Monthly Compliance Update

July 2026

*A brief update on what happened the prior month in group health benefits compliance at the **federal level** and organized chronologically.*

Final action on HIPAA Security Rule modifications projected for July 2027. HHS has extended its projected timeline for issuing final regulations modifying the HIPAA Security Rule out to July 2027. Note that this date is not set in stone and often gets extended further. But it represents HHS' current projection and their intent of when the previously issued proposed rule will be finalized and published.

- As a reminder, HHS issued a proposed rule titled ""HIPAA Security Rule to Strengthen the Cybersecurity of Electronic Protected Health Information" back in January 2025 that (if finalized) would strengthen the HIPAA Security Rule and would require covered entitles to:
    - Meet new and expanded requirements for implementing encryption and multi-factor authentication.
    - Maintain technology asset inventories and network maps.
    - Revise business associate agreements (BAAs) and obtain written verification at least once every 12 months that business associates deploy certain technical safeguards.
    - Treat all implementation specifications as mandatory, eliminating the distinction between "required" and "addressable" implementation specifications.
    - Review, verify, and update risk analyses on an ongoing basis and at least once every 12 months.
    - Perform penetration tests at least once every 12 months.
    - Perform vulnerability scans at least every six months.
    - Implement additional data backup and recovery controls and testing requirements.
    - Audit compliance with the Security Rule at least once every 12 months.
- If the proposed rule is finalized (now currently projected as July 2027 to be finalized), it would be the first modification to the HIPAA Security Rule since 2013 and would add significant compliance obligations (and costs) for HIPAA covered entities and business associates.

Court finds that time theft constitutes gross misconduct, relieving employer of COBRA obligations. As a reminder, the termination of a covered employee's employment (other than for gross misconduct) is a triggering event that may require an offer of COBRA continuation coverage. When the gross misconduct exception applies, an employer is not required to provide a COBRA election notice or offer continuation coverage.

- In recent litigation, a former employee sued his employer alleging that the employer failed to offer him COBRA coverage after terminating his employment. The employer had designated the termination as one for gross misconduct based on its determination that the employee had engaged in time theft by logging compensable work hours during periods when he was away from work attending medical appointments. Based on the gross misconduct designation, the employer notified the employee that he was ineligible for COBRA coverage.
- In its ruling, the court noted that the COBRA rules do not define "gross misconduct." Surveying case law from multiple jurisdictions, the court concluded that gross misconduct goes well

beyond mere negligence or occasional lapses in judgment and encompasses conduct that is intentional, wanton, willful, deliberate, reckless, or in deliberate indifference to an employer's interests. Applying that standard, the court agreed with the employer that the employee had engaged in time theft, illustrating an intentional, willful, deliberate, or reckless indifference to his employer's interests. So, the court held that the employer had no obligation to notify the employee of his right to continued COBRA coverage and ruled in the employer's favor.

- Note that the gross misconduct determination is highly fact-specific, and employers that incorrectly invoke the exception may face liability for COBRA notice failures and related penalties. This decision suggests that intentional falsification of time records, particularly when it results in compensation for unworked hours, may support a gross misconduct determination. However, employers considering reliance on the gross misconduct exception should carefully document the facts underlying the termination and ensure that the evidence demonstrates deliberate misconduct rather than poor performance, negligence, or misunderstanding of workplace rules.

Court upholds plan's exclusion of GLP-1 drugs for weight loss, despite FDA approval to treat sleep apnea. With the popularity of GLP-1 drugs, plan sponsors are taking a closer look at the costs and benefits of providing GLP-1 coverage. Many plan sponsors have decided to limit their coverage of GLP-1s to only diabetes and not extend coverage to weight loss or other conditions. To limit GLP-1 coverage, a common approach is to add "weight loss medications" or "non-surgical obesity treatments" to the list of the plan's coverage exclusions. A recent federal court case offers some comfort to plan sponsors that implement this type of weight loss medication exclusion. The plaintiff was prescribed Zepbound to treat sleep apnea, but he was denied coverage because his prescription benefit plan did not cover Zepbound. The plaintiff sued for denial of benefits and breach of fiduciary duty under ERISA. The plaintiff argued that the FDA's authorization of Zepbound to treat sleep apnea (a separate medical condition under the plan) removed it from the plan's exclusion for weight loss medications. That is, the use of the drug to treat sleep apnea trumped the plan's exclusion of weight-loss drugs. But the court disagreed and concluded that the claims administrator had properly denied coverage for Zepbound to treat sleep apnea. The court found that the plan's prescription drug plan unambiguously excluded coverage for "prescription drugs for weight loss," and that the GLP-1 medication—designated as an "anti-obesity agent" on the plan's formulary—fell squarely within that exclusion. The court focused on the wording of the FDA approvals, which stated that Zepbound aids sleep apnea "by reducing body weight." Based on this express FDA language, the court reasoned that Zepbound improves the condition of sleep apnea because it promotes weight loss, not as a separate, unrelated benefit. And concluded that Zepbound is a weight-loss drug that was excluded under the terms of the plan. In reaching its holding, the court differentiated coverage of similar GLP-1 medications for treatment of diabetes, pointing out that those similar GLP-1 medications have been FDA approved specifically to treat diabetes, regardless of whether the person is also obese. More lawsuits can be expected as group health plan participants seek coverage for usage of GLP-1 medications for a broadening range of conditions, but this case should give some comfort to those plan sponsors who are relying on a simple weight loss or obesity drug exclusion to limit their liability exposure under their plans.

DOL and HHS publish 2026 regulatory agenda. On July 3, the DOL and HHS released their 2026 regulatory agenda that serves as a public roadmap for how federal agencies intend to implement the President's policy priorities through rulemaking, guidance, and deregulatory actions. While agencies frequently adjust projected timelines, the regulatory agenda offers insight into areas where the agencies are likely to focus regulatory and oversight efforts in the year ahead. More specifically, the agenda reflects agency planning and priorities, but it does not create legal obligations or a guarantee that a

rulemaking will occur on the projected timeline. Below are items of interest to group health plan sponsors, and GBS will provide updates when any proposed and final rules are issued.

- HHS regulations:
    - Requirements Related to Advanced Explanation of Benefits and Other Provisions Under the Consolidated Appropriations Act 2021 (expected September 2026). As a reminder, an explanation of benefits (EOB) is a statement detailing how a medical claim is processed, what the insurer paid, and what the insured will pay. Currently, EOBs are provided after a healthcare provider files a claim. An advanced EOB would be disclosed in response to a provider's disclosure to a health plan of a good faith estimate (GFE) of the items and services to be provided to a participant. Between the GFE and the advanced EOB, the participant would be able to properly estimate the cost of care. The advanced EOB requirement was part of the CAA 2021, but regulations have not yet been issued to make the requirement effective.
    - Exchange Pre-Enrollment Eligibility Verification (expected July 2026).
    - Patient Protection and Affordable Care Act; State Innovation Waivers and Health Care Choice Compacts (expected July 2026).
    - Short-Term, Limited-Duration Insurance (expected August 2026).
    - Requirements Related to Air Ambulance Services, Agent and Broker Disclosures, and Provider Enforcement (expected September 2026).
    - Requirements Related to the Mental Health Parity and Addiction Equity Act (expected December 2026).
- DOL regulations:
    - Excepted Benefits (expected July 2026). These regulations may provide additional guidance on the newly proposed excepted fertility benefit.
    - Pooled Employer Plans and Association Health Plans (AHPs). This is a second bite at the apple on AHPs by the Trump administration, whose first attempt was vacated by the courts.
    - Individual Coverage Health Reimbursement Arrangements (ICHRAs) (expected July 2026). With only one round of guidance so far, ICHRA guidance will be welcome to resolve some outstanding compliance questions.
    - PBM Fee Disclosures and Prohibited Exemption Procedures (expected September 2026). These regulations will provide processes to help fiduciaries obtain fee information from their PBMs and explain how to analyze that information to avoid a prohibited transaction when engaging a PBM.
    - Transparency in Coverage Rules (expected July 2026). These proposed rules would begin to codify many of the actions already taken by employers and their carriers (machine readable files, self-service internet-based tools, and other transparency efforts).
    - 530A Accounts. Both the DOL and IRS are expected to offer proposed guidance on 530A Accounts, commonly referred to as Trump Accounts.

Initial contributions to Trump Accounts will default to S&P 500 ETF. As a reminder, effective July 4, contributions may now be made to Section 530A Trump Accounts. The IRS announced on July 1, that initial contributions will be default invested into the State Street SPDR Portfolio S&P 500 ETF (SPYM), a low-cost ETF that tracks the performance of the S&P 500 Index, with the potential for individuals to allocate to four additional ETFs afterwards.

IRS updates standard mileage rates for second half of 2026. On July 13, the IRS issued Bulletin No. 2026-29 with the standard mileage rates for business and medical use of an automobile. Normally, the IRS updates mileage rates only once a year, but occasionally it makes interim adjustments like this one, which reflects the rising cost of gas in 2026. For travel on or after July 1, 2026, the business standard mileage rate is 76 cents per mile (up from the original 2026 rate of 72.5 cents per mile). The rate when an automobile is used to obtain medical care—which may be deductible under Section 213 if it is primarily for, and essential to, the medical care—is 23.5 cents per mile for travel on or after July 1, 2026 (up from 20.5 cents per mile). Transportation expenses that are deductible medical expenses under Section 213 generally can be reimbursed on a tax-free basis by a health FSA, HRA, or HSA. (To simplify administration, some employers' health FSAs or HRAs exclude medical transportation expenses from the list of reimbursable items.) The applicable reimbursement rate is the one in effect when the expense was incurred.

Model state ICHRA tax credit bill emerges. The National Council of Insurance Legislators (NCOIL) has created a model bill for states to offer state income tax credits to employers sponsoring individual coverage health reimbursement arrangements (ICHRAs). The model bill establishes a tax credit for businesses that employ between 2 and 50 employees and offer an ICHRA. Currently, only Indiana provides an ICHRA tax credit, which has been in place since 2023. However, Georgia is considering a similar bill, and an Ohio state representative is sponsoring an ICHRA tax credit bill there. As a result, more states could soon offer the tax credit as an incentive to employers providing these plans.

2027 ACA affordability percentage increases to 10.22%. On July 21, the IRS announced in Rev. Proc. 2026-26 that the ACA affordability percentage for plan years beginning in 2027 will be increasing to 10.22% (from 9.96% for 2026). As a reminder, under the ACA employer mandate, applicable large employers (ALEs) must offer affordable health coverage to full-time employees or face potential penalties. The annually adjusted affordability percentage is used to determine the threshold, at or below which the cost of coverage will be considered affordable. Generally, coverage offered to a full-time employee will be considered affordable if the employee's contribution for self-only coverage does not exceed the applicable percentage of the employee's household income for the taxable year. Because employers typically are unaware of what an employee's actual household income is, the rules provide three affordability safe harbors: (1) employee's Form W-2 wages; (2) employee's rate of pay; and (3) the federal poverty line. Employers should review the required employee contribution for 2027 coverage if they plan to meet the ACA's affordability limit under the applicable safe harbor.

DOL proposes new safe harbor for electronic delivery of ERISA-required group health plan disclosures. On July 23, the DOL published a proposed rule titled "Electronic Disclosure by Group Health Plans Under ERISA" (and provided an associated news release). The proposed rule, if finalized, would create a new optional electronic disclosure safe harbor for ERISA-required group health plan documents (e.g., SPDs, SMMs, annual notices, etc.) that would make it easier for plan sponsors to furnish required notices electronically. As a reminder, the general rule for ERISA-required disclosures is that they are required to be distributed using a delivery method that is reasonably calculated to ensure actual receipt and likely to result in full distribution. Currently, plans may use the 2002 "wired at work" safe harbor to satisfy the general delivery requirements when furnishing disclosures electronically. The 2002 safe harbor applies to recipients in two categories: (1) participants who can be considered "wired at work" (i.e., have computer access as a regular part of their job); and (2) participants, beneficiaries, and other individuals who consent to receive documents electronically. The proposed rule adds to the current 2002 "wired at work" electronic distribution safe harbor and does not replace existing disclosure rules. Plan sponsors

can continue using current delivery methods or elect to use the new safe harbor if finalized. Here are the highlights of the new proposed electronic distribution safe harbor:

- Covered plans. The proposed safe harbor would be available only to group health plans and not to other welfare plans (such as disability or life plans). It is unclear how this distinction would impact the distribution of something like a wrap summary plan description (wrap SPD) that includes both health and welfare plans. But the DOL requested comments on whether the new safe harbor should later be extended to other welfare plans, and hopefully the DOL to provide additional guidance and clarification when and if the final rule is published.
- Covered individuals. The proposed safe harbor would be available to individuals entitled to receive the required ERISA disclosures and who provide an email address or smartphone number capable of receiving electronic notices. Adult dependent children (age 18 or older) who provide their own electronic address would be treated as covered individuals independently, to ensure they have access to their healthcare information as well.
    - The plan sponsor may obtain the email or phone number through the plan's enrollment process, as a condition of employment, or by other means. When an employee later terminates, the employer must take reasonable measures to obtain an accurate electronic address for continued use of the new safe harbor after termination.
    - Individuals may opt out of electronic delivery and continue to be entitled to paper copies, free of charge, on request.
- Covered documents. The proposed safe harbor generally covers all documents that ERISA requires a group health plan administrator to furnish, including SPDs, SMMs, and other required ERISA disclosures. It would also apply to documents that must be furnished only upon request (e.g., a wrap plan document).
- Website posting requirement. To rely on the safe harbor, a plan administrator would need to maintain a reasonably accessible website or electronic repository (such as a mobile application) where plan documents and disclosures are available. Key requirements include:
    - Participants must be able to access the site outside the workplace to ensure compliance with the reasonable access standard.
    - Documents must be posted by the date they are otherwise required to be furnished.
    - Documents must remain available for at least one year after posting or until superseded by a newer version, if later.
    - Documents must be presented in a widely available and searchable format suitable for online viewing and printing (e.g., PDF format).
    - The administrator must take reasonable measures to protect the confidentiality of participant information.
- Initial paper notification. Plan administrators must furnish an initial paper notification explaining default electronic delivery of covered documents and the right to opt out before using the new safe harbor. However, the proposed rule would honor consents obtained before the first day of the calendar year following publication of the final rule and exempt them from this initial notice requirement if those consents meet the 2002 safe harbor. The initial paper notification under the proposed new safe harbor must:
    - Be written in a manner calculated to be understood by the average plan participant.
    - Summarize the required disclosure to be provided electronically.
    - Identify the electronic address to be used for the particular individual.
    - Include instructions to access the documents.
    - Disclose that the documents are not required to be available on the site for more than one year or, if later, after it is superseded by a subsequent version.

- Notify the individual of their right to obtain a paper version, free of charge, and how to exercise that right.
- And notify the individual of their right to opt out of electronic delivery and receive only paper versions of covered documents, and an explanation of how to exercise this right.

- Notice of Internet Availability (NOIA). Participants would be required to receive a Notice of Internet Availability (NOIA) informing them that a plan document has been posted online and is available for review, download, or printing. A plan may use either a separate NOIA for each covered document or an annual combined NOIA that identifies multiple documents. To use the proposed safe harbor, a group health plan administrator would need to receive from the employee an email address or smartphone number that can receive a written NOIA. Employers may use employer-assigned email addresses, although personal email addresses and personal smartphone numbers are also permitted.
  - Timing rules:
    - A NOIA generally must be provided to covered individuals when a covered document is made available electronically.
    - A combined annual NOIA would be timely if it is furnished each plan year (and generally no later than 14 months after the prior year's combined notice).
    - Using a combined NOIA does not delay the underlying deadline for posting required documents.
    - Documents that must be furnished only upon request would require a NOIA when the requested document is made available electronically.
  - Required content of a NOIA:
    - A title or subject line must include a prominent statement, for example, "Disclosure About Your Health Plan."
    - A statement must be included that reads: "Important information about your health plan is now available. Please review this information."
    - Identification of the covered document by name (for example, a statement that reads: "your HIPAA Notice of Special Enrollment Rights is now available") and a brief description of the covered document if the document name does not convey the document's nature. For example, "Michelle's Law Notice" would not convey the nature of the right and would require a further brief description.
    - The internet address or hyperlink where the documents are available. A plan may require a log-in, but the login page must provide a prominent link to the covered document.
    - A statement of the right to request and obtain paper versions of covered documents, free of charge, and an explanation of how to exercise this right.
    - A cautionary statement that the disclosure is not required to be available for more than one year, or if later, until it is superseded by a new document.
    - Contact information for the plan administrator or designated representative.
  - The NOIA may include a statement as to whether action by the covered individual is invited or required in response to the covered document and how to take such action, or that no action is required, provided that such statement is not inaccurate or misleading. Notably, the NOIA may contain only the information permitted by the rule, although the administrator may include logos, branding, and other non-misleading design elements.
  - NOIA delivery standards:
    - NOIA must be sent electronically to the covered individuals' provided email address or smartphone number.

- NOIA must be provided separately from any other documents or disclosures provided to covered individuals (subject to the limited consolidation rules described above).
- And the NOIA must be written in a manner understandable by the average plan participant.

Court stays portions of 2027 Notice of Benefit and Payment Parameters Final Rules. As we discussed last month, in June a court invalidated portions of the 2025 ACA Marketplace integrity rule. And the same plaintiffs sued to block similar provisions in the 2027 ACA Notice of Benefit and Payment Parameters that was published in May. Then on July 16, a district court granted the plaintiff's motion to stay those challenged provisions of the 2027 ACA Notice of Benefit and Payment Parameters, which includes the following individual coverage Marketplace rules:

- The expansion of eligibility for less comprehensive forms of coverage.
- The increased out-of-pocket spending burdens for certain enrollees.
- Mandatory verifications for low-income enrollees.
- Refusal to accept attestation from applicants when tax data is lacking.
- Verification requirements for special enrollment periods.
- The failure-to reconcile penalty.
- Reduced standards for network adequacy.
- The elimination of standardized plans and non-standardized plan limits.

Updated model CHIP Notice released. The DOL has released a new model employer CHIP Notice (available HERE) with information current as of July 31, 2026. As a reminder, group health plans that maintain a plan with participants who reside in a state that provides premium assistance under Medicaid or CHIP have an annual notice requirement to notify employees of the potential opportunities for premium assistance. The model CHIP notice is updated periodically to reflect changes in the states that offer premium assistance and changes to the relevant state contact information.

dfd