McGOHAN BRABENDER'S

COMPLIANCE IN MOTION

December 2025

IRS Finalizes Instructions for ACA Reporting (1094/1095-B and 1094/1095-C)

On October 30, 2025, the IRS published final instructions for completing the Affordable Care Act reporting forms (1094-B/1095-B instructions, and 1094-C/1095-C instructions). The only change communicated in the "What's New" section is that proactively providing the 1095-B and 1095-C forms to individuals is not required as long as the employer includes a proper disclaimer on their public website and provides the 1095-B or 1095-C upon request (note, employers must proactively send NJ residents the 1095).

WHO THIS APPLIES TO:

- All employers who were an applicable large employer (ALE) in 2025 based on their calendar year 2024 employment counts averaging 50 or more full-time and equivalent employees (50+ FTEs), regardless of whether a health plan is offered (1094/1095-C).
    - Includes ALEs with fully-insured and self-insured health plans, including individual coverage health reimbursement arrangements (ICHRAs).
    - Also includes employers who did not average 50+ FTEs in 2024 but were part of a controlled group or affiliated service group of companies that did average a combined total of 50+ FTEs, making the related entities ALE members of an aggregated ALE group for 2025.
- Small employers with level-funded or self-insured health plans, including ICHRAs, in 2025 (1094/1095-B).

GO DEEPER:

Review our November Alert, *IRS Finalizes Instructions for ACA Reporting* for more details.

IRS Indexes Highly Compensated and Key Employee Thresholds

The IRS issued Notice 2025-67 announcing updated limits reflecting retirement plan indexing. These updates include thresholds used to identify highly compensated employees under Internal Revenue Code Section 414(q) and key employees under §416(i), which are used for annual non-discrimination testing for both retirement and several non-retirement benefit plans.

WHO THIS APPLIES TO:

- All size employers allowing employees to make pre-tax paycheck deductions under a §125 plan *(except for a Simple Cafeteria Plan exempt from non-discrimination testing)*
- All size employers sponsoring a dependent care assistance program (DCAP) subject to §129
- All size employers sponsoring group term life insurance subject to §79
- All size employers sponsoring other arrangements that test discrimination against a §414(q) definition, including but not limited to §127(a) education assistance

GO DEEPER:

Review our November Alert, *IRS Indexes Highly Compensated and Key Employee Thresholds* for more details.

FEDERAL UPDATES

2025 - 2026 PCORI Fees Announced

On November 3, the IRS issued Notice 2025-61 announcing the Patient-Centered Outcomes Research Institute (PCORI) fee amount for plan years ending on or after October 1, 2025, and before September 30, 2026. The newly updated PCORI fee amount is $3.84 per covered life (up from $3.47 per covered life).

To summarize by due date:

2025 PCORI Fees (due Jul. 31, 2026):

- Plan Years ending in January through September of 2025: $3.47 per covered life
- Plan Years ending in October through December of 2025: $3.84 per covered life

2026 PCORI Fees (due Jul. 31, 2027):

- Plan Years ending in January through September of 2025: $3.84 per covered life
- Plan Years ending in October through December of 2025: TBA

The 2026 - 2027 PCORI fee amounts are not expected to be announced until late 2026.

WHO THIS APPLIES TO:

- Self-insured or level-funded medical plan years ending in 2025, including health reimbursement arrangements (HRAs)
- Individual Coverage HRA (ICHRA) plan years ending in 2025
- Other less common types of coverage described here, including non-compliant FSAs that fail to meet the requirements of an excepted benefit (e.g., by offering the Health FSA to individuals who are not also eligible for an ACA-compliant major medical plan, or because the employer exceeded the maximum employer contribution allowed for the plan year in question)

GO DEEPER:

Review our November Alert, *PCORI Fee Amount Adjusted for 2025-2026* for more details.

Update Instructions for Gag Clause Prohibition Compliance Attestation (due to CMS by December 31, 2025)

Section 201 of the Consolidated Appropriations Act,2021 (CAA-21) requires group medical plans and medical insurance issuers to attest each year by December 31st that they do not have any agreements with prohibited gag clauses. Employers and other plan sponsors whose attestations are not performed by a third party need to submit their annual Gag Clause Prohibition Compliance Attestation (GCPCA) directly to CMS online here no later than December 31, 2025.

WHO THIS APPLIES TO:

- All size employers with fully-insured, level-funded, or self-insured medical plans.

WHO IS EXEMPT:

- Plans consisting of only excepted benefits (e.g., standalone dental or vision plans).
- Health Reimbursement Arrangements (HRAs) and Individual Coverage HRAs (ICHRAs) are not required to attest as these plans do not typically need to enter into agreement with medical providers. Instead, these arrangements are usually integrated with other medical coverage that is required to submit an attestation (e.g., HRAs integrated with group health plan and ICHRAs with individual medical coverage).

GO DEEPER:

Employers should confirm whether their health plan provider and service agreements contain any prohibited gag clauses, document any requests to remove prohibited gag clauses that exist, and verify whether the online attestation will be completed by a third party or by the employer.

A more detailed summary of prohibited gag clauses, a summary of who is required to file (and who is exempt), as well as a sample outreach language can be found in the BCS, October 2025 newsletter.

Only one attestation is required per Responsible Entity, even if the plan offers multiple health coverage options (e.g., an HMO and PPO).

How does the Submitter attest that their plans are compliant?

Click here to review our Tool in the Content Library, *Gag Clause Prohibition Compliance Instructions for Submitting Attestation* for a step-by-step guide on how to submit attestation.

How does the Submitter attest if their plans are not compliant?

In an FAQ published in January 2025, the federal government stated plans with known gag clauses must still complete their annual attestation by December 31, but can explain their concerns under the "Additional Information" box in the "Attestation Period" section during submission (instruction provided on the guide noted prior). Because even plans that are deemed noncompliant must attest, documenting efforts to remove gag clauses is essential in establishing that the Plan has done everything within its power to regain compliance with these rules.

How does the Submitter file a complaint against an insurer or TPA that uses prohibited gag clauses?

Click here to review our Tool in the Content Library, *Gag Clause Prohibition Compliance Instructions to File Complaint* for a step-by-step guide on how to file a complaint.

Penalties for Non-Compliance:

Plans and issuers who fail to submit their GCPCA by the December 31st deadline may be subject to enforcement action. No specific penalties are provided but they are presumed to be $100 per employee per day.

Next steps for employers:

Many insurers and TPAs proactively notify plan sponsors each year that their contracts do not contain prohibited gag clauses, but often when employers ask for data that should be available to them they are blocked from that data, so there actually are prohibited gag clauses. Each plan fiduciary should decide for themselves whether to accept a carrier/TPA's certification at face value and document discussions to identify and remove them.

To the extent written assurances or certifications have not been received for 2025, employers and advisors are encouraged to reach out to confirm well in advance of the December 31 attestation deadline whether there are prohibited gag clauses and whether the carrier/TPA will submit the attestation.

Attestors are also encouraged to visit the CMS GSPCA landing page for the 2025 instructions, templates and other information.

End-of-the-Year Reminders

As the year closes, employers and other plan sponsors should think about the various compliance considerations that may apply. This includes:

- Distributing MLR Rebates as required within 90 days of receipt
- Confirming all the necessary preventive services for the new year are incorporated
- Confirming deductibles/out-of-pocket maximums are compliant (paying particular attention to embedded deductible amounts)
- Amending the Section 125 plan as needed before the new plan year begins
- Completing annual nondiscrimination testing as applicable
- Resolving unsubstantiated FSA debit card claims
- Reminding FSA and DCAP participants of the use-or-lose rules along with describing any grace period or carryover details

- Reviewing wellness program materials in advance of the new year
- Aligning documents between employee handbook, employment policies, wrap plan/SPD, insurance/plan documents, and stop loss contracts

Likewise, employers subject to ERISA should remember to update any Plan Document/SPD wrap documents, SMMs, and any other materials describing the plan or benefits.

Finally, now is also the perfect opportunity to reflect on open enrollment. Ask what worked well, identify areas for improvement, and capture lessons for next year's open enrollment. This is also the right time to document enrollment activities and communications (retain for at least eight years), forward EOI applications to the life insurer, cross-check each benefit election, and confirm payroll deductions are set up correctly for the new year. Also, do not forget to update life and disability salary amounts, audit list bills or volume bills, and refresh beneficiary records where needed.

Question of the Month:

Can an employee enroll in a Dependent Care Assistance Program (DCAP) before their child is born?

A Dependent Care Assistance Program (DCAP), sometimes called a Dependent Care FSA (or "DCFSA"), is an account-based plan allowing employees to set aside pre-tax income to pay for eligible daycare expenses that enable the employee (and their spouse, if married) to work, actively look for work, or attend school. Although the birth, adoption, or placement for adoption triggers a HIPAA Special Enrollment Right allowing a new parent to elect the DCAP midyear, enrollment does not require an existing qualifying dependent. Therefore, an expectant parent can elect a DCAP during open enrollment to prepare for future childcare needs. That said, reimbursements cannot be accessed until after the child is born, adopted, or placed for adoption and once **work resumes**. In addition, any unused funds are generally forfeited at the end of the plan year (or at the end of its 2.5-month grace period, if designed to include such a feature). These restraints underscore the importance of considering the timing of the expected expenses as part of careful election planning.

CLICK HERE OR SCAN QR CODE TO VIEW PAST COMPLIANCE IN MOTION NEWSLETTERS

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REIMAGINING EMPLOYEE BENEFITS