February 2026

2026 Federal Poverty Level Updated, Increasing FPL Affordability Safe Harbor

Updated poverty guidelines set the 2026 Federal Poverty Level (FPL) at $15,960 (up from $15,650 in 2025) for a person living in the mainland US, $18,360 in Hawaii and $19,950 in Alaska. This means that the mainland FPL affordability threshold for non-calendar year plans beginning in 2026 is $132.46 per month (see chart below).

FPL Affordability	Calendar Year 2026 Plan	Non-Calendar Year 2026 Plan
Mainland FPL	$15,650÷12×9.96%= $129.89/mo.	$15,960÷12×9.96%= $132.46/mo.
Hawaii FPL	$17,990÷12×9.96%= $149.31/mo.	$18,360÷12×9.96%= $152.38/mo.
Alaska FPL	$19,550÷12×9.96%= $162.26/mo.	$19,950÷12×9.96%= $165.58/mo.

WHO THIS APPLIES TO:

- An Applicable Large Employer (ALE) that sponsors a fully insured, self-insured, or level-funded medical plan or Individual Coverage Health Reimbursement Arrangement (ICHRA). An employer is an ALE for calendar year 2026 based on averaging 50 or more full-time and equivalent employees in calendar year 2025 (subject to specific counting rules, including a combined count with commonly owned/controlled employers in a Controlled Group or Affiliated Service Group).

GO DEEPER:

Review our January 14, 2026 Alert - *Federal Poverty Level Updated* in the Content Library.

Reporting Creditability to CMS When the New Plan Year Begins

Within 60 days of the start of each new medical plan year, the employer (regardless of size) must notify the Centers for Medicare and Medicaid Services (CMS) whether their prescription drug plan options are creditable and/or non-creditable with Medicare Part D (i.e., whether the plans are expected to pay at least as well as Part D pays). This 60-day deadline is reduced to 30 days if prescription drug creditability changes or the plan terminates. So, calendar year plans must report by March 2 (or by January 30 if creditability changed or the plan terminated).

WHO THIS APPLIES TO:

- Employers of any size sponsoring a fully insured, self-insured, or level-funded medical plan with prescription drug coverage. For now, this appears to include HRAs that include reimbursement of prescription drug costs, and ICHRAs that are not just reimbursing insurance premiums but also reimburse prescription drug costs. *(However, CMS has suggested they might issue guidance to no longer require this of HRAs or ICHRAs in the future.)*

GO DEEPER:

Employers must submit their creditable/non-creditable status via the CMS Creditable/Non-Creditable web form.

The webform should take less than five minutes to complete. It is straightforward, but the employer must know the answers to the following questions:

- Whether all prescription coverage options offered are creditable, non-creditable, or a combination of creditable and non-creditable *(note, the employer must disclose creditability for the upcoming plans with open enrollment materials, so the employer should already know this information when it is time to submit this disclosure to CMS)*
- The last date the employer provided employees with a creditable and/or non-creditable coverage notice for the plan year that just started *(note, this will often be the date the employer provided open enrollment materials)*
- An estimate of the number of Medicare-eligible employees, spouses and dependents enrolled in the employer's prescription drug plans *(this can be zero if the employer is not aware of anyone eligible for Medicare due to age, disability, or end stage renal disease)*

The employer does not have to log in to a portal or download a template, but that also means there is no way to log in and see proof of prior submissions. So, once the employer submits the information, they should keep a copy for their records.

Penalties for Non-Compliance:

There is no specific penalty to the employer for not submitting this reporting to CMS. However, it is easy to do and takes very little time, so demonstrating good faith compliance is encouraged.

Practical Impact to Employers:

This process is very straightforward for reporting creditability to CMS. The only complicated part might be determining whether the prescription drug plans are creditable or not when the insurance carrier, third party administrator (TPA), or pharmacy benefits manager (PBM) will not make that determination for the employer. Erroneously calling a prescription plan creditable when it does not meet the creditability requirements can have adverse consequences to the employer and to participants in that plan who wait to enroll in Medicare Part D until after 65. So, it is best to have an actuarial-based determination of creditable coverage status.

Reporting the Value of Health Coverage on Form W-2

If an employer filed 250 or more W-2 forms the previous calendar year, they must include the value of health coverage on this year's W-2 forms in Box 12 using code DD.

WHO THIS APPLIES TO:

- Large employers who filed 250 or more W-2 forms last year and sponsored any of the following:
  - A fully-insured, self-insured, and/or level funded medical plan, but note this reporting is not required for an ICHRA
  - A health Flexible Spending Arrangement (FSA) that included employer contributions
  - A hospital indemnity or specified illness plan (insured or self-insured), paid for by the employer and/or by employees via pre-tax salary reduction
  - Employee Assistance Program (EAP) when a COBRA premium is charged
  - On-site clinic when a COBRA premium is charged
  - Wellness programs providing or reimbursing medical care when a COBRA premium is charged

GO DEEPER:

The requirement to report the value of health coverage on the W-2 is determined based on each employer's own number of W-2 forms issued the previous year. So, each legal entity is evaluated separately to determine whether they issued 250 or more W-2 forms, even if under common ownership/control in a Controlled Group or Affiliated Service Group.

The IRS provides a helpful table for employers explaining what information is required vs. optional, and what specifically to never report: IRS W2 Reporting Table

For example, the IRS makes it clear in their table that payment/reimbursement of health insurance premiums for a more-than-2% S-corp. shareholder, which was included in gross income, specifically is not reportable on their W-2 in box 12.

The value reported is the full premium paid by both the employer and employee. The only exception is for health FSAs, in which case only the employer's contributions are to be reported, not the employee's pre-tax contributions.

Penalties for Non-Compliance:

If an employer fails to include the required information, they could be subject to fines and penalties for filing incorrect/incomplete W-2 forms and required to reissue impacted W-2 forms.

Practical Impact to Employers:

The value of health coverage is provided for informational purposes only and does not impact the employee's taxable income. Payroll systems are typically set up to handle this automatically for the employer, but the table does highlight specifics of when certain plans are required or optional and specifically when certain coverages must not be reported. So, the employer may need to ensure they adhere to those details. For example, if the employer sponsors an EAP, the payroll set up may be not to report in box 12. So, if the employer charges a COBRA premium for the EAP, it is incumbent on the employer to notify the payroll company that the EAP actually must be included in box 12 to ensure full compliance is met.

ACA Reporting Due in March, Take Advantage of New Reporting Relief

The Affordable Care Act (ACA) mandates annual reporting each March under Internal Revenue Code sections 6055 and 6056. This works similar to W-2 and W-3 forms, with a 1095 individual statement (much like the functions of a W-2), and a 1094 transmittal cover sheet (much like the functions of a W-3). The 1095 statement is due to individuals by March 2, and those 1095 statements with a 1094 transmittal cover sheet must be electronically filed with the IRS by March 31. There is new reporting relief that may allow employers to provide statements to individuals upon request if the employer provides proper language on their main public webpage by March 2 and keeps it there through October 15.

WHO THIS APPLIES TO:

- The 1094-C and 1095-C forms are required of an ALE for calendar year 2025 based on averaging 50 or more full-time and equivalent employees in calendar year 2024 (subject to specific counting rules, including a combined count with commonly owned/controlled employers in a Controlled Group or Affiliated Service Group).
- The 1094-B and 1095-B forms are required of a non-ALE for calendar year 2025 who sponsored a self-insured or level-funded medical plan or an ICHRA.

GO DEEPER:

Employers required to submit ACA Reporting must comply with all the reporting requirements and deadlines to avoid filing penalties. Failing to file electronically can also incur separate penalties.

- **March 2:** Form 1095 individual statements must be provided to individuals.

  Alternatively, the employer can provide language on its public website by March 2 providing instructions to request a copy of the 1095 form and then only provide a 1095 to individual within 30 days of request. The main webpage should provide a conspicuous link to "Tax Information" which takes them to a page with the following:

  - A statement, in capital letters, "IMPORTANT HEALTH COVERAGE TAX DOCUMENTS"
  - Explains how individuals may request a copy of Form 1095
  - Includes the employer's email address, mailing address, and telephone number

- **March 31:** All 1095 forms must be electronically filed with a 1094 transmittal cover sheet to the IRS via an XML file on the IRS's AIR platform (ACA Information Returns).

- State requirements/deadlines may be different in CA, DC, MA, NJ, and RI.
    - For example, MA requires different forms than the 1095 and 1094.
    - As another example, NJ requires proactively providing the 1095 individual statement to NJ residents. So, posting language on the employer's public website with instructions for requesting the 1095 is not relief an employer can rely upon in NJ.

Penalties for Non-Compliance:

The penalties for late, incomplete, or incorrect reporting of 2025 forms due in March 2026 are $680 per form not correctly and timely provided to individuals plus $680 per form not correctly and timely e-filed with the IRS. This is reduced to $60 each if accurate and complete forms are provided within 30 days following the deadline, reduced to $130 each if provided by August 1, and $340 if provided after August 1.

In addition, there is a new six-year statute of limitations for the IRS to pursue Employer Shared Responsibility Penalties (ESRPs) which cannot begin until the later of the reporting deadline or the date accurate and complete forms are submitted. Thus, submitting incomplete or incorrect forms and having to resubmit later delays the start date of the employer's statute of limitations protections, exposing them to the potential penalties for more than six years.

Practical Impact to Employers:

ALEs are fully responsible for compliance with the 1094-C and 1095-C forms. Insurance companies and Third-Party Administrators (TPAs) will not provide this as a service. While most ALEs outsource the creation of the forms to a third party like their payroll administrator, Human Resources Information Systems (HRIS) vendor, or benefits administration platform, the ALE is responsible for all aspects of compliance, including accuracy, completeness, deadlines, and providing proper website notices. The new six-year statute of limitations may not begin on time if reporting is inaccurate, incomplete, or otherwise delayed.

Non-ALEs sponsoring level-funded plans may find the insurance carrier willing to complete the 1094-B and 1095-B process on the employer's behalf, but the employer is still fully responsible. Otherwise, only non-ALEs with fully insured medical coverage all 12 months of the calendar year are exempt from reporting. So, non-ALEs without an exception need to ensure they fully comply with the 1094-B and 1095-B reporting requirements and provide proper website notice.

HIPAA Privacy Notices Require SUD Language by February 16, 2026

The HIPAA Notice of Privacy Practices (NPP) must be updated by February 16, 2026, to reflect stricter Substance Use Disorder (SUD) rights and protections. The government has yet to provide model language, so as the deadline draws near, it may be time for employers to ask benefits counsel for help amending their NPP.

WHO THIS APPLIES TO:

- Employers sponsoring a fully insured medical plan that includes claims analytics drill-down data feeds or other access to Protected Health Information (PHI)
- Employers sponsoring a self-insured medical plan to include a level-funded plan, FSA, HRA, or ICHRA. The requirement also includes any carve-out/bolt-on benefit which is not fully insured and must be "integrated" with the employer's medical plan (telemedicine, fertility, Rx carve-out, etc.)

(Note, only a self-insured, self-administered health plan with fewer than 50 eligible employees is exempt from HIPAA Privacy & Security rules and NPP.)

GO DEEPER:

SUD health care providers are referred to in HIPAA as Part 2 providers. When they submit claims for payment to a health plan, that is considered Part 2 data subject to stricter requirements on uses and disclosures. When the employer is responsible for distributing the NPP for a health plan receiving Part 2 SUD data, they must ensure the NPP is updated by February 16, 2026, to reflect new rights and restrictions that apply to SUD data, including the following:

- Enhanced privacy for SUD records: Must explain the stricter rules that apply to uses and disclosures of SUD records received from a Part 2 program, and interactions with other laws
- Restricted access for legal proceedings: Must require specific consent or a court order to disclose SUD records for a civil, criminal, administrative, legislative, or other legal proceeding (SUD counseling notes are subject to the same legal restrictions that apply to psychotherapy notes)
- Redisclosure warning: Must warn that properly disclosed SUD PHI may not be protected from redisclosure
- Fundraising opt-out: Must provide a clear and conspicuous way to opt-out of fundraising communications tied to SUD records

With the deadline just next month and no model language from the government, employers may want to explore having benefits counsel update their NPP to meet the deadline.

Penalties for Non-Compliance:

Standard HIPAA penalties apply for failing to comply with the new requirements by the deadline, but given HHS promised employers they would provide model language, it seems reasonable that potential enforcement actions would not go straight to penalty assessment.

Practical Impact to Employers:

Time is running out in awaiting model language from HHS. For cautious employers, it may be worth engaging benefits counsel to update the NPP and distribute the updated version by the February 16, 2026, deadline. This may also require updates to some policies and procedures and some training for those handling PHI to understand the extra rights and restrictions for SUD PHI.

Fiduciary Lawsuits

Schlichter Bogard LLC is a well-known law firm that, for the last 15-20 years, has successfully challenged employers for exorbitant fees and poor performance in retirement plans. Court decisions and settlements on those cases led to industry-wide shifts in fiduciary accountability for retirement plans. In the final week of 2025, the firm launched four new lawsuits against large employers and their large insurance brokers alleging that fiduciaries of voluntary plans have improperly charged employees substantially more than the claims justify, with only 25% to 35% funding claims, and up to 40% of what employees pay used to pay commissions to brokers.

In 2025, there were several major fiduciary lawsuits against large employers over alleged breaches of fiduciary management of health plans, and this new wave focuses on voluntary benefits.

Plan participants and plaintiff attorneys appear poised to challenge how expensive benefit plans are becoming and are looking for ways with new transparency measures to hold fiduciaries accountable to act solely in the best interest of participants.

Practical Impact to Employers:

The employer, and specifically the decisionmakers and others with authority over the benefit plans, are fiduciaries of those plans and must manage them prudently, acting solely in the best interest of participants. Third parties, including insurance brokers, may also be functional co-fiduciaries or willing participants in known breaches of fiduciary duties. So, it is vital employers efficiently document the process each year that goes into selecting service providers, benefit offerings, fees, and more. It is not always about going with the lowest cost option, but rather about choosing what is best for participants overall. So, having a fiduciary committee with various employee representatives providing input is instrumental.

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REIMAGINING EMPLOYEE BENEFITS