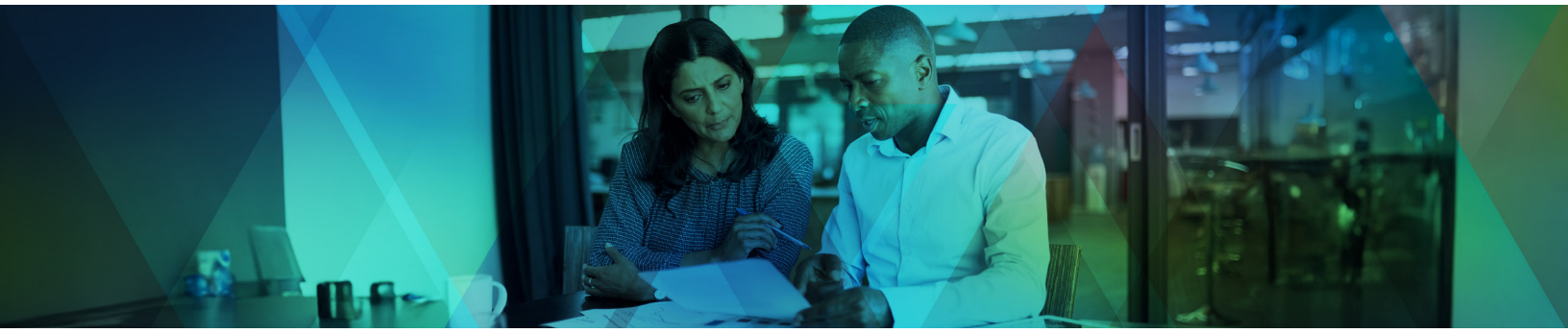

2025 End-of-year compliance checklist

Several new (2025/2026) employee benefit compliance requirements for 2025 and 2026 require particular attention from plan sponsors. This checklist highlights those requirements and provides reminders of some traditional year-end employee benefit compliance considerations. The list is intended to emphasize the need to focus on the task of year-end compliance activity in general and is not intended to serve as an exhaustive "to do" list of all employee benefit compliance tasks, which will likely vary from employer to employer depending on their size and employee benefits offered.

NEW FOR 2026

1 Telehealth, HSAs and HDHPs: Application of the Deductible

As part of 2025 legislation, the One Big Beautiful Bill Act (OBBBA) retroactively extended the pre-deductible telehealth exception and added a new exception for remote care for Health Savings Account (HSA) and High-Deductible Health Plan (HDHP) participants. This COVID-19 era relief had been set to expire on December 31, 2024, before OBBBA was enacted. This allows for telehealth benefits to be covered, pre-deductible, for plans starting January 1, 2025 onward.

Historically, telemedicine (virtual primary care or virtual specialty care) was disqualifying coverage for HSA purposes unless the telemedicine is only available once the participant meets the applicable deductible, or if the participant paid fair market value for the visit. The CARES Act provided a temporary safe harbor, allowing individuals to access free telemedicine before the deductible through December 2021 and then under an extension in the CAA through December 31, 2024.

2 HSAs and HDHPs: Direct Primary Care Exception

The OBBBA expanded the use of HSAs by adding direct primary care (DPC) arrangements as permissible coverage, if they meet certain requirements. The DPC arrangement must be for a monthly fixed periodic fee that is no more than $150 (individual) or $300 (more than one individual). These amounts will be inflation indexed. The DPC arrangement must not include coverage for procedures that require the use of general anesthesia, prescription drugs (other than vaccines) or laboratory services not typically administered in an ambulatory primary care setting. DPC arrangements that meet this criteria are permissible first dollar coverage effective beginning January 1, 2026.

3 Calculate Your 2026 ACA Plan Year Affordability

ACA Affordability Percentage for 2026 Increased to 9.96% (up from 9.02% in 2025).

- For calendar year groups, the new 2026 Poverty Line Safe Harbor will be:
  - $129.89 for the 48 contiguous states and the District of Columbia;
  - $162.26 for Alaska;
  - $149.32 for Hawaii.
- These calculations are based on the 2025 federal poverty levels. The 2026 levels will be announced in late January 2026.

Applicable large employers (ALEs) — generally those with an average of 50 or more full-time equivalent employees — must offer affordable qualifying coverage or face fines from the IRS under the Affordable Care Act (ACA).

Employers with calendar year plans should do their ACA affordability calculations before Open Enrollment to make sure that their plans are affordable. Ask your Alera Group consultant about our ACA affordability calculators.

4 2025 PLAN YEAR BENEFIT LIMITS

HSA	2025 AMOUNT	2026 AMOUNT
Max Contribution Level	$4,300/$8,550	$4,400/$8,750
Min Deductible for HDHP (non-embedded)	$1,650/$3,300	$1,700/$3,400
Max OOP Expenses for HDHP	$8,300/$16,600	$8,500/$17,000

FSA	2025 LIMIT	2026 LIMIT
FSA Contribution Limit	$3,300	$3,400
Max Carryover Amount	$660	$680
Dependent Care Contribution Limit	$5,000 ($2,500 *MFS)	$7,500 ($3,750 *MFS)

**MFS: married filing separately*

5 Medicare Part D: New Creditable Coverage Safe Harbor

Creditable prescription drug coverage means that an employer-sponsored health plan offers prescription benefits to Medicare-eligible individuals that are at least as good as the Medicare Part D drug benefit. It allows Medicare-eligible participants to maintain their current level of coverage and avoid late enrollment penalties under Part D. Coverage is considered creditable if its actuarial value meets or exceeds that of the standard Part D benefit, as determined by using generally accepted actuarial principles or applying a CMS safe harbor method.

Two design-based safe harbor methods are available to simplify the creditable coverage determination, and the applicable method depends on the calendar year in which it is applied. The existing Pre-2025 Safe Harbor Method may be used through the 2026 calendar year. Beginning in 2027, plans must use the new safe harbor method, though they may adopt it earlier if desired.

Employers should confer with their carriers/third-party administrators (TPAs) to determine whether their coverage will retain creditable status when they renew. If the carrier/TPA is unable to make this determination for the plan and the plan does not meet one of the safe harbor methods, our Alera Group actuarial team can help make the determination for a fee.

6 ACA Reporting: Furnishing Forms to Individuals

Under the Paperwork Burden Reduction Act signed on December 23, 2024, an Applicable Large Employer (ALE) or sponsor of a self-funded medical plan is no longer required to automatically furnish each individual with Form 1095-B or 1095-C (as applicable) beginning with the 2024 calendar year for forms due to participants in 2025. Instead, the filer may post a "clear, conspicuous and accessible" notice informing individuals that the form is available upon request. If requested, the filer must provide the form within 30 days (or by January 31 of the following year, whichever is later).

This new law applies only to furnishing statements to individuals, and does not change the requirement to electronically file 1094 and 1095 forms with the IRS. ALEs and sponsors of self-funded medical plans must also continue to meet filing requirements in states with their own individual healthcare mandates including California, the District of Columbia, Hawaii, Vermont, Massachusetts, New Jersey and Rhode Island.

7 Mental Health Parity Addiction Equity Act Update to the Final Rules

In 2024, several federal departments issued final rules regarding the Mental Health Parity Addition Equity Act (MHPAEA) regulations. Some of these final rules were supposed to take effect in 2025, others in 2026. Due to a lawsuit brought by the ERISA Industry Committee (ERIC) against HHS along with a Presidential order requiring regulatory review, federal agencies have suspended enforcement of the 2024 final rules. The lawsuit alleges that the final rules exceed the existing mental health parity law, violates the Due Process Clause of the Fifth Amendment, and are arbitrary and capricious. The complaint also argues that the final rules would substantially increase administrative costs.

The final rules aimed to ensure that quantitative treatment limits (QTL) such as deductibles, copayments and coinsurance are comparable between medical/surgical benefits and mental health/substance use disorder benefits, and that nonquantitative treatment limits (NQTL) such as network adequacy, provider reimbursement rates and prescription limitations are as well.

It is expected that health insurance carriers will bear the brunt of the compliance burden regarding fully insured health plans. Employer plan sponsors will bear more of the burden to show that self-funded or level-funded health plans are in compliance. Self-funded and level-funded plans should work with their plan administrator or an outside vendor to ensure the testing is completed to assure whether compliance has been achieved.

Resources:

- Final Rules
- Fact Sheet
- New Mental Health and Substance Use Disorder Parity Rules: What They Mean for Participants and Beneficiaries
- New Mental Health and Substance Use Disorder Parity Rules: What They Mean for Providers
- New Mental Health and Substance Use Disorder Parity Rules: What They Mean for Plans and Issuers
- White House Fact Sheet
- News Release

Plans must make a copy of the comparative analyses available when requested by any applicable state authority, a participant, beneficiary or enrollee who has received an adverse benefit determination related to MH/SUD benefits, and by participants and beneficiaries in ERISA plans at any time.

Plans required to do their own NQTL testing, including large self-funded plans, should prepare for these new standards to be incorporated into their NQTL testing occurring in 2025 and beyond. If you have any questions about NQTL testing, please reach out to your Alera Group consultant.

8 GLP-1 Coverage for Weight Loss

Employers are thinking of new and creative ways to cover GLP-1 medications for weight loss. There are many types of solutions for this coverage, whether it is included with your major medical plan as written or whether it is added on to your plan offerings. Compliance for GLP-1 coverage is nuanced and changing daily with new legislation and vendors in this space. There could be compliance implications to the plan's other offerings depending on how these benefits are added. Please consult with your Alera Group Compliance Consultant if you are interested in adding a GLP-1 benefit to your plan or if you have any questions.

9 Reoccurring Year-End Employee Benefit Compliance Considerations

a. **ACA REPORTING**

- ALEs and sponsors of self-funded medical plans should plan to prepare, review, and have Form 1095s ready for distribution to individuals by the March 2, 2026 deadline.
- Electronically submit Form 1094 to the IRS by March 31, 2026 (all filers submitting more than 10 forms are required to file electronically).
- For ALEs and sponsors of self-funded medical plans who wish to furnish 1095 forms upon request, post a "clear, conspicuous and accessible" notice informing individuals that the form is available upon request. Verify that ACA service providers can accommodate the new rules for optional distribution.
- Remember that the IRS no longer provides "good faith effort" penalty relief. It is vital that these forms are accurate and distributed/filed on a timely basis.

b. **GAG CLAUSE ATTESTATION**

The Consolidated Appropriations Act, 2021 (CAA) prohibits group health plans and health insurance carriers from entering into agreements that directly or indirectly restrict the release of certain information related to provider networks and de-identified encounter data, i.e., "gag clauses." Plans and carriers must submit annual attestations that their agreements do not contain impermissible gag clauses. These attestations must be submitted by December 31, 2025.

Employers should verify whether their insurance carrier, TPA or administrator will be submitting the attestation on their behalf. While most insurance carriers will submit the attestation for fully insured plans, not all will do so. With level-funded or self-funded plans, some TPAs and administrators will submit the attestation, but not all. Ultimately, the employer that sponsors the health plan is responsible for ensuring that the attestation is completed. See Alera Group's whitepaper on gag clause attestation for more information.

c. YEAR-END NONDISCRIMINATION TESTING

All employers offering benefits on a pretax basis must do so through a § 125 plan. Section 125 of the Internal Revenue Code requires nondiscrimination testing to be performed by the last day of the plan year. If the plan fails, then highly compensated employees and employers will need to pay additional payroll and income-based taxes.

Self-funded plans, including level-funded plans and Health Reimbursement Arrangements (HRAs), are required to perform IRS Code § 105(h) nondiscrimination tests. Plans must pass both an eligibility test and a benefits test by the end of the year to ensure that the program does not favor highly compensated individuals.

d. IMPUTED INCOME ON LIFE INSURANCE, DOMESTIC PARTNERS, AND FSAS

The IRS considers the value of Group Term Life Insurance in excess of $50,000 to be income to an employee. Income must be imputed and included in each employee's W-2, calculated for amounts in excess of $50,000 (common with 1x or 2x salary plan designs).

If Dependent Life Insurance exceeds $2,000, income is imputed on the entire amount of the Dependent Life coverage.

If a domestic partner is not an employee's tax dependent under Internal Revenue Code § 105(b), the value of the domestic partner's health coverage must be treated as income, reported on the employee's W-2, and subjected to withholding taxes, including Federal Insurance Contributions Act (FICA) and Federal Unemployment Tax Act (FUTA).

For employers who sponsor FSA's, ensure that all employee FSA expenditures are substantiated. Any unsubstantiated FSA claims must be applied as taxable income to employees' paychecks.

e. UPDATE AND DISTRIBUTE PLAN DOCUMENTS

Plan documents, summary plan descriptions (SPDs) and wrap documents may need to be updated due to changes in the health and welfare program. Remember to get these important documents updated or create summaries of material modification (SMMs) and distribute them to all plan participants. Do not forget to send them to retirees, COBRA enrollees and COBRA-qualified beneficiaries that are still in their extended enrollment period.

Cafeteria plan documents may also need to be updated for changes in plan design (e.g., increasing dependent care FSA maximums). These documents should be reviewed annually to ensure that any changes are captured in an amended cafeteria plan document.

f. A CHANGE IN EMPLOYER SIZE MAY CREATE NEW COMPLIANCE RESPONSIBILITIES.

As employers expand or contract, different health and welfare plans apply. Many of those rules are based on the number of employees a company had in the prior calendar year, so now is the time to do a review. Remember as well that controlled groups must consider the number of employees of their companies within the controlled group. These laws apply to groups that have the following employee counts:

- 10 or more employees
  - Forms submitted to the IRS must be done so electronically, including Forms 1099, Forms W-2, Affordable Care Act Forms 1094 and 1095, and others.[1]
- 15 or more employees
  - The Americans with Disabilities Act (ADA), Age Discrimination in Employment Act (ADEA), Pregnancy Discrimination Act, Genetic Information Nondiscrimination Act GINA) and Title VII of the Civil Rights Act.
- 20 or more employees:
  - COBRA and the Medicare Secondary Payer (MSP) rules.

[1] Employers, regardless of their size, must submit Forms 1094-B or C and 1095-B or C if their health plan is self-funded (including level funded).

— 50 or more employees

- Family and Medical Leave Act (FMLA), MHPAEA and the ACA Employer Shared Responsibility rules (including non-filing and late filing penalties, and Employer Shared Responsibility penalties).

— 100 or more employees

- Department of Labor requirements to submit Form 5500 apply to health and welfare plans that have 100 or more employees enrolled on the first day of the plan year.

— 250 or more Forms W-2

- Employers that issue 250 or more Forms W-2 must include the total value of the health plan on each Form W-2 in Box 10 with code DD.

As mentioned before, this is not an This **THIS IS NOT AN ALL-INCLUSIVE COMPLIANCE CHECKLIST.**

It is intended as a reminder of key things for employers to review. If you have questions about any of these topics or would like to have a more complete compliance audit, please discuss this with your Alera Group Employee Benefits team.

Employers that get these things done early can start the new year with less stress and a shorter to-do list for 2026.

Note

This checklist highlights and provides reminders of some traditional year-end employee benefit compliance considerations and requirements. This not intended to serve as an exhaustive "to do" list of all employee benefit compliance tasks. Refer to the document for detailed explanation on the listed items.

End-of-year compliance checklist

- [ ] 1. HSAs and HDHPs: Retroactive Exception for Telehealth and Remote Care
- [ ] 2. HSAs and HDHPs: Direct Primary Care Exception
- [ ] 3. 2026 ACA Plan Year Affordability Calculations
- [ ] 4. 2026 Plan year benefit limits
- [ ] 5. Medicare Part D: New Creditable Coverage Safe Harbor
- [ ] 6. ACA Reporting: Furnishing Forms to Individuals
- [ ] 7. Mental Health Parity Addiction Equity Act Update to the Final Rules
- [ ] 8. GLP-1 Coverage for Weight Loss
- [ ] 9. Reoccurring Year-End Employee Benefit Compliance Considerations
    - [ ] a. ACA Reporting
    - [ ] b. Gag Clause Attestation
    - [ ] c. Year-End Nondiscrimination Testing
    - [ ] d. Imputed Income for Life Insurance, Domestic Partners, and FSAs
    - [ ] e. Update and Distribute Plan Documents
    - [ ] f. A Change in Employer Size May Create New Compliance Responsibilities.

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About Alera Group

Alera Group is an independent financial services firm with more than $1.5 billion in gross revenue, offering comprehensive property and casualty insurance, employee benefits, wealth services and retirement plan solutions to clients nationwide. Working collaboratively across specialties and across the country, Alera Group's team of more than 4,600 colleagues offer unique solutions, personalized services and proactive insights to help ensure each client's business and personal success. For more information, visit **aleragroup.com** and follow us on **LinkedIn**.

*STATISTICS ACCURATE AS OF SEPTEMBER 30, 2025.

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