Brown & Brown

EMPLOYEE BENEFITS

2025 Compliance Issues to Consider

September 2024

Topics

2025 ACA Maximum Out-of-Pocket Expenses

(non-grandfathered plans)

Applicable to plan years beginning on or after 1/1/2025:

- $9,200 for self-only coverage ($250 decrease from $9,450 in 2024)
- $18,400 for family coverage ($500 decrease from $18,900 in 2024)

2025 HSA & HDHP Design Maximums

HDHP	2024	2025	Change in 2025
Minimum Annual Deductible	$1,600 for self-only coverage	$1,650 for self-only coverage	$50 increase
	$3,200 for family coverage	$3,300 for family coverage	$100 increase
Out-of-Pocket Maximums	$8,050 for self-only coverage	$8,300 for self-only coverage	$250 increase
	$16,100 for family coverage	$16,600 for family coverage	$500 increase
Maximum Annual HSA Contribution	$4,150 for self-only coverage	$4,300 for self-only coverage	$150 increase
	$8,300 for family coverage	$8,550 for family coverage	$250 increase

- Catch-up contribution (Age 55 and older by the end of the tax year): $1,000
- Maximums apply to plan years beginning in the applicable year.
- **Note:** DOL, HHS, and IRS guidance requires group health plans to embed an individual out-of-pocket maximum in the plan's family coverage when the family out-of-pocket maximum exceeds the ACA's out-of- pocket maximum for self-only coverage.

*When the HDHP includes an embedded deductible for those with family coverage, no plan benefit (other than for preventive care or other permitted coverage) may be available until one or more family members have satisfied the full minimum annual family deductible.

Health FSA Limits

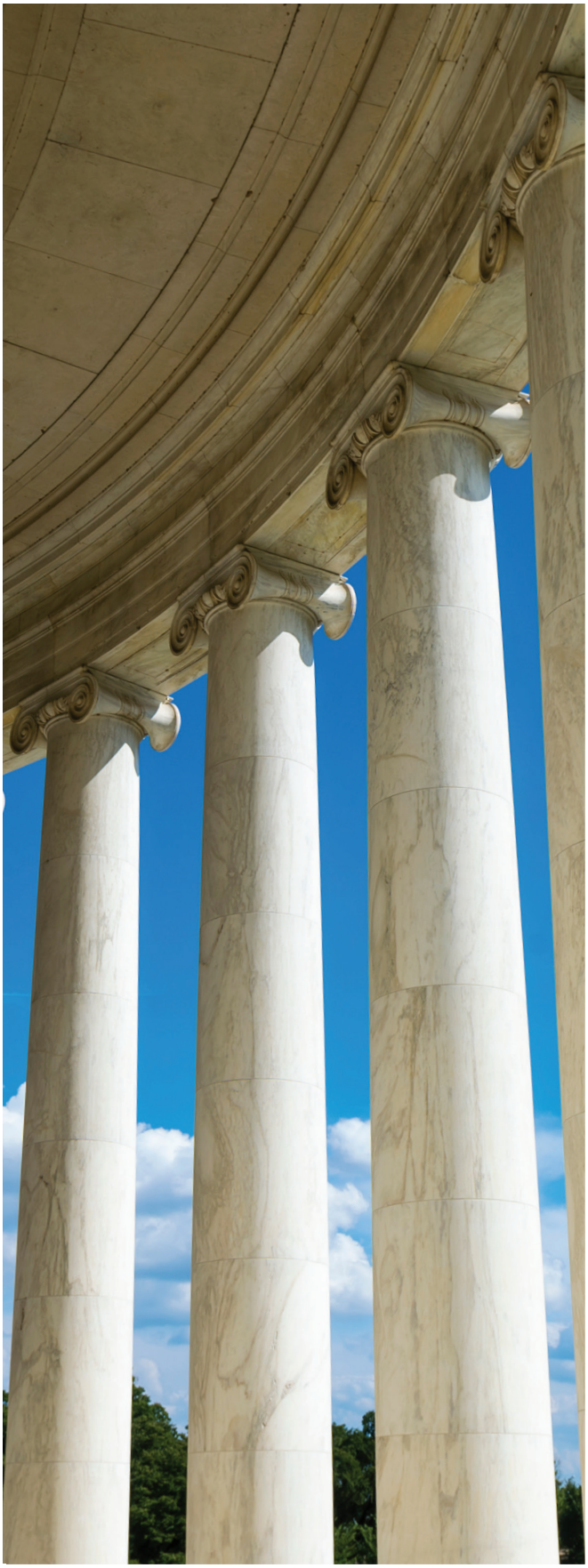
- The inflation-adjusted annual limit on employee salary reduction contributions for plan years beginning in 2025 is $3,300 (up from $3,200 in 2024).
- The limit on the amount that may be carried over from the plan year beginning in 2025 to the 2026 plan year increased to $660 (up from $640 for 2024).

DCAP Limits

Limit on the amount of DCAP benefits (including dependent care FSA benefits) that are excluded from income is $5,000 ($2,500 for married filing separately) for the calendar year.

Transportation Limits

The 2025 monthly limitation on non-taxable qualified transportation fringe benefits is $325 (up from $315 in 2024), as is the 2025 monthly limitation for qualified parking fringe benefits.



Employer Shared Responsibility Tax

(employer mandate) for 2025

- **4980H(a)** Tax for not offering minimum essential coverage to at least 95% of full-time eligible employees. For 2025, the ESRP will be $2,900 (annually) per full-time employee (less 30 full-time employees).
- **4980H(b)** Tax for offering coverage that is not minimum value or not affordable to a full-time employee or failure to offer coverage to a full-time employee when coverage is offered to at least 95% of full-time employees. For 2025, the ESRP will be $4,350 (annually) for each full-time employee not offered minimum value, affordable coverage that receives an Exchange subsidy.

Affordability Safe Harbors

The safe harbor percentage for 2025 is 9.02%. The 2024 affordability threshold is 8.39%.

PCORI Fee

FEE DUE JULY 31, 2024

Plan year end date	Fee per average covered life
Jan. 2024 – Sept. 2024	$3.22
Oct. 2024 – Dec. 2024	TBD - Proj. $3.40 based on 5.6% projected 2024 increase in National Health Expenditures

Selecting a Benchmark Plan

- The final market reform rules require self-insured and large insured plans to select one of the three Federal Employees Health Benefit Program (FEHBP) options or a state benchmark plan to define essential health benefits (EHB) for purposes of ensuring the plan imposes no annual or lifetime dollar limits on EHBs.
- This requirement applies to benefits provided in- or out-of-network.

Forms 1094-C/1095-C or Forms 1094-B/1095-B

Applicable Large Employers (ALEs) are responsible for disclosing and reporting information related to offers of coverage to full-time employees. ALEs typically report/ disclose this information in Forms 1094-C and 1095-C. Plan sponsors of a self-funded health plan must also disclose and report covered individuals participating in the health plan on Forms 1094-B and 1095-B or, if they are an ALE, on Forms 1094-C and 1095-C. The 1095-B/C must be disclosed/furnished to employees/covered individuals by March 2nd of the year following the applicable calendar year of coverage, and the applicable 1094-B/C Forms and 1095-B/C Forms would need to be filed with the IRS by February 28th of the year following the applicable calendar year of coverage if they were filed by paper form and by March 31st of the year following the applicable calendar year of coverage if such Forms were filed electronically with the IRS. **These dates may change if they fall on a weekend or holiday.** Previously, ALEs that issued less than 250 returns had the option to file paper copies of these Forms and were not required to file these Forms electronically with the IRS. However, beginning in 2024 (reporting information for the 2023 calendar year), ALEs/plan sponsors that issue ten (10) or more returns in aggregate (meaning all forms/ returns filed with the IRS, including W-2s, 1099s, etc.) are now required to file the Forms 1094-B/C and 1095-B/C electronically.

Wellness Incentive and Reward Limits

HIPAA

- **Participation-Only Program** (e.g., fitness club discounts): Unlimited.
- **Outcomes-Based:** Tobacco cessation 50% of employer + employee premium contribution. All other programs (e.g., biometrics) 30% of employer + employee premium contribution. Note: If combined, the total can be no more than 50% of employer + employee premium contribution, with any percentage over 30% being attributable to tobacco cessation.

ADA

- EEOC rules were withdrawn per President Biden's regulatory freeze order (January 2021). Replacement rules have not yet been issued.
- Employers should be careful about structuring incentives for wellness programs that ask for health information or involve medical exams.

GINA

Applies to incentives linked to the spouse or children of an employee participating in a medical exam or providing information regarding current or past health status: The maximum inducement to the employee ***was*** 30% of the employee only rate, and if the spouse can participate, an additional 30% of the employee-only rate. However, these rules have also been withdrawn.

Transparency

- Reporting on Prescription Drug Costs – Annual report due by June 1, 2025, with respect to 2024 calendar year data. Subsequent annual report due June 1st for the preceding calendar year.
- Prohibition on Gag Clauses Annual attestation of compliance will be required by December 31st of each year, for the period beginning with the date of the prior attestation, through the attestation date.

Additional Requirements

- Advanced Explanation of Benefits: Enforcement deferred until agencies implement future rulemaking.

Mental Health Parity and Addiction Equity Act (MHPAEA)

- Health plans and issuers providing coverage for both medical/surgical (M/S) and mental health or substance use disorder (MH/SUD) benefits have a statutory obligation to conduct and document a comparative analysis of the design and application of any nonquantitative treatment limitations (NQTLs) that apply to MH/SUD benefits.
- Final rules issued on September 23, 2024, confirm that plans and issuers must provide the comparative analysis to the requesting agency within ten (10) business days of receipt of the request. In addition, the final rules require that plans must make available a copy of the comparative analysis when requested by a participant/beneficiary who has received an adverse benefit determination related to MH/SUD benefits. Plans subject to ERISA must provide the comparative analysis within thirty (30) days to any participant/beneficiary who requests the analysis at any time, as required under ERISA § 104.
- Any restrictions that are not compliant with the parity rules must be corrected within a 45-day corrective action period. If a determination is made that the plan is still noncompliant following the corrective action period, the plan must provide a standalone notice within seven (7) business days to all participants and beneficiaries enrolled in the plan informing them that the plan has been determined to be noncompliant with MHPAEA and applicable regulations.
- For plan years beginning on or after January 1, 2025, employers/plan sponsors subject to ERISA (or that otherwise have a fiduciary duty to plan participants) are responsible for certifying that they have engaged in a "prudent process" of selecting one or more service providers to perform and document the comparative analysis in accordance with MHPAEA, as well satisfying their duty to monitor those service providers.
- Plan sponsors should speak with vendors/carriers prior to the plan year that occurs on or after January 1, 2025, to assess whether a comparison of MH/SUD and M/S benefits has been performed by the carrier/TPA in accordance with the final rules. If the plan sponsor is not receiving assistance from the vendor/carrier with a comparative analysis that ensures parity pursuant to MHPAEA, the plan sponsor should seek assistance from a third-party vendor to assist with this comparative analysis.

HSA Eligibility Relief for 2024 Set to Expire in 2025

Temporary relief applicable through plan years ending in 2024 permitted qualified HDHPs to cover COVID-19 testing and treatment prior to a covered individual satisfying the HDHP minimum deductible without jeopardizing an HDHP participant's HSA-eligible status (so long as they were otherwise HSA eligible). This relief applied for plan years **ending on or before December 31, 2024**, and will expire as of the plan year ending on or after January 1, 2025

Under further temporary IRS relief, an individual also would not jeopardize their HSA-eligible status if they participated in a qualified HDHP or other group health plan that provides coverage for telehealth or other remote care services prior to a covered individual satisfying the minimum HDHP deductible during a plan year **beginning before January 1, 2025**. Unless extended through future legislation, this relief is set to expire for plan years beginning on or after January 1, 2025.

Hospital/Fixed Indemnity Insurance

On March 28, 2024, the U.S. Departments of Health & Human Services, Labor, and Treasury (the "tri-agencies") released final rules related to hospital/fixed indemnity policies.

Hospital/Fixed Indemnity Notice Requirement

For any new or existing hospital or fixed indemnity plans in the group market with policy years starting on or after January 1, 2025, the final rules mandate that individuals seeking to enroll receive a notice outlining the key differences between comprehensive health coverage and hospital/fixed indemnity policies.

For group plans, the notice must be displayed "prominently on the first page (in either paper or electronic form, including on a website)" in all marketing, application, enrollment and re-enrollment materials. Plan sponsors should provide this notice to enrollees and re-enrollees during initial enrollment, open enrollment, and special enrollment (if applicable) each plan year. For individual plans, the notice must be prominently displayed in the policy, certificate, or insurance contract as well as on the first page of any marketing, application and enrollment materials related to the fixed indemnity plan.

A model notice is included in the final rules on page 23419.

How Brown & Brown Can Help

Connect with your Brown & Brown service team to learn more about how we can help find solutions to fit your unique needs.

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