MY BENEFIT ADVISOR

Issued date: 10/25/24

2025 Health & Welfare Compliance Requirements

The following should be carefully reviewed for plan years that begin in 2025. Some information is not yet available; this chart will be updated as guidance is issued.

Done or N/A?	Topic	Affected Plans/ Employers	Description
	Status of ACA	All employers	The Affordable Care Act ("ACA") remains the law of the land. IRS and other agencies continue to enforce the various requirements. The Individual Mandate penalty is $0 beginning January 1, 2019. Employers, especially those with group health plans, should continue to monitor and comply with various requirements.
	Grandfathering	Grandfathered medical plans	Employers should revisit grandfathered status requirements, weighing the restrictions of remaining grandfathered against the additional requirements that apply to non-grandfathered plans. Remember, an employer must look back to the coverage in effect on March 23, 2010 to know whether a change results in a loss of this status. If grandfathered status is retained, provide appropriate notice to participants and beneficiaries in all materials describing the group health plan and maintain records documenting the retention of this status for as long as it is claimed. Once grandfathered status is lost, even if inadvertently, it cannot be regained. This is true even if the defect causing the loss of grandfathered status can be cured.

Done or N/A?	Topic	Affected Plans/ Employers	Description
	Cost-sharing limits	Non-grandfathered medical plans	For plan years beginning on or after January 1, 2025, non-grandfathered plans cannot impose out-of-pocket limits on EHBs that exceed the following limits: • **$9,200** for self-only coverage (down from $9,450 for 2024) • **$18,400** for coverage other than self-only (down from $18,900 for 2024) Additionally, with respect to family coverage, an individual out-of-pocket maximum of $9,200 applies to each person with family coverage.
	Cost-sharing limits	Reference-based price programs (or other similar arrangements)	Plans with this type of structure should carefully review whether there is adequate access to quality providers willing to accept the reference price as a payment in full[1]. Otherwise the plan may be required to count an individual's out-of-pocket expenses and pay amounts that exceed the OOPM even if provided "out-of-network" (including balance billing amounts for the provider who did not accept the reference price toward the out-of-pocket maximum limitation). There is ongoing litigation, the result of which may impact these arrangements.
	Cost-sharing limits	Qualified HDHPs	For plan years beginning on or after January 1, 2025, qualified HDHPs are subject to the following limits: • Minimum deductible: **$1,650** for self-only coverage (up from $1,600 for 2024) and **$3,300** for coverage other than self-only (up from $3,200 for 2024) • Maximum out-of-pocket: **$8,300** for self-only coverage (up from $8,050 for 2024) and **$16,600** for coverage other than self-only (up from $16,100 for 2024)[2].
	Preventive items and services	Self-funded Qualified HDHPs	Employers should consider adding coverage of new pre-deductible expenses, including beta-blockers, insulin, and inhalers for individuals with chronic conditions.
	HSA Contributions	HSAs	The maximum contribution to an HSA for calendar year 2025 is: • **$4,300** for self-only coverage (up from $4,150 for 2024) • **$8,550** for coverage other than self-only (up from $8,300 for 2024) Account holders who are at least 55 years of age may make a $1,000 catch-up contribution. The IRS issued an Information Letter which lists seven new examples of situations where an employer can obtain a return of contributions mistakenly made to an employee's HSA.

1. The Departments have issued various FAQs specifying factors that will be considered to determine whether the reference-based price structure (or similar network design) is a reasonable method. Notably, FAQ 21 lays out five specific requirements the Departments will look at including the type of services, whether there is reasonable access, whether the providers meet quality standards, whether there is an exceptions process and disclosure regarding the pricing structure and providers. See FAQ 21 https://www.dol.gov/sites/default/files/ebsa/about-ebsa/our-activities/resource-center/faqs/aca-part-xxi.pdf and FAQ 31 https://www.dol.gov/sites/default/files/ebsa/about-ebsa/our-activities/resource-center/faqs/aca-part-31.pdf.
2. This is lower than what is required under the ACA. Non-grandfathered HDHPs must follow both sets of out-of-pocket maximum rules.

Done or N/A?	Topic	Affected Plans/ Employers	Description
	Health FSA limits	Health FSAs	For plan years beginning in 2024, the limit on annual salary reduction contributions to a health flexible spending arrangement ("health FSA") provided under a cafeteria plan is **$3,300** (up from $3,200 in 2024). For plans that permit carryover option, the maximum unused amount from a health FSA plan year that begins in 2025 that can be carried over to the following plan year is **$660** (up from $640 in 2024).
	PCOR fee	All medical plans and HRAs	Health plans have been assessed an annual fee to fund a Patient-Centered Outcomes Research (PCOR) program. • Insured plans: Insurance carriers pay the fee directly. • Self-insured plans, including HRAs: The employer pays the fee to the IRS each year by July 31 using the 2nd quarter Form 720 (quarter ending 6/30). While this fee was scheduled to sunset, legislation signed into law on December 20, 2019 extended the PCOR fee through September 30, 2029 for insured and self-funded plans. The next payment is due on **July 31, 2025**, as follows:

Plan Year	Amount of PCOR Fee
February 1, 2023 - January 31, 2024	$3.22/covered life/year
March 1, 2023 - February 29, 2024	$3.22/covered life/year
April 1, 2023 - March 31, 2024	$3.22/covered life/year
May 1, 2023 - April 30, 2024	$3.22/covered life/year
June 1, 2023 - May 31, 2024	$3.22/covered life/year
July 1, 2023- June 30, 2024	$3.22/covered life/year
August 1, 2023 - July 31, 2024	$3.22/covered life/year
September 1, 2023 - August 31, 2024	$3.22/covered life/year
October 1, 2023 - September 30, 2024	$3.22/covered life/year
November 1, 2023- October 31, 2024	$3.47/covered life/year
December 1, 2023 - November 30, 2024	$3.47/covered life/year
January 1, 2024 - December 31, 2024	$3.47/covered life/year

Note that special rules apply to short plan years.

Done or N/A?	Topic	Affected Plans/ Employers	Description
	MHPAEA	Employers with more than 50 employees offering group health plan coverage that includes Mental Health and/or Substance Use Disorder (MH/SUD) benefits Non-grandfathered insured plans, including small group coverage	Review the plan to determine whether there are provisions that may raise MHPAEA issues, such as: • Exclusions of ABA therapy for the treatment of autism as an experimental treatment. • Dosage limits on prescription drugs which are more restrictive on MH/SUD conditions than other medical conditions. • Exclusion of in-patient or out-patient treatment for eating disorders based on facility type. Review FAQ 39 for additional information: www.cms.gov/cciio/resources/fact-sheets-and-faqs/downloads/mhpaea-faqs-part-45.pdf
	Employer Penalty: Understand potential penalty exposure	ALEs	**"A" Penalty.** Applies if the ALE does not offer at least 95% of all ACA FTEs and their children to age 26 minimum essential coverage ("MEC") and one FTE receives a subsidy in the Marketplace. • $2,000 (as adjusted for inflation, **$2,970** for 2024) X total number of FTEs in excess of 30. **"B" Penalty.** Applies if the ALE offers coverage to at least 95% of all ACA FTEs (and their children to age 26), but that coverage is unaffordable or does not provide minimum value (or as to any excluded 5% of ACA FTEs and one FTE receives a subsidy in the Marketplace. • $3,000 (as adjusted for inflation; **$4,460** for 2024) X the total number of ACA FTEs who receive the subsidy in the Marketplace (maximum penalty is capped at the "A" penalty).
	Employer Penalty: Identify application and method of compliance	All Employers	• Determine ALE status (i.e., whether the employer has at least 50 full-time employees ("FTEs") each calendar year, considering all common law employees in the entire controlled group and counting each part-time employee as a fraction of an FTE). • Determine full-time status using the monthly measurement method or look-back measurement method. • Offer coverage to FTEs and dependent children. • Evaluate minimum value. • Evaluate affordability and elect a safe harbor[3]. • Ensure that all plan language accurately reflects the selections.

3. An employer will not be subject to a penalty with respect to an FTE if the employer meets the 95% MEC offer requirement and that employee's required contribution for 2025 for the employer's lowest cost self-only coverage that provides MV does not exceed:
   - 9.02% (up from 8.39% for 2024) of W-2; or
   - 9.02% (up from 8.39% for 2024) of employee's rate of pay; or
   - 9.02% (up from 8.39% for 2024) of FPL ($117.63 for 2025 calendar years plans starting February 1st or later in the lower 48 states and DC.)

Done or N/A?	Topic	Affected Plans/ Employers	Description
	Employer Penalty: Reporting	All ALEs, with additional requirements for ALEs with self-insured health plans	All ALEs must use Forms 1095-C and 1094-C to report offers of coverage (or no offer of coverage) to ACA FTEs. For calendar year 2024, Forms 1095-C are due to ACA FTEs by March 3, 2025 (delayed from January 31, 2025). For calendar year 2024, Forms 1094-C and all Forms 1095-C must be filed electronically with the IRS by March 31, 2025 (unless filing by paper, then February 28, 2025). Electronic filing is required if filing 10 or more forms for both original and corrected filings. **ALEs with self-funded health plans** must also report MEC information for each covered member on these Forms, including covered non-ACA FTEs (e.g., part-time employees and COBRA qualified beneficiaries). Information on family members who have coverage through the covered member (e.g., a spouse or child) must be included.
	MEC Reporting	Non-ALEs with self-insured plans	Employers that are not considered ALEs but offer a self-funded group health plan are responsible for MEC reporting on behalf of covered members. Small employers with self-insured plans may use Forms 1094-B and 1095-B. This report includes individuals who receive coverage through the covered member (e.g., spouse, children). The timeframe for submitting these reports is the same as described above for Forms 1094-C and 1095-C. Employers that file less than 10 returns are urged to consider filing electronically by the IRS.
	Employer Penalty: Reporting and Penalty Assessments	Employers	The IRS has notified certain employers regarding missing or incomplete Form 1094-C and 1095-C filings (Letter 5699). The IRS has issued Letter 226J notifying employers of potential penalty assessments as far back as the 2015 plan year including more recent years. ALEs should ensure that they review and handle them timely. Employers should continue to comply with the employer mandate until and unless guidance is issued.

Done or N/A?	Topic	Affected Plans/ Employers	Description
	Marketplace Notices	Employers	The Marketplace is supposed to issue a notice if any employee of an employer receives a subsidy in the Marketplace. If an applicable large employer ("ALE") receives this notice on an ACA full-time employee, the employer should verify whether there is any penalty exposure (i.e., inquire as to whether the individual was offered affordable health insurance coverage). The Marketplace Notice is NOT a notice that a penalty is imminent. Any penalty assessment notice will come from the IRS. Ensure good recordkeeping processes to demonstrate offers of coverage, acceptance, waivers, affordability and minimum value as applicable.
	ACA's integration requirement and prohibition of employer payment of individual insurance policies	HRAs	HRAs must be integrated with group health plans and not reimburse individual policy premiums with the following exceptions: 1. **Qualified Small Employer HRA (QSEHRA).** A small employer (fewer than 50 full-time employees) with no group health plan can offer reimbursements up to indexed amounts $6,350 self-only / $12,800 family for 2025 (up from $6,150 / $12,450 for 2024). 2. **Retiree HRA.** An HRA covering fewer than two participants who are active employees. 3. **Individual Coverage HRA.** Since 2020, an HRA can be integrated with an individual policy if the employer does not offer a group plan to same class of employees. ALEs must evaluate affordability for Employer Penalty purposes. 4. **Excepted Benefit HRA.** Beginning 2025, employers can offer an HRA offering reimbursements up to $2,150 (up from $2,100 in 2024). A group medical plan must be offered, but the employee doesn't have to enroll in it. 5. **Stand-Alone HRA for Dental and/or Vision Expenses.**
	Wellness Programs	Tax Treatment Clarified	The IRS is concerned about "double dipping" wellness programs. These are programs where "employees make pre-tax elections, and then do certain things to receive that election (less a fee) back on a non-taxable basis." The IRS informally clarified that some wellness arrangements and fixed indemnity products are being marketed as "tax free" when in fact the design would require inclusion of the employee elections in the employee's gross income. • Payments of cash rewards (including gift cards) for participating in a wellness program must be included as income to the employee. • Certain "de minimis fringe" benefits, such as a t-shirt or water bottle, can be excluded from income as a fringe benefit. However, a payment of a gym membership fee that does not qualify as medical care would not be excludible from the employee's income. • Wellness programs where the employee must contribute on a pre-tax basis and then "gets back" the money "tax free" for doing certain tasks (e.g., complete a health risk questionnaire) are not excludable from income.

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	Wellness Incentives	Employers using incentives with wellness programs	Incentive based wellness programs continue to be complicated. Effective January 1, 2019, the court vacated the ADA and GINA rules regarding wellness incentives. The most conservative approach is to remove incentives associated with employee medical exams or spousal completion of health risk assessments. This may be overly conservative, and some employers may be comfortable continuing programs with reward thresholds at or below the pre-2019 rules which generally limit the incentive to no more than 30% of the total cost of self-only coverage in the lowest cost health plan option offered by the employer to any employee. Employers looking at rewards beyond the 30% limits should consult with their own counsel.
	Transportation Benefits	Employers Offering Transportation Benefits	For calendar year 2025, the monthly exclusion limitation for transportation in a commuter highway vehicle (vanpool) and any transit pass and qualified parking expenses is **$325** (up from $315 in 2024). Parity between these accounts is permanent. The employer deduction for all transportation fringe benefits was unavailable beginning January 1, 2018.
	Highly Compensated and Key Employee Definitions	Cafeteria plans, Life Insurance Discrimination (Sec. 79)	The compensation threshold for a **highly compensated individual** or participant (for purposes of Section 125 nondiscrimination testing) is **$155,000** in CY 2024 for 2025. The dollar limitation concerning the definition of a **key employee** is **$220,000** in CY 2024 for 2025.
	FMLA Leave	All employers	Since 2018 and until January 1, 2026, a tax credit is available for employers that provide paid leave that would generally not otherwise be paid (e.g., not due to sick pay or vacation policies) for FMLA-qualifying circumstances (whether or not the employer is subject to FMLA).
	Cross-Plan Offsetting	Self-funded medical plans	Cross-plan offsetting is a mechanism used by TPAs to resolve overpayments to a provider made through one plan by withholding (or reducing) payment to the same provider through another plan. Based on a past court ruling, employers should review and understand whether their TPA engages in cross-plan offsetting and whether there is language in the plan documents to support this practice. Further, it is advisable to review whether to continue cross-plan offsetting or “opt-out” of this practice.

Done or N/A?	Topic	Affected Plans/ Employers	Description
	State Required Paid Sick Leave	Various	Many states already require (or will soon require) paid sick leave for employees; specifically, Arizona, California, Connecticut, D.C., Illinois, Maine, Maryland, Massachusetts, Michigan, Nevada, New Jersey, New Mexico, New York, Oregon, Rhode Island, Vermont, and Washington.
	State Required Paid Family Leave	Various	Many states require paid family leave. They include California, Colorado (2024), Connecticut, D.C., Delaware (2026), Maine (2026), Maryland (2026), Massachusetts[4], Minnesota (2026), New Jersey, New York, Oregon, Rhode Island, and Washington.
	State Required Paid Time Off	Various	Many states require some type of Paid Time Off for employees; specifically, Arizona, California, Colorado, Connecticut, Delaware, D.C., Maine, Maryland, Massachusetts, Michigan, Minnesota, Nevada, New Jersey, New Mexico, New York, Oregon, Rhode Island, Vermont, Washington
	City and Other Required Paid Leave	Various. **This summary does not address all applicable city or other local mandates.**	Some cities that have passed sick leave laws are New York City, Dallas, San Antonio, and Austin. Other cities include Berkeley, Oakland, San Diego, San Francisco and Santa Monica, CA; Chicago and Cook County, IL; Montgomery County, MD, Minneapolis, and St. Paul, MN; Seattle, Pittsburgh, Philadelphia, and Los Angeles. These are examples only.
	State Individual Mandate Reporting	Employers with employees in California, D.C., Massachusetts, New Jersey, Rhode Island, and Vermont	Forms reporting on offers of coverage to employees are to be sent to the New Jersey Division of Taxation by March 31, 2025. California employers that sponsor a health plan must file reports similar to Form 1095-C or 1095-B with the state's Franchise Tax Board on all CA residents covered by the plan. The initial deadline will be March 31, 2025 with respect to calendar year 2024. D.C., Rhode Island, and Vermont also have employer notice requirements in 2025. The Massachusetts Form 1099-HC remains in effect.
	Surprise Medical Bills	Various – usually insured plans with contracts written in the applicable states (self-funded plans may opt in if permitted under state law)	Many states including Arizona, California, Colorado, Connecticut, Delaware, Florida, Georgia, Illinois, Indiana, Iowa, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Carolina, Ohio, Oregon, Pennsylvania, Rhode Island, Texas, Vermont, Virginia, Washington, and West Virginia offer relief to patients for out-of-network charges at in-network facilities.

4. Includes 2019 notice and payroll deduction requirements.