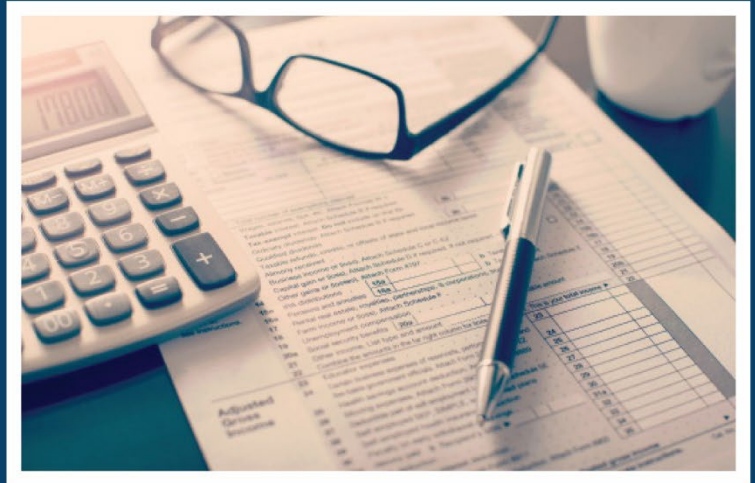


# 2025 OPEN ENROLLMENT CHECKLIST



## 2025 Open Enrollment Checklist

To get ready for open enrollment, employers who sponsor group health plans should be aware of compliance changes affecting the design and administration of their health plans for plan years beginning on or after Jan. 1, 2025. These changes include limits that are adjusted for inflation each year, such as the Affordable Care Act's (ACA) affordability percentage and cost-sharing limits for high deductible health plans (HDHPs). Employers should review their health plan's design to confirm that it has been updated, as necessary, for these changes.

In addition, any changes to a health plan's benefits for the 2025 plan year should be communicated to plan participants through an updated summary plan description (SPD) or a summary of material modifications (SMM).

Health plan sponsors should also confirm that their open enrollment materials contain certain required participant notices, such as the summary of benefits and coverage (SBC), when applicable. Some participant notices must also be provided annually or upon initial enrollment. To minimize costs and streamline administration, employers should consider including these notices in their open enrollment materials.

### PLAN DESIGN CHANGES

#### **ACA Affordability Standard**

The ACA requires ALEs to offer affordable, minimum-value health coverage to their full-time employees (and dependents) or risk paying a penalty to the IRS. This employer mandate is also known as the "pay-or-play" rules. An ALE is an employer with at least 50 full-time employees, including full-time equivalent employees, during the preceding calendar year. An ALE's health coverage is considered affordable if the employee's required contribution for the lowest cost self-only coverage that provides minimum value does not exceed a certain percentage of the employee's household income for the taxable year. **For plan years beginning in 2025, the adjusted affordability percentage is 9.02%.**

- If you are an ALE, confirm that at least one of the health plans offered to full-time employees satisfies the ACA's affordability standard. Because an employer generally will not know an employee's household income, the IRS has provided three optional safe harbors that ALEs may use to determine affordability based on information that is available to them: the Form W-2 safe harbor, the rate-of-pay safe harbor and the federal poverty line safe harbor.

## Out-of-Pocket Maximum Limits

Non-grandfathered health plans and health insurance issuers are subject to limits on cost sharing for essential health benefits (EHB). The annual limits on total enrollee cost sharing for EHB for plan years beginning on or after Jan. 1, 2025, are **\$9,200** for self- only coverage and **\$18,400** for family coverage. With this in mind, employers should take the following steps:

- Review the out-of-pocket maximum limits for the health plan to ensure they comply with the ACA's limits for the 2025 plan year; and
- Keep in mind that the out-of-pocket maximum limits for HDHPs compatible with HSAs must be lower than the ACA's limits. For the 2025 plan year, the out-of-pocket maximum limits for HDHPs are **\$8,300** for self-only coverage and **\$16,600** for family coverage.
- Group health plans with a family out-of-pocket maximum that is higher than the ACA's self-only out-of-pocket maximum limit must embed an individual out-of-pocket maximum in family coverage so that no individual's out-of-pocket expenses exceed \$9,200 for the 2025 plan year.

## Preventive Care Benefits

The ACA requires non-grandfathered health plans and issuers to cover a set of recommended preventive services without imposing cost-sharing requirements, such as deductibles, copayments or coinsurance, when the services are provided by in- network providers. The recommended preventive care services covered by these requirements are:

- Evidence-based items or services with an A or B rating in recommendations of the U.S. Preventive Services Task Force; Immunizations recommended by the Advisory Committee on Immunization Practices for routine use in children, adolescents and adults;
- Evidence-informed preventive care and screenings in guidelines supported by the Health Resources and Services Administration (HRSA) for infants, children and adolescents; and
- Other evidence-informed preventive care and screenings in HRSA-supported guidelines for women.

Health plans and issuers are required to adjust their first-dollar coverage of preventive care services based on the latest preventive care recommendations. In general, coverage must be provided for a newly recommended preventive health service or item for plan years beginning on or after the one-year anniversary of when the recommendation was issued. For example, health plans and issuers must cover [screenings for anxiety disorders in adults](#), including pregnant and postpartum patients, effective for plan years beginning on or after June 30, 2024 (e.g., the plan year beginning Jan. 1, 2025, for calendar-year plans). More information on the recommended preventive care services is available at [www.HealthCare.gov](http://www.HealthCare.gov).

Before the beginning of the 2025 plan year, employers should take the following step:

- Confirm the health plan covers the latest recommended preventive care services without imposing any cost sharing when the care is provided by in-network providers.

## Health FSA Contributions

The ACA imposes a dollar limit on employees' pre-tax contributions to a health FSA. This limit is indexed each year for cost-of- living adjustments. An employer may set their own dollar limit on employees' contributions to a health FSA as long as the employer's limit does not exceed the ACA's maximum limit in effect for the plan year. For plan years beginning in 2024, the health FSA limit is \$3,200. The IRS has not yet released the health FSA limit for plan years beginning in 2025. Moving forward, employers with health FSAs should take these steps:

- Monitor future developments for the release of the health FSA limit for 2025;
- Once the IRS releases the health FSA limit, confirm that employees will not be allowed to make pre-tax contributions in excess of the limit for the 2025 plan year; and
- Communicate the health FSA limit to employees as part of the open enrollment process.

## HDHP and HSA Limits

The IRS limits for HSA contributions, HDHP minimum deductibles and HDHP maximum out-of-pocket expenses all increase for 2025. The HSA contribution limits will increase effective Jan. 1, 2025, while the HDHP cost-sharing limits will increase effective for plan years beginning on or after Jan. 1, 2025. Looking ahead, employers should take these steps:

- Check whether HDHP cost-sharing limits need to be adjusted for the 2025 limits; and
- Communicate HSA contribution limits for 2025 to employees as part of the enrollment process.

The following table contains the HDHP and HSA limits for 2025 compared to 2024. It also includes the catch-up contribution limit that applies to HSA-eligible individuals age 55 and older, which is not adjusted for inflation and stays the same from year to year.

Type of Limit		2024	2025	Change
<b>HSA Contribution Limits</b>	Self-only	\$4,150	\$4,300	Up \$150
	Family	\$8,300	\$8,550	Up \$250
<b>HSA Catch-up Contributions</b>	Age 55 and older	\$1,000	\$1,000	No change
<b>HDHP Minimum Deductibles</b>	Self-only	\$1,600	\$1,650	Up \$50
	Family	\$3,200	\$3,300	Up \$100
<b>HDHP Maximum Out-of-Pocket Expense Limits (deductibles, copayments and other amounts, but not premiums)</b>	Self-only	\$8,050	\$8,300	Up \$250
	Family	\$16,100	\$16,600	Up \$500

## HDHPs: Expiration of Design Options

To be eligible for HSA contributions for a month, an individual must be covered under an HDHP as of the first day of the month and have no other impermissible coverage. In general, except for preventive care benefits, no benefits can be paid by an HDHP until the minimum annual deductible has been satisfied. However, there are a few narrow exceptions to the minimum deductible requirement, including the following exceptions that are expiring:

- For plan years ending on or before Dec. 31, 2024, an HDHP is no longer permitted to provide benefits for COVID-19 testing and treatment without a deductible (or with a deductible below the minimum deductible for an HDHP); and
- For plan years beginning on or after Jan. 1, 2025, an HDHP is no longer permitted to provide benefits for telehealth or other remote care services before plan deductibles have been met.

Due to these changes, employers with HDHPs should take these steps for plan years beginning in 2025:

- Confirm that HDHPs will not pay benefits for COVID-19 testing and treatment before the annual minimum deductible has been met;
- Confirm that HDHPs will not pay benefits for telehealth or other remote care services (except for preventive care benefits) before the annual minimum deductible has been met; and
- Notify plan participants of any changes for the 2025 plan year regarding COVID-19 testing and treatment and telehealth services through an updated SPD or SMM.

## **Mental Health Parity – Required Comparative Analysis for NQTLs**

The Mental Health Parity and Addiction Equity Act (MHPAEA) requires parity between a group health plan's medical/surgical benefits and its mental health or substance use disorder (MH/SUD) benefits. These parity requirements apply to financial requirements and treatment limits for MH/SUD benefits. In addition, any nonquantitative treatment limitations (NQTLs) placed on MH/SUD benefits must comply with MHPAEA's parity requirements. For example, NQTLs include prior authorization, step therapy protocols, network adequacy and medical necessity criteria.

MHPAEA requires health plans and issuers to conduct comparative analyses of the NQTLs used for medical/surgical benefits compared to MH/SUD benefits. This analysis must contain a detailed, written and reasoned explanation of the specific plan terms and practices at issue and include the basis for the plan's or issuer's conclusion that the NQTLs comply with MHPAEA. Plans and issuers must make their comparative analyses available to specific federal agencies or applicable state authorities upon request. In recent years, the U.S. Department of Labor (DOL) has made MHPAEA compliance a top enforcement priority, with a primary focus being MHPAEA's parity requirements for NQTLs. Considering this information, employers should take the following step:

- Reach out to health plan issuers (or third-party administrators) to confirm that comparative analyses of NQTLs will be updated, if necessary, for the plan year beginning in 2025.

## **Prescription Drug Benefits – Creditable Coverage Determination**

The Inflation Reduction Act of 2022 (IRA) includes several [cost-reduction provisions](#) affecting Medicare Part D plans, which may impact the creditable coverage status of employer-sponsored prescription drug coverage beginning in 2025. For example, effective for 2025, Medicare enrollees' out-of-pocket costs for prescription drugs will be capped at \$2,000.

Employers that provide prescription drug coverage to individuals who are eligible for Medicare Part D must inform these individuals and the Centers for Medicare and Medicaid Services (CMS) whether their prescription drug coverage is creditable, meaning that the employer's prescription drug coverage is at least as good as Medicare Part D coverage. These disclosures must be provided on an annual basis and at certain other designated times, including when there is a change to a prescription drug benefit's creditable coverage status.

Previously, CMS stated that one of the methods for determining whether coverage is creditable (the "simplified determination" method) would no longer be valid as of calendar year 2025, given the significant changes made to Medicare Part D by the IRA. However, CMS subsequently decided that it will continue to permit the use of the simplified determination methodology, without modification, for calendar year 2025 for group health plan sponsors who are not applying for the retiree drug subsidy.

Due to these developments, employers should take the following steps:

- Confirm whether their health plans' prescription drug coverage for 2025 is creditable or noncreditable as soon as possible to prepare to send the appropriate Medicare Part D disclosure notices; and
- Continue to utilize the simplified determination method for determining whether prescription drug coverage is creditable for 2025, if applicable.

## **ACA EMPLOYER MANDATE REQUIREMENTS**

### **Applicable Large Employer Status (ALE)**

Under the ACA's employer penalty rules, applicable large employers (ALEs) that do not offer health coverage to their full-time employees (and dependent children) that is affordable and provides minimum value will be subject to penalties if any full-time employee receives a government subsidy for health coverage through an Exchange.

To qualify as an ALE, an employer must employ, on average, **at least 50 full-time employees, including full-time equivalent employees (FTEs)**, on business days during the preceding calendar year. All employers that employ at least 50 full-time employees, including FTEs, are subject to the ACA's pay or play rules.

- Determine your ALE status for 2025.
- Calculate the number of full-time employees for all 12 calendar months of 2024. A full-time employee is an employee who is employed on average for at least 30 hours of service per week.
- Calculate the number of FTEs for all 12 calendar months of 2024 by calculating the aggregate number of hours of service (but not more than 120 hours of service for any employee) for all employees who were not full-time employees for that month and dividing the total hours of service by 120.
- Add the number of full-time employees and FTEs (including fractions) calculated above for all 12 calendar months of 2024.
- Add up the monthly numbers from the preceding step and divide the sum by 12. Disregard fractions.
- If your result is 50 or more, you are likely an ALE for 2025.

## Identify Full-time Employees

All full-time employees must be offered affordable minimum value coverage. A full-time employee is an employee who was employed on average at least 30 hours of service per week. The final regulations generally treat 130 hours of service in a calendar month as the monthly equivalent of 30 hours of service per week. The IRS has provided two methods for determining full-time employee status—the **monthly measurement method** and the **look-back measurement method**.

- Determine which method you are going to use to determine full-time status
- Monthly measurement method involves a month-to-month analysis where full-time employees are identified based on their hours of service for each month. This method is not based on averaging hours of service over a prior measurement method. Month-to-month measuring may cause practical difficulties for employers, particularly if there are employees with varying hours or employment schedules, and could result in employees moving in and out of employer coverage on a monthly basis.
- Look-back measurement method allows an employer to determine full-time status based on average hours worked by an employee in a prior period. This method involves a measurement period for counting/averaging hours of service, an administrative period that allows time for enrollment and disenrollment, and a stability period when coverage may need to be provided, depending on an employee's average hours of service during the measurement period.

## Offer of Coverage

An ALE may be liable for a penalty under the pay or play rules if it does not offer coverage to "substantially all" (**95%**) full-time employees (and dependents) and any one of its full-time employees receives a premium tax credit or cost-sharing reduction for coverage purchased through an Exchange. Employees who are offered health coverage that is **affordable** and provides **minimum value** are generally not eligible for these Exchange subsidies.

- Offer minimum essential coverage to all full-time employees
- Ensure that at least one of those plans provides minimum value (**60%** actuarial value)
- Ensure that the minimum value plan offered is affordable to all full-time employees by ensuring that the employee contribution for the lowest cost single minimum value plan does not exceed **9.02%** of an employee's earnings based on the employee's W-2 wages, the employee's rate of pay, or the federal poverty level for a single individual.

## Reporting of Coverage

The ACA requires ALEs to report information to the IRS and to employees regarding the employer-sponsored health coverage on Form 1095-C. The IRS will use the information that ALEs report to verify employer-sponsored coverage and to administer the employer shared responsibility provisions (**Code Section 6056**).

In addition, the ACA requires every health insurance issuer, **sponsor of a self-insured health plan**, government agency that administers government-sponsored health insurance programs and any other entity that provides minimum essential coverage (MEC) to file an annual return with the IRS and individuals reporting information for each individual who is provided with this coverage (**Code Section 6055**).

**Beginning in 2024, employers that file at least 10 returns during the calendar year must file their ACA returns electronically.** Reporting entities must aggregate most information returns, such as Forms W-2 and 1099, to determine if they meet the 10-return threshold for mandatory electronic filing. The previous threshold was 250 returns. **Due to the lowered threshold, only the smallest employers will be permitted to file using paper returns. As a result, employers that are subject to the ACA reporting rules should begin to explore options for filing ACA reporting returns electronically beginning in 2025.**

- Determine which reporting requirements apply to you and your health plans (depending if fully insured or self-funded)
- Determine the information you will need for reporting and coordinate internal and external resources to help compile the required data for the 1094-C and 1095-C
- Complete the appropriate forms for the 2024 reporting year. Furnish statements to individuals on or before March 3, 2025, and file returns with the IRS on or before February 28, 2025 (March 31, 2025, if filing electronically).

## Comparative Effectiveness Research Fee (PCORI)

Sponsors of self-funded plans and health insurance issuers of fully insured plans are required to pay a fee each year, by July 31st, to fund comparative effectiveness research. Fees will increase to \$3.22 per covered life in 2025 and are next due July 31, 2025.

## W-2 Reporting

Healthcare Reform requires employers to report the aggregate cost of employer-sponsored group health plan coverage on their employees' Forms W-2. This reporting requirement was originally effective for the 2011 tax year. However, the IRS later made reporting optional for 2011 for all employers.

The IRS further delayed the reporting requirement for small employers (those that file fewer than 250 Forms W-2) by making it optional for these employers until further guidance is issued. For the larger employers, the reporting requirement was mandatory for the 2012 Forms W-2 and continues.

## OPEN ENROLLMENT NOTICES

Employers who sponsor group health plans should provide certain benefits notices in connection with their plans' open enrollment periods. Some of these notices must be provided at open enrollment time, such as the SBC. Other notices, such as the WHCRA notice, must be distributed annually. Although these annual notices may be provided at different times throughout the year, employers often choose to include them in their open enrollment materials for administrative convenience.

In addition, employers should review their open enrollment materials to confirm that they accurately reflect the terms and cost of coverage. In general, any plan design changes for 2025 should be communicated to plan participants either through an updated SPD or an SMM.

## Summary of Benefits and Coverage

The ACA requires health plans and health insurance issuers to provide an SBC to applicants and enrollees each year at open enrollment or renewal time. Federal agencies have provided a [template](#) for the SBC, which health plans and issuers are required to use. To comply with the SBC requirements, employers should include an updated SBC with open enrollment materials. Take note that the plan administrator is responsible for providing the SBC for self-funded plans. For insured plans, the issuer usually prepares the SBC. If the issuer prepares the SBC, an employer is not required to also prepare an SBC for the health plan, although they may need to distribute the SBC prepared by the issuer.

## Medicare Part D Notices

Group health plan sponsors must provide a notice of creditable or non-creditable prescription drug coverage to Medicare Part D-eligible individuals covered by, or who apply for, prescription drug coverage under the health plan. This creditable coverage notice alerts individuals about whether their prescription drug coverage is at least as good as the Medicare Part D coverage. The notice generally must be provided at various times, including **when an individual enrolls in the plan and each year before Oct. 15** (when the Medicare annual open enrollment period begins). Model notices are available on the Centers for Medicare and Medicaid Services' [website](#).

## Annual CHIP Notices

Group health plans covering residents in a state that provides a premium subsidy to low-income children and their families to help pay for employer-sponsored coverage must send an annual CHIP notice about the available assistance to all employees residing in that state. The DOL has provided a model notice. Employers should confirm they are using the most recent [model notice](#), as the DOL updates it regularly.

## Initial COBRA Notices

COBRA applies to employers with 20 or more employees who sponsor group health plans. Group health plan administrators must provide an initial COBRA notice to new participants and certain dependents within 90 days after plan coverage begins. The initial COBRA notice may be incorporated into the plan's SPD. A [model initial COBRA notice](#) is available from the DOL.

## SPDs

Plan administrators must provide an SPD to new participants within 90 days after plan coverage begins. Any changes made to the plan should be reflected in an updated SPD booklet or described to participants through an SMM. Also, an updated SPD must be furnished every five years if changes are made to SPD information or the plan is amended. Otherwise, a new SPD must be provided every 10 years.

## Notices of Patient Protections

Under the ACA, group health plans and issuers that require the designation of a participating primary care provider must permit each participant, beneficiary and enrollee to designate any available participating primary care provider (including a pediatrician for children). Additionally, plans and issuers that provide obstetrical/gynecological care and require a designation of a participating primary care provider may not require preauthorization or referral for such care. If a health plan requires participants to designate a participating primary care provider, the plan or issuer must provide a notice of these patient protections whenever the SPD or similar description of benefits is provided to a participant. If an employer's plan is subject to this notice requirement, they should confirm that it is included in the plan's open enrollment materials. This notice may be included in the plan's SPD. [Model language](#) is available from the DOL.

## Grandfathered Plan Notices

If an employer has a grandfathered plan, they should make sure to include information about the plan's grandfathered status in plan materials describing the coverage under the plan, such as SPDs and open enrollment materials. [Model language](#) is available from the DOL.

## Notices of HIPAA Special Enrollment Rights

At or before the time of enrollment, an employer's group health plan must provide each eligible employee with a notice of their special enrollment rights under HIPAA. This notice may be included in the plan's SPD.

## HIPAA Privacy Notices

The HIPAA Privacy Rule requires self-insured health plans to maintain and provide their own privacy notices. Special rules apply for fully insured plans. Under these rules, the health insurance issuer, and not the health plan itself, is primarily responsible for the privacy notice. Self-insured health plans are required to send privacy notices at certain times, including to new enrollees at the time of enrollment. Thus, the privacy notice should be provided with the plan's open enrollment materials. Also, at least once every three years, health plans must either redistribute the privacy notice or notify participants that the privacy notice is available and explain how to obtain a copy.

The Department of Health and Human Services has [model privacy notices](#) for health plans to choose from.

## WHCRA Notices

Plans and issuers must provide a notice of participants' rights to mastectomy-related benefits under the WHCRA at the time of enrollment and on an annual basis. The DOL's [compliance assistance guide](#) includes model language for this disclosure.

## NMHPA Notice

Plan administrators must include a statement within the Summary Plan Description (SPD) timeframe describing requirements relating to any hospital length of stay in connection with childbirth for a mother or newborn child under the Newborn's Mother's Health Protections Act. Model language for this disclosure is available on the DOL's [website](#).

## SARs

Plan administrators required to file Form 5500 must provide participants with a narrative summary of the information in Form 5500, called a summary annual report (SAR). Group health plans that are unfunded (that is, benefits are payable from the employer's general assets and not through an insurance policy or trust) are not subject to the SAR requirement. The plan administrator generally must provide the SAR within nine months of the close of the plan year. If an extension of time to file Form 5500 is obtained, the plan administrator must furnish the SAR within two months after the close of the extension period. A [model](#) notice is available from the DOL.

## Wellness Program Notices

Group health plans that include wellness programs may be required to provide certain notices regarding the program's design. As a general rule, these notices should be provided when the wellness program is communicated to employees and before employees provide any health-related information or undergo medical examinations. These notices are required in the following situations:



- ◆ **HIPAA Wellness Program Notice**—HIPAA imposes a notice requirement on *health-contingent wellness programs* offered under group health plans. Health-contingent wellness plans require individuals to satisfy standards related to health factors (e.g., not smoking) to obtain rewards. The notice must disclose the availability of a reasonable alternative standard to qualify for the reward (and, if applicable, the possibility of waiver of the otherwise applicable standard) in all plan materials describing the terms of a health-contingent wellness program. The DOL’s [compliance assistance guide](#) includes a model notice that can be used to satisfy this requirement.
- ◆ **Americans with Disabilities Act (ADA) Wellness Program Notice**—Employers with 15 or more employees are subject to the ADA. Wellness programs that *include health-related questions or medical exams* must comply with the ADA’s requirements, including an employee notice requirement. Employers must give participating employees a notice that tells them what information will be collected as part of the wellness program, with whom it will be shared and for what purpose, as well as includes the limits on disclosure and the way information will be kept confidential. The U.S. Equal Employment Opportunity Commission has provided a [sample notice](#) to help employers comply with this ADA requirement.

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