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DOL Proposes New, Additional Electronic Delivery Safe Harbor for Group Health Plans

The U.S. Department of Labor (DOL) has proposed a new optional electronic disclosure safe harbor that would expand the way ERISA-covered group health plans provide required notices and disclosures to participants and beneficiaries. If finalized, the proposal would give employers and plan administrators greater flexibility to deliver many required documents electronically while reducing printing and mailing costs.

The proposed rule does not replace existing disclosure methods. Instead, it introduces an additional voluntary option that group health plans may use along with the DOL's existing electronic disclosure safe harbor or traditional paper delivery.

Why the DOL Is Proposing This Change

When the DOL established the electronic disclosure rules in 2002, electronic communication was far less common than it is today. Since then, employees have increasingly relied on email, smartphones, and online benefit portals to receive important information.

Recognizing these changes, the DOL previously adopted a modern electronic disclosure safe harbor for retirement plans in 2020. The agency is now proposing a similar framework for ERISA-covered group health plans to make participant communications more efficient while maintaining participant protections.

According to the DOL, group health plans currently distribute as many as 11 billion sheets of paper disclosures each year. The agency estimates the proposed safe harbor could reduce administrative costs by approximately $3.9 billion over the next decade while improving participants' access to benefit information.

How the Proposed Safe Harbor Would Work

Under the proposal, plan administrators could satisfy many ERISA disclosure requirements by posting required documents on a secure website or online benefits portal and furnishing participants and beneficiaries with a notice of internet availability (NOIA) directing them to those documents.

Notably, the proposed safe harbor does *not* include a direct email delivery option for covered documents — a key difference from the 2020 retirement plan safe harbor, which permits email delivery. The DOL excluded this option primarily due to privacy concerns, because group health plan disclosures may contain protected health information (PHI) that could be exposed if sent to an employee's company-monitored email inbox.

Before relying on the safe harbor for an individual, the administrator would need to furnish an initial notification on paper stating that covered documents will be delivered electronically, identifying the electronic address that will be used, providing instructions for accessing documents, and describing the individual's rights to request paper copies and to opt out of electronic delivery.

To use the safe harbor, plans would need to satisfy specific conditions designed to ensure participants receive timely access to required information. Individuals would also retain important consumer protections, including:

- The ability to request paper copies of disclosures at no charge.
- The right to opt out of electronic delivery and continue receiving paper documents.
- The requirement to receive electronic notices are understandable, accessible, and reasonably calculated to ensure actual receipt.

Existing Electronic Delivery Rules Would Remain Available

Importantly, the proposal would *not* eliminate the DOL's existing 2002 electronic disclosure safe harbor.

If finalized, employers and plan administrators could continue using the current rules, which generally permit electronic delivery to employees who are considered "wired at work" or to individuals who consent to receiving electronic disclosures. Traditional paper delivery would also remain an acceptable option.

The new safe harbor would simply provide an additional compliance option for employers seeking greater flexibility.

What Types of Plans Are Affected?

The proposed rule applies to ERISA-covered group health plans — that is, employee welfare benefit plans to the extent they provide medical care, as defined under Section 733(a)(1) of ERISA. This includes employer-sponsored medical plans and, in certain scenarios, benefits such as vision and dental when provided as part of a group health plan.

The safe harbor does *not* extend to other types of welfare benefit plans, such as life insurance, disability, accident, sickness, unemployment, or stand-alone vision or dental plans. Employers that use a wrap document covering both health and non-health welfare benefits would need to continue relying on the 2002 safe harbor for the non-health portions.

The proposal does not change the content of required notices or create new disclosure obligations. Instead, it focuses solely on the way existing required documents may be furnished to participants and beneficiaries.

Current Status

The DOL issued the proposed rule on July 22, 2026, with publication in the *Federal Register* on July 23, 2026 (91 Fed. Reg. 46602). Public comments are due by September 21, 2026. Because the rule is still in the proposal stage, employers are not yet required to change their current disclosure practices. The agency will review public comments before deciding whether to issue a final rule.

If finalized, the rule would apply on the first day of the first calendar year following publication of the final rule.

Employer Action Items

Although no immediate action is required, employers and plan sponsors may wish to begin evaluating how the proposed rule could affect their employee communications if it is finalized.

- Review your current process for distributing required ERISA health plan disclosures.
- Determine whether your organization maintains accurate participant email addresses and electronic contact information.
- Evaluate whether your benefits administration platform or employee portal could support the proposed notice-and-access model, including posting documents online and furnishing notices of internet availability.
- Continue following the existing 2002 DOL electronic disclosure rules or provide paper disclosures until any new safe harbor becomes final.
- Monitor future DOL guidance and the final rule for implementation dates and any changes made during the rulemaking process.

New Jersey Family Leave Act Expands Employer Responsibilities

New Jersey employers face important changes to the New Jersey Family Leave Act (NJFLA) that significantly expand the law's reach and modify several employee protections. Effective July 17, 2026, the amendments broaden employer coverage, shorten employee eligibility requirements, establish new job restoration rights tied to state benefit programs, and give employees greater control over the way certain paid leave benefits are used.

NJFLA Coverage Expands to Smaller Employers

One of the most significant changes is the reduction in the employer coverage threshold. The NJFLA now applies to employers with 15 or more employees, down from the prior threshold of 30. Public employers of any size remain covered as they were before.

When determining whether the threshold has been met, employers must count all employees, regardless of where they work. For example, an employer with offices in multiple states may be covered by the NJFLA even if only a small number of employees work in New Jersey. The threshold is measured by whether the employer had 15 or more employees for each working day during each of 20 or more calendar workweeks in the current or immediately preceding calendar year.

Employee Eligibility Begins Sooner

The amendments also make it easier for employees to qualify for protected family leave by significantly reducing the amount of time they must work before becoming eligible.

Under the prior law, an employee had to be employed for at least 12 months and have worked at least 1,000 base hours during the preceding 12-month period. Under the amended law, an employee becomes eligible after just three months of employment and 250 base hours worked during the immediately preceding 12-month period.

This change allows newer employees – including many part-time, seasonal, and recently hired workers – to access job-protected leave far sooner than under the prior law.

Understanding When the NJFLA Applies

The NJFLA provides job-protected leave for qualifying family-related reasons, but it does not cover an employee's own serious health condition. Because several federal and state leave laws may apply to the same workplace, employers should evaluate each leave request individually before determining which law governs.

Common examples include:

Reason for Leave	Laws That May Apply
Employee's own serious health condition	Family and Medical Leave Act (FMLA) Americans with Disabilities Act (ADA) New Jersey Law Against Discrimination (LAD) New Jersey Earned Sick Leave
Bonding with a new child	NJFLA and FMLA
Caring for a family member with a serious health condition	NJFLA, FMLA, New Jersey Earned Sick Leave
Certain public health emergencies	NJFLA and New Jersey Earned Sick Leave
Domestic violence or a sexually violent offense	New Jersey SAFE Act and New Jersey Earned Sick Leave

Because the applicable law depends on the reason for the leave request, supervisors should avoid making eligibility determinations. Instead, they should promptly refer all potential leave requests to HR for review.

NJFLA and FMLA Remain Separate Laws

Although the NJFLA and the federal Family and Medical Leave Act often overlap, they contain different employer coverage thresholds, employee eligibility rules, and qualifying reasons for leave. The FMLA applies to employers with 50 or more employees within a 75-mile radius, 12 months of employee tenure, and 1,250 hours worked. The NJFLA now applies to employers with only 15 or more employees (counted worldwide), three months of tenure, and 250 hours worked.

As a result, an employee may qualify for leave under one law but not the other or leave under each law may begin and end at different times. Employers should evaluate both statutes whenever a leave request may involve family or medical leave protections.

New Job Restoration Rights Tied to TDI and FLI Benefits

The same legislation that amended the NJFLA also amended New Jersey's Temporary Disability Benefits Law (the statute governing the state's Temporary Disability Insurance (NJTDI) and Family Leave Insurance (NJFLI) programs) to create new job restoration rights.

Separate protection from the NJFLA. Under the amended TDI law, an employee who receives NJTDI or NJFLI benefits during a period of unpaid leave that is not already covered by the NJFLA or FMLA is entitled to be restored, upon expiration of the leave, to the same position held when the leave began or to an equivalent position with equivalent seniority, status, employment benefits, pay, and other terms and conditions of employment.

It is important to distinguish between wage replacement benefits and job protection. Historically, NJTDI and NJFLI functioned primarily as income replacement programs and did not, by themselves, create reinstatement rights. After July 17, 2026, however, receiving these benefits independently triggers job restoration protections under the amended TDI law—even when the NJFLA and FMLA do not apply.

No employer size or tenure threshold. Unlike the NJFLA, the TDI/FLI job restoration provisions are not subject to a minimum employer size threshold or employee work history requirement. Eligibility is tied solely to whether the employee qualifies for NJTDI or NJFLI benefits, which is based on recent earnings. This means that even employers with fewer than 15 employees who are not covered by the NJFLA may now have reinstatement obligations if an employee receives NJTDI or NJFLI benefits.

Duration of protection. According to guidance issued by the New Jersey Department of Labor and Workforce Development (NJDOL), the job protection lasts up to 26 weeks for employees receiving NJTDI benefits and up to 12 weeks for employees receiving NJFLI benefits taken continuously. These periods can exceed the 12 weeks of leave available under the NJFLA.

The NJDOL issued guidance on July 15, 2026, and has since published detailed FAQs for employers and employees clarifying how these provisions are administered.

Employees May Choose Which Benefits to Use

The amendments also provide employees with greater flexibility when multiple paid leave benefits are available.

Employees who qualify for both New Jersey Earned Sick Leave and TDI or FLI benefits may choose which benefit to use and the order in which those benefits are applied. Employers may explain the available options but may not require employees to exhaust one benefit before another or dictate the sequence.

However, employees may not receive more than one type of paid leave benefit simultaneously during the same period. Employers should ensure their payroll systems prevent overlapping payments and document each employee's benefit election and chosen order.

Supervisor Training Remains Critical

Front-line supervisors are often the first people that employees notify when they need leave. Casual comments that appear to discourage leave requests may create compliance concerns. Managers should avoid statements such as:

- "We're really short staffed right now."
- "Can you wait until after our busy season?"
- "Who's going to cover your work?"
- "I don't think you qualify."

Instead, supervisors should respond consistently by thanking the employee for bringing the request forward and referring the matter to Human Resources for evaluation.

A simple response such as, "Thank you for letting me know. I'll connect with HR so we can review your request and discuss the leave options that may be available," helps ensure requests are handled appropriately without making commitments or legal determinations.

Employer Action Items

- Confirm whether the organization meets the new 15-employee coverage threshold by counting all employees, including those working outside New Jersey, across 20 or more calendar workweeks in the current or preceding calendar year.

- Update eligibility evaluations to reflect the reduced requirements of three months of employment and 250 base hours in the preceding 12-month period.
- Review and update leave policies, employee handbooks, and leave request procedures to reflect the amended NJFLA thresholds and the new TDI/FLI job restoration provisions.
- Revise manager and supervisor training to ensure leave requests are referred promptly to HR and that supervisors do not make eligibility determinations.
- Educate HR staff on the differences between the NJFLA, FMLA, New Jersey Earned Sick Leave, the NJ SAFE Act, the TDI/FLI job protection provisions, and other applicable leave laws.
- Review leave administration procedures to address the amended job restoration provisions, including the new TDI/FLI reinstatement obligations that apply regardless of employer size.
- Add TDI and FLI cases to job-protection reviews, requiring HR sign-off before any employee receiving these benefits is terminated or permanently replaced.
- Coordinate with payroll, benefits administrators, and leave management vendors to ensure consistent administration, including encoding the 15-employee threshold and three-month/250-hour eligibility rules into HRIS and vendor systems.
- Establish a process for documenting employee paid leave elections and the order leave is chosen and implement controls to prevent simultaneous payment of Earned Sick Leave and TDI/FLI benefits for the same period.
- Review ongoing leaves that began before July 17, 2026, as the new TDI/FLI job protection may apply to employees receiving benefits on or after that date even if the leave began earlier.

SBC vs. SPD: Understanding Two Required Health Plan Disclosures

Employers sponsoring ERISA-covered group health plans are responsible for providing several required participant disclosures. Two of the most important—and most often confused—are the Summary of Benefits and Coverage (SBC) and the Summary Plan Description (SPD).

Although both documents help employees understand their health coverage, they serve different purposes and are required under different federal laws. Providing one document does not satisfy the requirement to provide the other.

Summary of Benefits and Coverage

The Summary of Benefits and Coverage (SBC) is required under the Affordable Care Act (ACA) and is designed to help employees compare health plan options using a standardized format.

The SBC provides a high-level overview of a health plan's key features, including:

- Covered benefits and services
- Cost-sharing provisions, such as deductibles, copayments, and coinsurance
- Coverage limitations and exclusions

- Coverage examples that illustrate how the plan may pay for common medical situations
- A reference to the Uniform Glossary, a separate standardized resource that must be made available upon request

Because most applicable group health plans must use the same standardized template, employees can more easily compare available coverage options during enrollment.

SBC Distribution Requirements

The SBC must be provided at several specific times.

- As part of written enrollment application materials during initial enrollment
- No later than the first date the participant is eligible to enroll (when no written application materials are used)
- During automatic renewal, no later than 30 days before the first day of the new plan or policy year
- Upon special enrollment, within 90 days of enrollment
- Upon request, within seven business days
- When a material modification affects SBC content, at least 60 days before the change takes effect

The SBC requirement applies to most group health plans and health insurance issuers offering group coverage. Plans covering only excepted benefits—such as dental-only or vision-only plans, most health FSAs, HSAs, and retiree-only plans—are exempt.

Summary Plan Description

The Summary Plan Description (SPD) is required under the Employee Retirement Income Security Act (ERISA) and serves as the primary communication describing how the health plan operates.

Unlike the SBC, the SPD provides detailed information about the administration of the plan, including:

- Eligibility requirements
- Enrollment and termination rules
- Plan benefits and limitations
- Participant rights and responsibilities
- Claims and appeals procedures
- Plan administrator, plan sponsor, agent for service of legal process, and funding or insurer information
- ERISA rights statement
- Continuation coverage (COBRA) rights and obligations
- Circumstances that may result in disqualification, loss, or forfeiture of benefits

HIPAA special enrollment notices may be described in the SPD if the SPD is provided at or before the time the employee is initially offered the opportunity to enroll in the plan. However, HIPAA privacy notices are a separate disclosure obligation and are not an SPD content requirement.

The SPD is intended to help participants understand not only what benefits are available, but also how the plan is administered and how to exercise their rights under ERISA.

SPD Distribution Requirements

The SPD must be furnished according to specific deadlines.

- New plans: within 120 days after the plan becomes subject to ERISA
- New participants: within 90 days after the participant first becomes covered under the plan
- Updated SPD: at least every five years if material changes have been made during that period
- If no material changes: at least every 10 years
- Summary of Material Modifications (SMM): within 210 days after the close of the plan year in which the change was adopted
- Material reductions in covered services or benefits (group health plans): within 60 days after adoption of the change
- Upon written request: within 30 days

Key Differences Between the SBC and SPD

Feature	SBC	SPD
Required by	Affordable Care Act (PHSA §2715)	ERISA (§§102, 104)
Format	Standardized federal template	Plan-specific summary disclosure
Focus	Benefit summaries and cost-sharing	How the plan operates and participants' rights
Purpose	Helps employees compare health plan options	Helps participants understand plan administration
Distribution	During enrollment, upon request, upon special enrollment, and 60 days before material modifications	To new participants within 90 days, updated every 5 years (if amended) or 10 years (if not), SMM within 210 days, material reductions within 60 days
Length limit	No more than four double-sided pages, 12-point font minimum	No statutory length limit

Employer and Plan Administrator Action Items

Both the SBC and SPD are mandatory disclosures for most ERISA-covered group health plans, and each has its own timing and content requirements. ERISA duties attach to the plan administrator, as defined by ERISA section 3(16), which is often the employer but may be a different entity.

Plan administrators should:

- Confirm both documents are current and reflect the plan's design.
- Ensure the SBC is distributed during open enrollment, upon initial eligibility, upon special enrollment, and at least 60 days before any material modification affecting SBC content.

- Provide SPDs to newly covered participants within 90 days and distribute updated SPDs or SMMs when material plan changes occur, following the applicable deadlines.
- Coordinate with insurance carriers, third-party administrators, and benefits consultants to determine who prepares each document, while remembering that the plan administrator ultimately remains responsible for compliance.

CMS Announces End of Medicare Part D Premium Stabilization Demonstration

The Centers for Medicare & Medicaid Services (CMS) recently announced that the Medicare Part D Premium Stabilization Demonstration will conclude after the 2026 plan year. The temporary demonstration program was introduced to help stabilize Medicare Part D premiums as significant prescription drug benefit changes under the Inflation Reduction Act (IRA) took effect. CMS stated that participating Part D sponsors have now gained sufficient experience with the redesigned benefit, making continued premium subsidies unnecessary.

While the announcement primarily affects Medicare beneficiaries enrolled in Part D prescription drug plans, it also has implications for employers that sponsor prescription drug coverage for Medicare-eligible retirees.

What Was the Premium Stabilization Demonstration?

The demonstration was implemented in 2025 to reduce premium volatility during the transition to the redesigned Medicare Part D benefit under the Inflation Reduction Act. The program provided participating Part D plan sponsors with additional financial support to help limit premium increases while insurers adjusted to greater financial responsibility for prescription drug costs.

CMS modified the demonstration for 2026 by reducing the level of federal premium support and expanding insurer responsibility, signaling its intent to transition the market back to normal operating conditions. The agency has now confirmed that the demonstration will not continue in 2027.

What Does This Mean for Employers?

For most employers sponsoring active employee group health plans, there is no direct compliance impact. The demonstration applies to the Medicare Part D program rather than employer-sponsored commercial health plans.

However, employers that offer retiree prescription drug coverage or sponsor Employer Group Waiver Plans (EGWPs) should pay close attention.

Potential areas of impact include:

- Higher retiree plan premiums. As the temporary subsidies end, some Medicare Part D premiums may increase beginning in 2027, depending on the plan sponsor's bids and market conditions. CMS has indicated that many beneficiaries may experience relatively modest increases, although final 2027 premiums will not be available until later this year.
- Retiree communication. Employers sponsoring Medicare-eligible retiree plans may receive questions from participants about premium changes during the upcoming enrollment season.

- EGWP planning. Employer Group Waiver Plans were eligible for a limited portion of the demonstration. Employers working with insurers that administer EGWPs should discuss how the demonstration's conclusion may affect 2027 premiums and plan costs.
- Creditable coverage evaluations. Although the demonstration itself does not change the Medicare Part D creditable coverage rules, employers should continue reviewing their prescription drug coverage annually to determine whether it remains creditable and to meet required CMS disclosure obligations.

No Changes to Employer Compliance Requirements

The end of the demonstration does not modify existing employer responsibilities under Medicare Part D.

Employers that offer prescription drug coverage to Medicare-eligible individuals must continue to:

- Determine whether their prescription drug coverage is creditable or non-creditable.
- Provide annual Medicare Part D Creditable Coverage Notices to eligible individuals before the Medicare Part D annual enrollment period.
- Submit the required online disclosure to CMS regarding the creditable status of their prescription drug coverage.

These longstanding compliance requirements remain unchanged.

Looking Ahead

Final Medicare Part D premiums for the 2027 plan year will be released after CMS completes the annual bid review process. Employers sponsoring retiree drug coverage should work with their carriers and pharmacy benefit managers to understand any potential premium or plan design changes before open enrollment materials are finalized.

Employer Action Items

Although the conclusion of the Medicare Part D Premium Stabilization Demonstration does not create new compliance obligations for employer-sponsored group health plans, employers with Medicare-eligible retirees should prepare for potential downstream effects.

- Review any Medicare retiree prescription drug offerings for potential premium changes in 2027.
- Coordinate with insurers or third-party administrators regarding the impact on Employer Group Waiver Plans (EGWPs), if applicable.
- Prepare employee and retiree communications explaining any changes to premiums or prescription drug coverage.
- Continue to satisfy all Medicare Part D creditable coverage notice and CMS disclosure requirements.
- Monitor future CMS announcements for final 2027 premium information and additional guidance.

ACA Affordability Threshold Increases to 10.22% for 2027

The IRS has announced that the Affordable Care Act (ACA) affordability threshold will increase to 10.22% for plan years beginning in 2027, up from 9.96% for 2026. The new percentage was established in IRS Revenue Procedure 2026-26.

For applicable large employers (ALEs), generally those with at least 50 full-time and full-time equivalent employees, this percentage is important when determining whether an offer of coverage is affordable under the ACA employer shared responsibility rules. In general, affordability is based on the employee's required contribution for the lowest-cost self-only coverage that provides minimum value. Because employers typically do not know an employee's household income, they may use one of the ACA's affordability safe harbors.

Employer Action Items

The higher 2027 threshold may give employers additional flexibility when setting employee contributions for health coverage. Employers preparing for 2027 should:

- Review employee contribution requirements during renewal and budgeting.
- Update affordability calculations to use the 10.22% threshold for plan years beginning in 2027.
- Confirm that applicable affordability safe harbors are being calculated and applied correctly.
- Coordinate any contribution changes with ACA reporting and compliance processes.

Question of the Month | FSA Limits

Q. An employer's flexible spending arrangement (FSA) renews 7/1. With the increase to the dependent care limit, can employees contribute the full $7,500 in 2026?
One employee has contributed $2,500 to date in 2026. Since the plan renews 7/1, the contribution limit from 7/1 to 12/31 is $3,750, leaving the employee $1,250 short of the 2026 maximum. Can the employee contribute an additional $1,250 in 2026, or are they limited to $3,750?

A. The DCAP limits run on a calendar year basis. As long as the employer's DCAP is amended to incorporate the new limit, the employee in question can contribute the extra $1,250 in 2026.

Answers to the Question of the Week are provided by Kutak Rock.