

McGohan Brabender's Compliance IN MOTION

September 2026

ACA Affordability Percentage for ALEs Increased to 10.22% for Plan Years Beginning in 2027

On July 21, 2026, the IRS [announced](#) a **10.22% affordability percentage for plan years starting in 2027** (an increase from 9.96% for plan years starting in 2026). This increase is partially due to a recent change in the indexing methodology.

This affordability percentage is used by Applicable Large Employers (ALEs) to determine whether the **employee-only tier of the lowest-cost medical plan providing minimum value** is affordable for each full-time employee. Coverage does not have to be affordable on additional plan options that cost more and does not have to be affordable for dependent coverage tiers.

There are three affordability safe harbors an ALE can use to determine whether coverage is “affordable” for each full-time employee:

- Rate of Pay (most common)
- W-2 (hardest to use, typically reserved for commission or tipped employees)
- Federal Poverty Line (FPL is easiest to use, and provides advantages for the employer)

A calendar year 2027 plan will be FPL affordable at \$135.92/mo (which is \$6.03/mo more than the \$129.89/mo for 2026 calendar year FPL affordability). If coverage costs \$135.92 or less, the employer's offer of coverage for the lowest cost plan for the self-only tier is automatically affordable for all employees eligible for that rate, regardless of their rate of pay or hours. While a non-calendar year plan beginning in 2027 can also use this figure, updated Federal Poverty Guidelines are expected in the third week of January, which typically provides an even higher threshold for plans that subsequently renew. An alert will be sent when that new figure becomes available (probably on or around January 22, 2027).

As an example of the rate of pay safe harbor, if the lowest paid full-time employees make \$15 per hour, the employer would multiply that by 130 hours per month (which is \$1,950

per month) to evaluate how much they need to pay for the employee-only tier of the lowest-cost plan providing minimum value.

- For the plan year that began in 2026 to be considered rate-of-pay affordable, the hourly employee could pay no more than \$194.22/mo (9.96% of \$1,950).
- For the plan year beginning in 2027 to be considered rate-of-pay affordable, the hourly employee could pay no more than \$199.29/mo (10.22% of \$1,950).

Note that plan years starting in 2026 would need to use the 2026 affordability percentage, which is 9.96%, for the entire plan year.

ALEs need to decide which affordability safe harbor(s) they will use and ensure premium contributions are set properly before the plan's start date, and NOT wait to determine during ACA reporting.

IRS Proposes Trump Account Contribution Program Rules and Changes to DCAP Nondiscrimination Rules

On August 11, 2026, the Department of the Treasury and Internal Revenue Service (IRS) [published](#) a proposed rule addressing Trump Account Contribution Programs (TACPs) and amending the nondiscrimination rules for Dependent Care Assistance Programs (DCAPs).

The IRS indicates taxpayers may rely on these proposed rules until a final rule is published. So, while employers may still need more time to review and implement TACPs (as the IRS is still asking for comments on logistics), the proposed DCAP nondiscrimination testing changes can be relied upon now until a final rule is published.

WHO THIS APPLIES TO:

- Employer of any size sponsoring a DCAP, and employer of any size interested in sponsoring a TACP.



GO DEEPER:

Several TACP rules under Internal Revenue Code (IRC) Section 128 are similar to the rules applicable to DCAPs under §129. In particular, three of the four DCAP nondiscrimination tests will apply, so the proposed guidance introduces some improvements to the DCAP nondiscrimination rules that will also apply to TACP nondiscrimination.



Proposed DCAP Nondiscrimination Changes (which may be relied upon immediately and also apply to TACPs)

- **Eligibility Test:** The DCAP must be offered to employees on a nondiscriminatory basis. To better define what the IRS finds nondiscriminatory, the proposed rules provide a new numerical safe harbor for the Eligibility Test. The safe harbor deems a class nondiscriminatory if the percentage of non-highly compensated employees (non-HCEs) eligible for the program is at least 90% of the percentage of highly compensated employees (HCEs) who are eligible. In other words, if all HCEs are eligible, the eligibility safe harbor can be passed if at least 90% of all non-HCEs are eligible. Employers with a higher concentration of non-HCEs may be able to satisfy the safe harbor using a lower percentage. For each percent non-HCEs comprise more than 60% of all employees, the safe harbor percentage can be $\frac{3}{4}$ of a percent lower.

For example, if 80% of all employees are non-HCEs, then the non-HCE concentration test is 20 percentage points higher than 60%, so the 90% safe harbor percentage can be reduced by 15 percentage points to 75% ($20 \times 0.75 = 15$). In that example, if all HCEs are eligible, the eligibility safe harbor can be passed if at least 75% of all non-HCEs are eligible.

Employers that do not satisfy the safe harbor may still be able to pass under a facts-and-circumstances analysis.

Passing the Eligibility Test does not mean the program automatically passes nondiscrimination testing overall. The program would still need to satisfy the other applicable tests, such as the Contributions and Benefits Test and the 55% Average Benefits Test (and, in the case of DCAPs, the More-than-5% Owners Concentration Test).

- **55% Average Benefits Test:** The most consequential proposal would amend the 55% Average Benefits Test to only account for employees receiving more than \$0 in DCAP benefits during the year. Employees receiving no DCAP benefits would no longer need to be included in the denominator of that test.

This means the average for non-HCEs will be an actual average of just those participating, rather than being dragged down to a significantly lower average by a substantial number of \$0 values from those not participating.

This may help employers who were hesitant to adopt the increased \$7,500 DCAP contribution limit be more comfortable with adopting the increased allowance.

- **End-of-Year Testing Failure:** A new remedial rule would allow a failure of the 55% Average Benefits Test (and, in the case of DCAPs, the More-than-5% Owners Concentration Test) on the last day of the year to simply add the excess benefits as taxable income on the W-2 of affected HCEs/owners by the Form W-2 furnishing deadline (usually January 31) immediately following the year of the failure.

Currently, when employers do not discover failures until the end of the year, HCEs/owners potentially get taxed on the entirety of benefits they received from the DCAP. So, employers endeavor to cure failures before the end of the year to ensure affected HCEs



can get at least some tax-favored DCAP reimbursements.

As a reminder, pass-through entity owners (and certain employed family members of more-than-2% S-corp shareholders) cannot participate in the DCAP on a pre-tax basis, so they usually do not make DCAP elections.

Proposed TACP Guidance

The proposed rule's guidance on TACPs included the following provisions and requirements:

- Written plan document required, including required content elements.
- Reasonable notification of availability and terms (without prescribing specific content or furnishing methods).
- Annual written statement (typically via W-2 box 12 using code TA).
- Optional employee certification that this is a request to contribute to a qualifying Trump Account (must be in writing, either paper or electronic, with specific representations made unless the employer has actual knowledge that the certification is incorrect).
- Employer communication protocols with Trump Account trustees (this is where most comments are still needed to provide employers with electronic transaction protocols).
- Employer prohibition on restricting contributions to certain Trump Account trustees.
- Section 125 rules, including a requirement to allow employees to make prospective election changes at least monthly without the need for a qualifying event (similar to HSAs).
 - As a reminder, employees can only make pre-tax salary reductions toward the Trump Account of their dependent, not toward an employee's own Trump Account.
 - It would appear a TACP can simply be written into the §125 cafeteria plan document, much like DCAPs are today.
- Clarification that an employee may not receive more than \$2,500 per year in tax-favored TACP contributions across all employers they might work for that year (subject to future indexing after 2027), regardless of the number of qualifying dependents.
 - Any excess TACP contributions will be taxable compensation.
 - A married couple filing jointly and working for the same employer or controlled group of employers may each receive the full TACP.
 - Only one parent may claim a dependent for divorced or separated parents or married taxpayers filing separately (similar to DCAPs).
 - Self-employed owners are not eligible for TACP contributions.



- Delineation that TACP contributions are excludable from federal income taxes but not excludable from other payroll taxes (i.e, employees and employers cannot glean FICA/FUTA savings).
- Employer Pilot Match Contributions that meet the safe harbor are disregarded for the contributions-and-benefits requirement and the average-benefits test, but remain relevant for the eligibility test.

Practical Impact to Employers:

Since the proposed rule can be relied upon immediately:

- DCAP nondiscrimination testing may be run using updated criteria, including:
- The 55% Average Benefits Test can exclude employees receiving no DCAP benefits from the denominator, and
 - A failure of that test or More-than-5% Owners Concentration Test may be rectified by including the excess in affected individuals' gross income by the W-2 distribution date immediately following the year of the failure.
 - The 90% Eligibility Safe Harbor Percentage can also be relied upon now, but most employers have not been struggling with the Eligibility Test for DCAPs.
 - Employers should work with their testing vendors to determine the earliest date at which the vendor can facilitate updated testing.
- The comment period is open through September 25, 2026. Comments are requested on specific TACP and DCAP administrative provisions, such as:
 - What electronic mechanisms should be available to allow employers or service providers to verify that the designated accounts are valid Trump accounts. For example, to ensure these are not the Trump Accounts of non-tax dependent children.
 - How best to address operational challenges of corrective notices/actions.
 - For DCAPs, whether any additional information would be helpful in applying the average benefits test.

Updated Model Employer CHIP Notice: Illinois Added, Plus New Jersey Change

The Department of Labor (DOL) has updated the [Model Employer Children's Health Insurance Plan \(CHIP\) Notice](#) as of July 31, 2026. This version **adds Illinois to the list of states providing premium assistance**, which means that employers must now also distribute the notice to employees and dependents residing in Illinois. This new version also reflects a revised Medicaid website address for **New Jersey**. All other state entries remain unchanged from the January 31, 2026, version.

WHO THIS APPLIES TO:

- All size employers sponsoring any type of medical plan in which employees pay part of the premium, with employees living in a state with a Medicaid and/or CHIP premium assistance subsidy (which now includes Illinois).



GO DEEPER:

An employer must provide the Employer CHIP Notice to employees eligible for the employer's medical plan who reside in a state with a premium assistance subsidy, regardless of the employer's location.

The notice is typically updated at the end of January and end of July each year reflecting whether states made changes to phone, email, and website information. **For the July 2026 update, Illinois has been added** to the list of premium subsidy states, while **New Jersey made changes** to its website address.

Employers sponsoring a group health plan should provide the CHIP notice with other health plan eligibility materials, such as new hire and annual open enrollment materials.

Penalties for Non-Compliance:

Employers who fail to provide the Employer CHIP Notice to employees in premium assistance states may face a penalty of up to \$145 per person per day. The Model Employer CHIP Notice is considered a safe harbor way to meet the notice language requirements. While the employer is permitted to remove from the notice any states in which employees do not reside, keep in mind that if they eventually hire anyone in such a state, they need to add that state back to the notice.

Practical Impact to Employers:

The intent of the notice is to ensure employees understand how to contact a state to inquire about and apply for premium assistance. Even though it is not necessary to redistribute the notice just because a newer version has become available, it is strongly recommended employers always provide the latest version of the model notice to incorporate into plan materials for new hires and for open enrollment (in this instance, particularly if there are employees or other plan participants residing in Illinois or New Jersey)



DOL Proposes New Electronic Disclosure Safe Harbor for Group Health Plans

On July 23, 2026, the DOL's Employee Benefits Security Administration (EBSA) [published](#) a proposed rule that would create a new, optional electronic disclosure safe harbor for group health plans, modeled closely on the "notice and access" safe harbor available to retirement plans since 2020. **Importantly, this is a proposed rule and the safe harbor will not be available for use until the rule is final.**

If finalized, this gives group health plan administrators a third option for satisfying ERISA's disclosure requirements, in addition to (not instead of) the current options of:

- The 2002 electronic disclosure safe harbor (available to participants who are "wired at work" or who affirmatively consent to electronic delivery), or
- Traditional paper delivery.

WHO THIS APPLIES TO:

- Employer of any size sponsoring ERISA group health plans, whether fully-insured, self-insured, or level-funded (note the proposal may not impact non-group health plans such as life or disability insurance).



GO DEEPER:

Group health plans have largely been left out of the more flexible approach of defaulting to electronic delivery that retirement plans have used since 2020. The DOL points to high rates of internet and smartphone use among the general population as justification for extending that same approach to group health plan disclosures. The DOL further advised that it has consulted with HHS and the Treasury Department in developing the proposal.

How the New Safe Harbor Would Work, if Finalized

- **Default Electronic Delivery:** Any participant, beneficiary, or eligible adult dependent (age 18 or older) providing an electronic address (email or mobile number) would be a "covered individual" who could receive disclosures electronically by default, without needing to be "wired at work" or providing the formal affirmative consent required under the 2002 safe harbor. If the employer provides an employee an email address for work, that can be used for this default electronic delivery method.
- **Broad Scope of Documents:** The safe harbor would apply to essentially any document a group health plan is required to furnish under Title I of ERISA, including SPDs, SMMs, SARs, COBRA notices, HIPAA Notice of Special Enrollment Rights, and



other Part 7 disclosures, including documents that must be furnished only upon request.

Note, the COBRA notice requirements often cannot be met electronically due to the requirements to provide certain notices to spouses, dependents, and terminated employees. So the inclusion of COBRA here may be of limited utility.

- **Notice of Internet Availability (NOIA):** Plans would post covered documents on a website or online portal and send a separate electronic notice alerting individuals that a document is available, with specific required content.
- **No Delivery Through Email:** Unlike the retirement plan safe harbor, this proposal would not allow documents to be sent directly within an email or attached to an email due to concerns about the sensitivity of private health information.
- **Paper Rights Preserved:** Individuals would retain the right to request a free paper copy of any document at any time, and the right to opt out of electronic delivery entirely, free of charge.
- **Transition Protections.** Plans would still be required to send an initial notice describing the shift to electronic delivery and the individual's rights, and take reasonable steps to keep electronic addresses accurate, including after an employee's severance from employment.

Practical Impact to Employers:

Because this is only a proposed rule, no action is required at this time, and plans should continue following their current disclosure practices under the existing 2002 safe harbor or paper delivery.

The comment period is open for 60 days following publication in the Federal Register. We will continue to monitor this rulemaking and update you when a final rule is issued, including the confirmed applicability date.

Once (and if) finalized, this will be an optional safe harbor. Plans that prefer to continue using the 2002 safe harbor or paper delivery will be able to do so (and may need to do so with respect to their non-health plans if the new safe harbor remains limited to just health plans).



Projected 2027 Indexing for FSAs and Commuter Plans

The annual indexing for the next calendar year can be published at unpredictable times, which in any given year may be too late to announce during open enrollment. However, over the years many industry leaders have reliably projected some upcoming figures based on publicly available consumer inflation data and the prescribed federal formulas. To that end, it is possible to announce the new projected limits in open enrollment materials but let employees know if the official limit comes in lower than projected, anyone electing more than the official limit will be automatically reduced to the official maximum allowed.

WHO THIS APPLIES TO:

- Employers of any size who sponsor, or are interested in newly sponsoring, a Health Flexible Spending Arrangement (Health FSA) and/or §132(f) Commuter Plan.



GO DEEPER:

The two main limits that can be reliably projected are those for Health FSAs and Commuter Plans.

	2026	2027
Health FSA (including Limited Purpose FSA)	\$3,400	\$3,500 projected
Qualified Parking	\$340/mo	\$350/mo projected
Qualified Transit/Vanpool	\$340/mo	\$350/mo projected



Update on Tobacco Wellness Lawsuits

There are currently over 75 tobacco wellness lawsuits in America, and their outcomes have so far been unpredictable depending on the facts of the case and the court where they land. However, three recent decisions from July 2026 are worth a look.

Following are tips for a practical roadmap of how to approach wellness programs and incentives:

- Set up all wellness deadlines for the upcoming plan year, including all deadlines to qualify for a reasonable alternative, to be wrapped up before open enrollment.
- Include the government's model reasonable alternative language in *all* materials pertaining to the wellness program *and* rates and the SPD.

WHO THIS APPLIES TO:

- All size employers sponsoring a wellness incentive, particularly one focused on tobacco.



GO DEEPER:

Several court opinions have dismissed wellness lawsuits for various reasons. However, several cases which came close to being dismissed have had a wrinkle or two that allows them to proceed. In July 2026, three such cases received decisions (*Spencer v. Campbell Soup Company*, *Williams v. Target Corporation*, and *Mueller v. United Surgical Partners International, Inc.*) which may help employers for their upcoming open enrollment decisions and communications.

The two main areas of contention are (1) the requirement to provide the “same full reward” to those who qualify for a reasonable alternative and (2) notice language required to explain the wellness program, reward, and availability of a reasonable alternative.

- In *Spencer*, the plaintiff never completed the tobacco cessation course which could have served as a reasonable alternative, so the court determined they lacked standing to sue.
- In *Spencer and Mueller*, both courts held that the “full reward” language in the statute does not require retroactively providing to the start of the plan year for those who complete a reasonable alternative after the plan year has started. These courts disagreed with and did not give deference to the federal government's regulatory guidance stating retroactive application is required.
- In *Spencer and Williams*, both courts held that the statute does not require providing language about accommodating the recommendations of the person's



personal physician. These courts disagreed with the federal government's regulatory guidance imposing a requirement to include the physician disclaimer language.

- In *Mueller*, the court determined that the case may proceed based on the Summary Plan Description (SPD) not including a description of the wellness program and incentive terms and the availability of a reasonable alternative.

There is also a case against Cracker Barrel being allowed to proceed on all six counts due to allegations that the plan failed to provide a compliant reasonable alternative or give appropriate notice. Likewise, a case against Marriott is proceeding due to allegations that communications explaining the smoking cessation program did not explain how to enroll or that it would qualify tobacco users to avoid the \$15 per week tobacco surcharge.

Penalties for Non-Compliance:

Wellness programs and incentives, including tobacco-related ones expressly authorized under the Affordable Care Act, are being subjected to a deluge of lawsuits against employers. So, litigation risk remains the paramount concern for employers, who risk having to pay to settle with affected participants. Additionally, if the DOL were to investigate a non-compliant tobacco surcharge or wellness program, they would likely require an offending employer to pay all the surcharges back to affected participants.

Practical Impact to Employers:

Following are tips for a practical roadmap of how to approach wellness programs and incentives:

- Set up all wellness deadlines for the upcoming plan year, including all deadlines to qualify for a reasonable alternative, to be wrapped up before open enrollment. This ensures all employees go into open enrollment understanding what rates/incentives they qualify for as they review and make elections for the upcoming plan year. This avoids the need to wonder whether anyone can meet a reasonable alternative after the plan year begins and might be owed a retroactive reward.

This once-a-year approach is expressly authorized in ACA FAQs Part 18, Q&A #8, [here](#).

- Include the required reasonable alternative language (including the disclaimer about accommodating the recommendations of their personal physician) in a short and easy paragraph in **all** materials pertaining to the wellness program *and* rates and the SPD.

Final regulations provided a [sample](#) which employers may use:

"Your health plan is committed to helping you achieve your best health. Rewards for participating in a wellness program are available to all employees. If you think you might be unable to meet a standard for a reward under this wellness program, you might qualify for an opportunity to earn the same reward by different means. Contact us at [insert contact information] and we will work with you (and, if you wish, with your doctor) to find a wellness program with the same reward that is right for you in light of your health status."



MLR Rebates Reminder for Employers

Health insurance carriers are required to send Medical Loss Ratio (MLR) payments to employers by September 30th when they did not spend enough of the premiums collected the three previous calendar years on claims and allowable plan expenses. Most carriers are becoming better about not collecting more insurance premiums than MLR rules allow, so MLR rebates are not usually expected. However, occasionally they still occur for relatively small amounts, and the employer has 90 days to calculate and distribute the share of the rebate owed to participants (and former participants).

WHO THIS APPLIES TO:

- Any size employer with a fully-insured health plan the previous calendar year who receives an MLR rebate check this August or September.



GO DEEPER:

When an employer receives an MLR rebate check from the insurer, they need to carefully consider how the funds must be spent. They may not be able to keep the rebate unless their plan document specifies such rebates are retained by the employer. An employer with such language can simply retain the full rebate as taxable income to the organization, assuming the rebate does not exceed what the employer paid in premiums.

Without such plan language, any portion of the rebate that is considered “plan assets” must be used in a very specific manner as described below. In other words, if employees paid any portion of the total premium, then that portion related to the MLR rebate may be considered plan assets which can only be used to benefit those participants, not the employer.

For instance, if employees paid 20% of total premiums last year and the employer contributed 80%, then 20% of the MLR rebate may be considered “plan assets” and should only be used for the benefit of plan participants.

There are three basic methods an employer may use to spend the participants portion of the MLR rebate:

- 1) Pay out a taxable cash refund
- 2) Offer a premium holiday for the amount of the rebate
- 3) Provide some type of benefit enhancement (keeping in mind participants must actually receive this within 90 days)

If the employer determines they need to share some of the rebate with former participants, a premium holiday or benefit enhancement might not work for them and sending a check may be more appropriate.



There is no de minimis exception to get out of distributing any portion that is considered plan assets (with a small exception regarding whether to include former participants). In other words, even if the rebate is a very small amount and dividing it up between participants results in a few dollars, the employer must still give back any portion related to plan assets to current participants (which includes COBRA participants and those enrolled in retiree coverage), and possibly to former employees (such as those who waived COBRA).

Employers have express latitude under federal guidance to just divvy up the amount attributable to employees in an equal distribution. So, unless they choose, the employer does not need to further allocate the rebate for a more equitable distribution reflective of how much different individuals paid. For example, if the employer provides single coverage at no cost to employees, the employer could issue an equal payment to all plan participants or could do further calculations to determine those in single coverage should not receive funds because they did not pay for coverage last year, so the rebate is shared with those who did pay.

[DOL Guidance for Handling MLR Rebates](#)

[Separate Guidance for Governmental Plans](#)



Los Angeles Hotel Workers Ordinance Requires New Health Payment

Los Angeles amended the hotel workers ordinance to start requiring a minimum health payment as of July 1, 2026. The minimum starts at \$4.25 per non-overtime hour but indexes to \$6.00 July 1, 2027, and then indexes in alignment with the Airport worker ordinance each July 1 thereafter.

WHO THIS APPLIES TO:

- Any size employer with a hotel within the geographic boundaries of the City of Los Angeles with 60 or more guest rooms and/or hotel with 50 or more guest rooms located within the Airport Hospitality Enhancement Zone (AHEZ).



GO DEEPER:

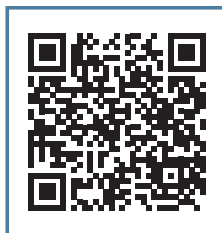
The ordinance [requires](#) a “Covered Hotel” to post a required worksite [poster](#) and pay Covered “Hotel Workers” an extra \$4.25 per hour toward qualifying benefits, or to the extent not paid toward qualifying benefits, that shortfall must be paid as **taxable cash**. Only regular, non-overtime hours count, but this is for any employee and not just full-time.

Qualifying benefits include **medical, dental, vision, mental health, and disability income**. Next July 1, the rate [increases](#) to \$6.00 per hour. Then each July thereafter indexes to the requirements as indexed under the Airport worker ordinance.

The only way to avoid paying the \$4.25 per hour to employees who waive or are not eligible is to ask them to voluntarily submit [this waiver form](#) to the City and employer for review and approval. If approved by the City, then instead of the \$4.25 per non-overtime hour in extra wages, that employee is paid a flat \$50 per month if under 30 hours per week or \$100 per month if 30+ hours per week. If that form cannot apply or the employee does not want to complete and submit the form, then the extra \$4.25 per hour is required.

Covered hotels may exempt managerial, supervisory, or confidential employees from this requirement.

Employers subject to this ordinance are strongly encouraged to work with their employment counsel familiar with Los Angeles and California employment and wage laws to address this local ordinance.



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