



DOL Proposes New Electronic Disclosure Safe Harbor for Group Health Plans

By: Kate Belyayeva

On July 21, 2026, the U.S. Department of Labor ("DOL") announced *Electronic Disclosure by Group Health Plans Under ERISA* (the "Proposed Rule"), which was published in the Federal Register the next day. The Proposed Rule would create an optional notice-and-access safe harbor permitting administrators of group health plans subject to the Employee Retirement Income Security Act of 1974 ("ERISA") to default to electronic delivery without obtaining affirmative consent. The Proposed Rule would supplement, not replace, the existing 2002 electronic delivery safe harbor. Comments are due September 21, 2026.

Background

ERISA generally requires plan administrators to furnish disclosures using methods reasonably calculated to ensure actual receipt. Under the 2002 safe harbor, electronic delivery is generally available for employees who have work-related electronic access as an integral part of their duties and for other recipients who affirmatively consent. Those limits can make electronic delivery difficult for employees without regular workplace computer access, as well as retirees and beneficiaries. In 2020, the DOL adopted a default electronic delivery safe harbor for pension plans. The Proposed Rule would establish a similar, but not identical, framework for ERISA-covered group health plans. The DOL estimates that the proposal would affect approximately 2.77 million plans covering 134.7 million participants and beneficiaries and generate approximately \$3.9 billion in net savings over 10 years.

Key Considerations

- **Notice-and-access framework.** A plan administrator relying on the Proposed Rule

would post a required disclosure on a website or mobile application and send the recipient an electronic notice of internet availability ("NOIA"). The NOIA must use the heading "Disclosure About Your Health Plan," state that important plan information is available, identify the document, provide a link, explain the right to free paper copies and to opt out of electronic delivery, include the required availability caution, and provide a telephone number.

An NOIA generally must be a standalone communication and contain only the required or expressly permitted content. A separate NOIA generally would be required for each document. A combined annual NOIA may cover a summary plan description ("SPD"), certain recurring annual disclosures that do not require action by a deadline, authorized disclosures, and documents accompanying annual enrollment or plan-benefit materials. It must be furnished each plan year and no more than 14 months after the prior combined NOIA. It does not extend the posting deadline for any underlying document.

- **Covered individuals.** The safe harbor would apply to a participant, beneficiary, or other person entitled to a covered document who provides an email address or internet-connected mobile telephone number. An employer-assigned electronic address would qualify if it is assigned for employment-related purposes that include, but are not limited to, delivery of plan documents. A dependent child who is a plan beneficiary and has reached age 18 would be a covered individual only after providing an electronic address.
- **Covered documents.** The Proposed Rule broadly defines a "covered document" as any document or information that a group health plan administrator must furnish to participants or beneficiaries under Title I of ERISA. This would include SPDs, summaries of material modifications, summary annual reports, documents furnished only upon request, and health-plan notices such as notices under the Consolidated Omnibus Budget Reconciliation Act, special enrollment notices under the Health Insurance Portability and Accountability Act, Children's Health Insurance Program notices, and Summaries of Benefits and Coverage ("SBCs"), to the extent applicable and otherwise permitted. The proposal also would amend DOL's claims procedure regulation so the new safe harbor could be used for electronic notices of adverse benefit determinations and decisions on appeal.

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The Proposed Rule would not override separate delivery requirements under other federal or state laws. Employers therefore should not assume that it creates a single delivery standard for SBCs, transparency disclosures, cafeteria plans, etc.

- ▶ **Website requirements.** Covered documents must be posted by the applicable deadline and remain available for at least one year or, if later, until superseded. They must be readable, printable, searchable, electronically retainable, reasonably accessible outside the workplace, and protected by appropriate confidentiality measures. Temporary outages would not defeat the safe harbor if the administrator maintains reasonable procedures and promptly restores access. Notably, the covered document itself generally could not be delivered by email under the Proposed Rule. The NOIA may be sent by email or text, but the document must be posted to a compliant website or application. Direct email could still be used if it independently satisfies the 2002 safe harbor or another permissible delivery method.
- ▶ **Paper rights and delivery failures.** Before using the safe harbor, the administrator generally must provide a paper notice explaining the change and the recipient's paper-copy and opt-out rights. The notice may be electronic for individuals already receiving disclosures electronically under the 2002 safe harbor. Recipients may request paper copies at no charge or opt out of electronic delivery entirely. If an electronic address becomes invalid and cannot be corrected promptly, the recipient must be treated as having opted out and the affected document furnished on paper. Administrators also must address employer-assigned addresses when employment ends.
- ▶ **Scope and timing.** The Proposed Rule would apply only to ERISA covered group health plans. It would not apply to non-health welfare plans, such as stand-alone life or disability plans, although DOL requested comments on a possible expansion. The proposal would leave the 2002 safe harbor and paper delivery available. If finalized as proposed, the new safe harbor would become available on the first day of the first calendar year following publication of the final rule.

Employer Impact

No compliance change is required while the rule remains proposed. Employers interested in using the safe harbor can begin by inventorying group health plan disclosures, identifying the delivery rule and responsible party for each, and evaluating whether existing insurer or third-party administrator ("TPA") platforms can satisfy the website, NOIA, tracking, paper-copy, and opt-out requirements. Electronic-address procedures also will need to account for retirees, COBRA qualified beneficiaries, adult dependents, and former employees.

Implementation will require clear allocation of responsibility among the employer, insurer, TPA, COBRA administrator, and other vendors. Service agreements may need to address document hosting, delivery records, bounced notices, paper requests, privacy safeguards, reporting, and responsibility for failures. Delegating these functions does not relieve the plan administrator of responsibility for satisfying the safe harbor or prudently selecting and monitoring service providers.

Conclusion

The Proposed Rule would give ERISA-covered group health plans a broader path to electronic disclosure while preserving access to paper documents. If finalized as proposed, the new safe harbor would not become effective until January 1, 2027, at the earliest (i.e., the first day of the first calendar year following publication of a final rule). Employers should monitor the rulemaking, assess operational readiness with their insurers and TPAs, and consider submitting comments by September 21, 2026. Until a final rule becomes effective, the existing electronic delivery standards (e.g., the 2002 safe harbor) remain in place, and plan administrators may not rely on the Proposed Rule as a basis for electronic delivery in the interim.

Overview of the Blue Cross Blue Shield Settlement Proceeds

By: Abby Blankenship

Employers across the country have begun receiving settlement payments from the \$2.67 billion antitrust class action settlement involving the Blue Cross Blue Shield Association ("BCBSA") and class plaintiffs. If your organization is among those receiving funds, it is important to understand that the Employee Retirement Income Security Act of 1974, as amended ("ERISA"), may impose fiduciary obligations on how you handle the proceeds.

Background

The settlement arose from a class action lawsuit consolidated in the U.S. District Court for the Northern District of Alabama (the "District Court"), which accused BCBSA of violating antitrust laws. While BCBSA denied all allegations of wrongdoing, BCBSA agreed to resolve the litigation through a settlement fund. In addition to the monetary payment, the settlement also required BCBSA and its member plans to implement significant operational changes.

The settlement received final approval from the District Court in August 2022. On October 25, 2023, the U.S. Court of Appeals for the Eleventh Circuit affirmed the District Court's approval of the settlement.

Distribution of the Settlement

While the total settlement was \$2.67 billion, after administrative expenses, attorneys' fees, and other court-approved costs, around \$1.9 billion remains available for distribution to authorized claimants who submitted valid claims by the November 5, 2021, deadline. The initial distribution of payments began on May 11, 2026.

Settlement payments were calculated using coverage data provided by the Blue Cross Blue Shield member plans and generally reflect what each claimant paid during the applicable class periods (February 7, 2008, through October 16, 2020, for individuals and insured groups; September 1, 2015, through October 16, 2020, for self-funded accounts).

For fully-insured plans, in cases where both an employer and an employee filed claims, the settlement divided the premium amounts between them according to preset assumptions about who pays what share of the cost:

- 15% employee / 85% employer for single coverage; or
- 34% employee / 66% employer for family coverage.

For self-funded plans, where both an employer and an employee submitted overlapping claims, the settlement split administrative fees between them using similar preset assumptions of:

- 18% employee / 82% employer for single coverage; or
- 25% employee / 75% employer for family coverage.

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BCBS Proceeds Continued...

If the preset percentages did not accurately represent how costs were actually shared, employers and employees had the option to provide their own contribution figures when filing a claim so that the allocation better matched the actual cost-sharing arrangement.

ERISA Considerations

For employers sponsoring group health plans, receiving settlement proceeds raises important questions under ERISA. When employees contribute toward the cost of their group health coverage, those contributions are generally treated as plan assets. As a result, a portion of the settlement proceeds may be considered plan assets as well – to the extent the proceeds are traceable to employee contributions – similar to the treatment of Medical Loss Ratio (“MLR”) rebates under the Affordable Care Act.

Under ERISA, any portion of the settlement proceeds deemed to be plan assets must be used for the exclusive benefit of plan participants (and their beneficiaries) or to defray reasonable administrative expenses of the plan.

To date, the Department of Labor (“DOL”) has not issued any specific guidance on the proper treatment of settlement proceeds from the litigation. Additionally, it is worth noting that FAQ #39 on the official settlement website (<https://www.bcbssettlement.com/faq>) states that employers are not required to share their settlement proceeds with employees because employees had the opportunity to file their own separate claims. While this position is not binding on the DOL or any court, it may provide additional support for employers that determine their share of the proceeds is not traceable to employee contributions.



No Surprises Act: What the New Federal IDR Rule Means for Employer Health Plans

By Kate Belyayeva

On June 4, 2026, the Departments of Health and Human Services, Labor, and the Treasury, together with the Office of Personnel Management, published a final rule (the “Final Rule”) revising the federal independent dispute resolution (“IDR”) process under the No Surprises Act (the “NSA”). Although the Final Rule became effective August 3, 2026, several provisions will apply later based on agency guidance and portal updates. Thus, employers sponsoring self-insured plans should coordinate with their third-party administrators (“TPAs”) as soon as possible to ensure timely compliance with the Final Rule.

Background

Enacted as part of the Consolidated Appropriations Act, 2021, the NSA generally protects patients from surprise medical bills for out-of-network emergency services, certain non-emergency services furnished at in-network facilities, and out-of-network air ambulance services. These protections generally took effect January 1, 2022.

When neither a specified state law nor an applicable All-Payer Model Agreement determines the payment amount, the parties may use federal

IDR following a 30-business-day open negotiation period. If negotiation fails, either party generally may initiate IDR during the following four-business-day period. Each party submits an offer, and a certified IDR entity selects one after considering the qualifying payment amount (“QPA”) and properly submitted information concerning the other statutory factors. The QPA generally is based on the median contracted rate for the same or a similar item or service in the applicable insurance market and geographic region, adjusted for inflation.

Key Considerations

- ▶ **Expanded disclosures.** Effective August 3, 2026, plans and issuers must provide the QPA and related information with an initial payment or notice of denial even when the provider’s billed amount, rather than the QPA, is used to calculate participant cost sharing. The disclosures must also include the legal business name of the self-insured plan or issuer, the plan sponsor’s legal business name, and the plan’s or issuer’s federal IDR registration number once assigned. The Final Rule also requires plans and issuers to use specified claim adjustment reason codes (“CARCs”) and remittance advice remark codes (“RARCs”) on paper and electronic remittance advice sent to noncontracted entities. Under subsequent agency guidance, plans and issuers must use the specified RARCs for items and services furnished on or after January 1, 2027.
- ▶ **Portal-based negotiation and eligibility review.** Once the necessary portal functionality is available, parties will submit open negotiation notices, responses, and supporting documentation through the federal IDR portal. The receiving party must respond by the 15th business day of the 30-business-day negotiation period. A certified IDR entity generally must determine eligibility within five business days after its final selection. These requirements will apply to disputes with open negotiation periods beginning 90 days after the agencies announce that the supporting functionality is available.
- ▶ **Batching and bundled arrangements.** The Final Rule permits batching when qualified IDR items or services involve a single patient encounter billed on the same claim form, the same or comparable service codes, or specified anesthesiology, radiology, pathology, and laboratory services within the same Category I CPT code range identified in agency guidance. A batch may contain no more than 50 qualified IDR items or services, and the cooling-off period for batched disputes decreases from 90 calendar days to 30 business days. The Final Rule separately defines a bundled payment arrangement, which may be submitted as a single payment determination and is not generally subject to the batching requirements. The agencies have announced that the revised batching provisions will apply to disputes with open negotiation periods beginning on or after November 1, 2026.
- ▶ **Lower administrative fee.** The nonrefundable administrative fee decreased from \$115 to \$15 per party for disputes initiated on or after June 11, 2026. Beginning August 3, 2026, a party that does not timely pay the administrative fee or, for an eligible dispute, the certified IDR entity fee will not have its offer considered and will remain liable for the unpaid fee.
- ▶ **Federal IDR Registry.** Self-insured plans, issuers, and Federal Employees Health Benefits Program carriers subject to federal IDR will be required to register and obtain a federal IDR number. Fully insured group plans will not register separately from their issuers. Registration will be due by the later of 90 business days after the agencies announce that the registry is available or the date the plan or coverage becomes subject to federal IDR. A TPA may register for a self-insured plan, but the plan remains responsible for compliance. Registration information must be updated within 30 calendar days after a change and confirmed annually during the fourth quarter.

Employer Impact

Federal IDR activity has substantially outpaced the agencies’ projections. Although the agencies initially estimated that approximately 22,000 disputes would be initiated during the first year of implementation, CMS reports that more than 6.3 million disputes were initiated between April

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No Surprises Continued...

15, 2022, and May 31, 2026. This continued growth highlights the potential financial and administrative significance of the federal IDR process for employers sponsoring self-insured plans.

In light of the Final Rule, plan sponsors can begin by confirming that their TPAs have implemented the disclosure requirements effective as of August 3, 2026, and are preparing for the November 1, 2026 batching changes and January 1, 2027 RARC requirements. Other near-term priorities include assigning responsibility for federal IDR registration, gathering the required plan-specific information, and reviewing the plan's QPA methodology before the current enforcement relief expires on October 1, 2026. Administrative services agreements also warrant review to address IDR notices, payment authority, fees, reporting, registration, and responsibility for missed deadlines or inaccurate submissions.

Conclusion

Employers sponsoring self-insured plans should coordinate with their TPAs to implement the Final Rule's phased requirements, prepare for registration and portal changes, and establish regular oversight of IDR activity. Because delegation to a TPA does not eliminate the plan's compliance obligations, continued monitoring of agency guidance and the pending TMA III litigation remains important.



Fifth Circuit Holds OSHA Lacks Authority to Require Mental Illness Recordkeeping

By: Abby Blankenship

On July 21, 2026, U.S. Court of Appeals for the Fifth Circuit (the "Fifth Circuit") ruled that the Occupational Safety and Health Administration ("OSHA") did not have the statutory authority to mandate employers to record certain work-related mental illnesses on their OSHA injury and illness logs.

OSHA's Recordkeeping Requirements

Under OSHA's recordkeeping regulations, most covered employers are required to maintain records of work-related injuries and illnesses using OSHA Forms 300 and 301. Form 300 serves as an ongoing log of qualifying safety and health incidents throughout the calendar year, capturing basic information about the affected employee, the nature of the injury or illness, the date and location of the incident, the body part involved, and whether the incident resulted in days away from work, restricted duty, job transfer, or other recordable outcomes. Form 301 provides additional detail for each recordable event.

Additionally, the recordkeeping requirements also require employers to record work-related mental illnesses when a qualified healthcare provider's opinion supported a causal connection between the condition and the workplace.

Background of Fifth Circuit Case

In *Exxon Mobil Corp. v. Occupational Safety and Health Review Commission*,

the injury arose from an explosion and fire at an Exxon Mobil ("Exxon") refinery in Texas. An employee who assisted with the emergency response was subsequently diagnosed with post-traumatic stress disorder ("PTSD") by multiple healthcare providers, each of whom attributed the condition to the workplace incident. Exxon then declined to record the PTSD diagnosis on its OSHA 300 Log after obtaining a separate medical opinion that disputed the work-relatedness of the condition. OSHA then cited Exxon for failing to record the illness, and an administrative law judge upheld the citation and imposed a monetary penalty. After the Occupational Safety and Health Review Commission allowed the decision to become final, Exxon sought judicial review in the Fifth Circuit.

The Court's Holding

In its ruling, the Fifth Circuit framed the central question as one of statutory authority rather than workplace mental health policy. Specifically, the Fifth Circuit examined whether Congress authorized OSHA to require employers to record work-related mental illnesses under the Occupational Safety and Health Act ("OSH Act"), which empowers the agency to require employers to maintain records of work-related "deaths, injuries and illnesses."

Because the statute does not define the term "illnesses," the Fifth Circuit undertook a textual analysis drawing on several interpretive tools.

First, the Fifth Circuit considered the statutory context. The language surrounding "illnesses" in the OSH Act centers on concepts such as first aid treatment, loss of consciousness, restricted work activity, and job transfer – all of which address physical injuries and conditions. The court found that these contextual indicators reflected a congressional focus on physical occupational hazards.

Second, the Fifth Circuit looked to the broader structure of the OSH Act. It observed that other statutory provisions address occupational accidents, exposure to toxic materials, and harmful physical agents. The recordkeeping framework as a whole, the Fifth Circuit reasoned, reflects congressional concern with physical workplace hazards rather than psychological conditions.

Third, the Fifth Circuit reviewed dictionary definitions of "illness" contemporaneous with the enactment of the OSH Act. The Fifth Circuit determined that the ordinary meaning of the term at that time referred to physical disease or sickness and did not clearly encompass mental or psychological conditions.

Applying the Supreme Court's framework following *Loper Bright Enterprises v. Raimondo*, the Fifth Circuit acknowledged that OSHA had advanced a plausible reading of the statute, but concluded it was not the best interpretation. Because the agency's regulation exceeded the scope of the authority conferred by Congress, the court vacated the OSHA regulation and set aside the citation and penalty imposed on Exxon.

Key Takeaways for Employers

Because the Fifth Circuit vacated the underlying regulation, federal OSHA no longer has a valid regulatory basis to cite any employer for failing to record work-related mental illnesses. The decision is binding precedent within the Fifth Circuit, which encompasses Texas, Louisiana, and Mississippi. However, approximately half of all states operate their own occupational safety and health programs under approved state plans, many of which have adopted mental illness recordkeeping provisions that mirror the now-vacated federal rule. The Fifth Circuit's decision does not automatically invalidate those state-level requirements, and employers should consult with counsel to determine whether comparable obligations remain in effect in their jurisdictions.

Additionally, in light of this decision, employers should review and update their OSHA recordkeeping procedures, training materials, and incident response protocols to ensure they reflect the current regulatory landscape.

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STAY IN THE KNOW...

- On July 31, 2026, Illinois enacted the state's Civil Rights Safeguard Act, which amends the Illinois Human Rights Act to codify disparate impact liability for discriminatory employment decisions under state law, which is intended to ensure a means of recovery for discrimination claims based on purportedly neutral employment decision that have a disproportionate effect or impact on the basis of a protected class. The Illinois law is a response to recent efforts by the Trump Administration and the Equal Employment Opportunity Commission to abandon disparate impact liability in favor of focusing on discrimination claims alleging a discriminatory intent.
- The Department of Labor's Wage and Hour Division recently released two opinion letters (FLSA2026-9 and FLSA2026-10) on when employee travel time is compensable under the Fair Labor Standards Act (FLSA). Both letters address hybrid-work scenarios where employees work at home and at another location the same day. Employers should review travel-time and timekeeping practices to ensure mid-day trips and pre-appointment work activities are properly recorded and paid under the FLSA.
- Last month, the United States Office of Federal Contract Compliance Programs ("OFCCP") approved [Form CC-305](#) for federal contractors, subject to the Rehabilitation Act of 1973, to use to solicit applicant and employee voluntary self-identification of disability status. The newly approved form is substantially unchanged from OFCCP's prior self-identification form for disability status, is authorized for use through July 31, 2029, and may be downloaded from the OFCCP's website.