage and to administer the employer shared responsibility provisions (**Code Section 6056).**

In addition, the ACA requires every health insurance issuer, ***sponsor of a self-insured health plan***, government agency that administers government-sponsored health insurance programs and any other entity that provides minimum essential coverage (MEC) to file an annual return with the IRS and individuals reporting information for each individual who is provided with this coverage (**Code Section 6055).**

Beginning in 2024, employers that file at least 10 returns during the calendar year must file their ACA returns electronically. Reporting entities must aggregate most information returns, such as Forms W-2 and 1099, to determine if they meet the 10-return threshold for mandatory electronic filing.

In addition, at the end of 2024, Congress passed two new laws, the Paperwork Burden Reduction Act and the Employer Reporting Improvement Act, which ease ACA reporting requirements for employers. The new laws ease ACA reporting requirements for employers as follows:

- **Individual statements only required upon request**—Beginning in 2025, employers are **no longer required to send Form 1095-C to individuals unless a form is requested**. Employers must give individuals timely notice of this option by posting a clear and conspicuous notice on their website, which must remain accessible through Oct. 15 of the year following the calendar year to which the return relates. Any request must be fulfilled by Jan. 31 of the year following the calendar year to which the return relates or 30 days after the date of the request, whichever is later;
- **Electronic consent for individual statements**—The legislation clarifies that statements can be provided electronically to individuals if they have affirmatively consented "at any prior time" (unless they have revoked such consent in writing); and
- **Substituting birth dates for taxpayer identification numbers (TINs)**—The legislation confirms that employers may substitute a covered individual's birth date in lieu of their TIN (though the legislation does not address whether reporting entities are still required to make reasonable efforts to obtain the TIN before doing so).

Comparative Effectiveness Research Fee (PCORI)

Sponsors of self-funded plans and health insurance issuers of fully insured plans are required to pay a fee each year, by July 31st, to fund comparative effectiveness research. Fees will increase to $3.47 per covered life in 2026 and are next due July 31, 2026.

W-2 Reporting

Healthcare Reform requires employers to report the aggregate cost of employer-sponsored group health plan coverage on their employees' Forms W-2. This reporting requirement was originally effective for the 2011 tax year. However, the IRS later made reporting optional for 2011 for all employers.

The IRS further delayed the reporting requirement for small employers (those that file fewer than 250 Forms W-2) by making it optional for these employers until further guidance is issued. For the larger employers, the reporting requirement was mandatory for the 2012 Forms W-2 and continues.

OPEN ENROLLMENT NOTICES

Employers that sponsor health plans should provide certain benefits notices in connection with their plans' open enrollment periods. Some of these notices must be provided at open enrollment time, such as the SBC. Other notices, such as the WHCRA notice, must be distributed annually. Although these annual notices may be provided at different times throughout the year, employers often choose to include them in their open enrollment materials for administrative convenience.

In addition, employers should review their open enrollment materials to confirm that they accurately reflect the terms and cost of coverage. In general, any plan design changes for 2026 should be communicated to plan participants either through an updated SPD or an SMM.

Summary of Benefits and Coverage

The ACA requires health plans and health insurance issuers to provide an SBC to applicants and enrollees each year at open enrollment or renewal time. Federal agencies have provided a template for the SBC, which health plans and issuers are required to use. To comply with the SBC requirements, employers should include an updated SBC with open enrollment materials.

Take note that the plan administrator is responsible for providing the SBC for self-funded plans. For insured plans, the issuer usually prepares the SBC. If the issuer prepares the SBC, an employer is not required to also prepare an SBC for the health plan, although they may need to distribute the SBC prepared by the issuer.

Medicare Part D Notices

Employers that provide prescription drug coverage to individuals who are eligible for Medicare Part D must inform these individuals whether their prescription drug coverage is creditable, meaning that the employer's prescription drug coverage is at least as good as Medicare Part D coverage. There is no penalty or fee for employers that offer prescription drug coverage that is non-creditable. Non-creditable prescription drug coverage can still be a valuable benefit for employees. However, individuals need to know whether their prescription drug coverage is creditable or non-creditable. If the coverage is non-creditable, and Medicare-eligible individuals fail to enroll in Part D during their initial enrollment period, they can be subject to a higher Part D premium if they enroll in Part D at a later date.

The notice must be provided at various times, including when an individual enrolls in the plan and each year before Oct. 15 (when the Medicare annual open enrollment period begins). Also, a new notice must be provided whenever prescription drug coverage ends or changes so that it is no longer creditable or becomes creditable. Model notices are available on the Centers for Medicare and Medicaid Services' website.

Annual CHIP Notices

Health plans covering residents in a state that provides a premium subsidy to low-income children and their families to help pay for employer-sponsored coverage must send an **annual** CHIP notice about the available assistance to all employees residing in that state. The U.S. Department of Labor (DOL) has provided a model notice. Employers should confirm they are using the most recent model notice, as the DOL updates it regularly.

Initial COBRA Notices

COBRA applies to health plans sponsored by employers with 20 or more employees. Health plan administrators must provide an initial COBRA notice to new participants and certain dependents within **90 days** after plan coverage begins. The initial COBRA notice may be incorporated into the plan's SPD. A model initial COBRA notice is available from the DOL.

SPDs

Plan administrators must provide an SPD to new participants within **90 days** after plan coverage begins. Any changes made to the plan should be reflected in an updated SPD booklet or described to participants through an SMM. Also, an updated SPD must be furnished every five years if changes are made to SPD information or the plan is amended. Otherwise, a new SPD must be provided every 10 years.

Notices of Patient Protections

Under the ACA, health plans and issuers that require the designation of a participating primary care provider must permit each participant, beneficiary and enrollee to designate any available participating primary care provider (including a pediatrician for children). Additionally, plans and issuers that provide obstetrical/gynecological care and require a designation of a participating primary care provider may not require preauthorization or referral for such care. If a health plan requires participants to designate a participating primary care provider, the plan or issuer must provide a notice of these patient protections whenever the SPD or similar description of benefits is provided to a participant. If an employer's plan is subject to this notice requirement, they should confirm that it is included in the plan's open enrollment materials. This notice may be included in the plan's SPD or benefit summary provided by the issuer or TPA. Model language is available from the DOL.

Grandfathered Plan Notices

If an employer has a grandfathered plan, it should include information about the plan's grandfathered status in plan materials describing the coverage under the plan, such as SPDs and open enrollment materials. Model language is available from the DOL.

Notices of HIPAA Special Enrollment Rights

An employer's health plan must notify each eligible employee of their special enrollment rights under HIPAA **at or before enrollment.** This notice may be included in the plan's SPD or benefit summary provided by the issuer or TPA.

HIPAA Privacy Notices

The HIPAA Privacy Rule requires covered entities (including health plans and issuers) to provide a Notice of Privacy Practices (or Privacy Notice) to each individual who is the subject of protected health information (PHI). Health plans are required to send the Privacy Notice at certain times, including **to new enrollees at the time of enrollment**. Also, at least once every three years, health plans must either redistribute the Privacy Notice or notify participants that the Privacy Notice is available and explain how to obtain a copy.

Self-insured health plans must maintain and provide their own Privacy Notices. However, special rules apply for fully insured plans, where the issuer, not the plan itself, is primarily responsible for the Privacy Notice.

Model Privacy Notices are available through the U.S. Department of Health and Human Services.

WHCRA Notices

Health plans and issuers must provide a notice of participants' rights to mastectomy-related benefits under the WHCRA **at the time of enrollment and on an annual basis**. The DOL's compliance assistance guide includes model language for this disclosure.

NMHPA Notice

Plan administrators must include a statement within the Summary Plan Description (SPD) timeframe describing requirements relating to any hospital length of stay in connection with childbirth for a mother or newborn child under the Newborn's Mother's Health Protections Act. Model language for this disclosure is available on the DOL's website

SARs

Plan administrators required to file Form 5500 must provide participants with a narrative summary of the information in Form 5500, called a summary annual report (SAR). Health plans that are unfunded (that is, benefits are payable from the employer's general assets and not through an insurance policy or trust) are not subject to the SAR requirement. The plan administrator generally must provide the SAR **within nine months of the close of the plan year**. If an extension of time to file Form 5500 is obtained, the plan administrator must furnish the SAR within two months after the close of the extension period. A model notice is available from the DOL.

Wellness Program Notices

Health plans that include wellness programs may be required to provide certain notices regarding the program's design. As a general rule, these notices should be provided **when the wellness program is communicated to employees and before employees provide any health-related information or undergo medical examinations**. These notices are required in the following situations:

- **HIPAA Wellness Program Notice**—HIPAA imposes a notice requirement on health-contingent wellness programs offered under health plans. Health-contingent wellness plans require individuals to satisfy standards related to health factors (e.g., not smoking) to obtain rewards or avoid surcharges. The notice must disclose the availability of a reasonable alternative standard to qualify for the reward (and, if applicable, the possibility of waiver of the otherwise applicable standard) and be included in all plan materials describing the terms of a health-contingent wellness program. The DOL's compliance assistance guide includes a model notice that can be used to satisfy this requirement.
- **Americans with Disabilities Act (ADA) Wellness Program Notice**—Employers with 15 or more employees are subject to the ADA. Wellness programs that include health-related questions or medical exams must comply with the ADA's requirements, including an employee notice requirement. Employers must give participating employees a notice that tells them what information will be collected as part of the wellness program, with whom it will be shared and for what purpose, as well as include the limits on disclosure and the way information will be kept confidential. The U.S. Equal Employment Opportunity Commission has provided a sample notice to help employers comply with this ADA requirement.