Compliance Watch

June 2025 Roundup: Rulings, Reversals & Rising Costs

PROVANT

In the News:

JUNE 2025

Supreme Court Upholds ACA Preventive Care Mandates

On June 27, 2025, the US Supreme Court upheld Congress's ability to have many of the Affordable Care Act (ACA) preventive care mandates be determined based on "A" and "B" recommendations of the US Preventive Services Task Force (USPSTF). As a result, there is no change to the method for determining which ACA preventive care services non-grandfathered medical/Rx plans must cover in-network without cost sharing.

Applies To: All employers sponsoring a non-grandfathered medical/Rx plan.

Go Deeper:

In *Kennedy v. Braidwood*, plaintiffs argued that members of the USPSTF are not appropriately appointed with the power to dictate federal health coverage mandates. The Supreme Court concluded that "Congress has by law vested appointment authority in the Secretary of HHS" over members of the USPSTF. Therefore, they are appropriately authorized to make "legally binding healthcare recommendations" to determine the preventive care which all non-grandfathered plans must cover in-network without cost-sharing.

Practical Impact to Employers:

For employers sponsoring non-grandfathered medical/Rx plans, nothing changes. The usual list of ACA-mandated preventive care services which must be covered in-network without cost-sharing remains.

Keep in mind, the ACA's preventive care list is updated occasionally. When the USPSTF adds or amends its A or B recommendations, plans must cover those beginning the start of the plan year that is one year from the date the updated recommendation is published.

WHAT'S NEW

ACA Preventive Care Mandates Upheld
Supreme Court confirms authority of USPSTF; no change to required no-cost coverage.

Reproductive Privacy Rule Overturned
2024 HIPAA reproductive health protections struck down by federal court.

ACA Out-of-Pocket Max & ALE Penalties Increase
Revised final rule bumps 2026 OOP limits and §4980H employer penalties.

PCORI Fees Due July 31
Annual IRS filing and fee deadline for self-funded and HRA/ICHRA plans is approaching.

TAKEAWAY

Legal rulings reshape HIPAA and reinforce ACA mandates, while updated 2026 limits and fast-approaching PCORI and Form 5500 deadlines demand immediate employer attention.

Court Overturns 2024 HIPAA Rule on Reproductive Health Privacy:

In June 2024, a new HIPAA Privacy Rule took effect adding extra privacy protections for reproductive health care information. On June 18, 2025, the U.S. District Court for the Northern District of Texas struck down the rule, saying regulators exceeded their authority.

Applies To:

- All employers sponsoring a self-insured health plan, including level-funded plans, health flexible spending accounts (health FSAs), and health reimbursement arrangements (HRAs, ICHRAs, etc.).
- Fully-insured carriers for plans that are fully-insured.

Go Deeper:

The 2024 rule required employers (and their vendors) to:

- Put extra privacy safeguards in place for medical information related to reproductive care
- Update HIPAA Privacy policies and procedures to reflect the rule's requirements by December 23, 2024
- Train staff on new procedures for handling this information
- Require an official attestation form before sharing reproductive health-related info with law enforcement or government agencies
- Update HIPAA privacy notices to reflect these new reproductive health protections by February 16, 2026

Because the court overturned the rule:

- Employers can now pause or undo the changes made last year for reproductive health privacy.
- The attestation form is no longer required.

While we do not expect HHS to appeal the ruling, it is certainly possible it could be appealed and requirements may change again. So, cautious employers may prefer to wait before making changes.

Practical Implications to Employers

Even though the reproductive privacy rule was struck down, the usual privacy rules still apply for proper uses and disclosures of protected health information (PHI).

Also, one extra requirement from that rule still requires updating privacy notices by February 16, 2026, to include new language about substance use disorder privacy. We expect the government to issue a revised model notice with this language by early 2026.

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Federal Updates:

Final Rules Amend Some 2026 ACA Figures

On June 23, 2025, a final rule amended the methodology for determining the Affordable Care Act's (ACA) premium adjustment percentage, which is used to index the out-of-pocket (OOP) maximums for non-grandfathered medical plans and the §4980H penalties for applicable large employers (ALEs). With the 2026 premium adjustment percentage increasing under the revised methodology, the OOP maximums and ALE penalties previously announced last October are also increasing.

Applies To:

- Non-grandfathered medical plans subject to the ACA's annual OOP maximums
- Applicable large employers (ALEs) subject to potential penalties under §4980H

Go Deeper:

With the premium adjustment percentage being increased for 2026, this is causing both the OOP maximums and ALE penalties to increase. Below is a table of the 2025 amounts along with the 2026 original and revised amounts.

- The revised OOP applies to plan years beginning in 2026.
- The revised ALE penalties apply to calendar year 2026.

	2025 Amounts	2026 Original Amounts *(Announced Oct. 2024)*	2026 Revised Amounts *(Announced Jun. 2025)*
OOP Max per Person	$9,200	$10,150	$10,600
OOP Max per Family	$18,400	$20,300	$21,200
§4980H(a) ALE Penalty	$2,900 *$241.67/mo.*	$3,200 *$266.67/mo.*	$3,340 *$278.33/mo.*
§4980H(b) ALE Penalty	$4,350 *$362.50/mo.*	$4,800 *$400.00/mo.*	$5,310 *$442.50/mo.*

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Hot Topics:

PCORI Fees Due by July 31, 2025

Each year by July 31, employers sponsoring certain self-funded health plans must file and pay an annual fee to the IRS to fund the Patient Centered Outcomes Research Institute (PCORI). Employers must report the fee on the second quarter IRS Form 720.

Employers can gather enrollment counts from their third-party administrator (TPA) for their health plan that ended during calendar year 2024, and complete the filing and payment using the second quarter Form 720 anytime between now and July 31.

Applies To:

- Self-funded plans, including level-funded plans, HRAs that are paired with fully insured plans, and ICHRAs.
- Fully insured plans are the carrier's responsibility.

Exempt: Excepted benefits (e.g., stand-alone vision or dental, HSAs or health FSAs) are exempt.

Go Deeper:

The PCORI fee must be reported each year on the second quarter version of IRS Form 720 and paid electronically or mailed to the IRS using the Form 720-V payment voucher.

Employers that are subject to PCORI fees but no other types of excise taxes should file Form 720 only for the second quarter. In other words, no filings are needed for the other quarters, only the second quarter.
For plan years ending in 2024 before October 1, the PCORI fee due July 31, 2025 is $3.22 per covered life. For plan years ending between October 1, 2024 and December 31, 2024, the PCORI fee due July 31, 2025 is $3.47 per covered life.

How to Calculate the Number of Covered Lives?

The PCORI fee is based on the number of employees, spouses and dependents that are covered by the plan (for an HRA, it is based only on the number of enrolled employees, not spouses and dependents).
There are four permissible counting methods to calculate covered lives. The employer can choose the method that generates the lowest count and does not have to choose the same counting method each year. Below is more information on each of the approved counting methods:

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Actual Count Method: This method calculates the average of covered lives by adding the number of lives covered each day of the plan year divided by the number of days in the plan year.
For example, a plan that starts on January 1 calculates the sum of covered lives (including spouses and dependents) as 3,285,000 divided by 365, which is 9,000. Thus, the PCORI fee for plan year ending in 2024 is 9,000 times $3.47, or $31,230.

Snapshot Method: This method calculates the average by adding the total number of lives covered on a date during the first, second, or third month in each quarter, or an equal number of dates during each quarter, and dividing by the number of dates. The date chosen in each quarter must be within ±3 days of the date used in other quarters.
For instance, on January 4, 2024, the plan covers 2,000 lives; on April 5, 2024, 2,100 lives; on July 5, 2024, 2,050 lives; and on October 4, 2024, 2,050 lives, which totals 8,200. Since the plan ends on December 31, 2024, the employer multiplies $3.47 by 2,050 (8,200/4), which equals $7,113.50.

Snapshot Factor Method: This method uses the number of participants with other than self-only coverage (e.g., family, EE + spouse, EE + child, etc.) on the designated quarterly dates discussed above under the snapshot method, multiplied by 2.35, and adds the number of employees on each date with self-only coverage to come up with the enrollment total for each date.
As another example, on January 10, 2024, the plan has 600 employees with self-only and 800 with coverage other than self-only. On April 11, 2024, 608 with self-only and 800 with other. On July 11, 2024 and October 10, 2024, there were 610 with self-only and 809 with other. Since the plan ends December 31, 2024, the total is 9,990.3 [(600 + (800 × 2.35)) + (608 + (800 × 2.35)) + (610 + (809 × 2.35)) + (610 + (809 × 2.35))] divided by 4, which is 2,497. Thus, the PCORI fee for the 2024 plan year is $3.47 multiplied by 2,497, which equals $8,664.59.

Form 5500 Method: This is based on the average number of covered lives reported on Form 5500 for the plan year. This can only be used if the Form 5500 is filed no later than the due date for the PCORI fee imposed for that plan year. In other words, if the plan files a Form 5500 (or requests an extension to file) after July 31, 2025, this method cannot be used.

Under this method, the total number of lives is calculated by adding the total participant counts at the beginning and end of the year and dividing by 2 for a plan that only offers single coverage. If a plan offers single coverage along with other coverage (e.g., family coverage), the total number of lives is determined by adding the total participant counts at the beginning and end of the year (without dividing by 2).

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For instance, a calendar year plan with single and family coverage tiers files a Form 5500 for the plan year ending December 31, 2024 and files the corresponding 5500 as of July 31, 2025 (no extension), which reports 4,000 plan participants on the first day of the plan year and 4,200 plan participants on the last day of the plan year. This group must treat the number of lives covered for the plan year ending December 31, 2024, as equal to the sum of 4,000 and 4,200, or 8,200. To calculate the PCOR fee, they would multiply $3.47 by 8,200, which equals $28,454.

What if the employer did not pay in prior years?

Employers must file Form 720 for the applicable year(s) missed. Voluntary compliance may help mitigate penalties, but professional tax guidance is advised to avoid compounding errors. Failing to file or pay PCORI fees may result in:

- IRS interest and penalties, as the fee is considered an excise tax.
- Challenges correcting past non-compliance due to complex amendment processes.

Note, if corrections are needed to prior filings, submit corrections on Form 720-X to amend.
Copies of counts, the completed Form 720, and proof of payment should be kept on file for four years.

Where to get assistance with calculating the number of covered lives?

Employers should rely on the TPA to assist with the calculation. Even if the employer uses a TPA or a vendor to assist with the calculation, the PCORI fee for a self-insured plan, ICHRA or HRA is the responsibility of the plan sponsor and must be paid by the employer to the IRS directly. Failure to file likely carries the same penalty for failure to pay other taxes due on Form 720.

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Reminder to File Form 5500 for Calendar Year Plans

Employers must file Form 5500 for health and welfare plans by the end of the seventh month following the last day of the plan year, unless the small plan exception applies.

Applies To:

- Plan sponsors with fully insured ERISA plans that have 100 or more participants on the first day of the plan year
- Plan sponsors with self-funded ERISA plans that have 100 or more participants on the first day of the plan year
- Plan sponsors with funded plans (i.e., using a trust), regardless of size
- All multiple employer welfare arrangements (MEWAs) providing group health plan benefits

Go Deeper:

Calendar year 2024 plans must file by July 31, 2025, or can request a 2 ½ -month extension by filing Form 5558 before the plan's original filing due date. (Note, effective January 1, 2025 Form 5558 can be electronically filed through EFAST2). Governmental, church or Indian tribal plans are not required to file a Form 5500 unless they have opted to be subject to ERISA requirements.

Additionally, the plan administrator must distribute the Summary Annual Report (SAR) within nine months after the close of the plan year when 5500 filing is required. If a 5500 extension was filed, the employer must send the SAR within 2 months after the close of the period for which the extension was granted. For example, a calendar year plan has to distribute the SAR for the 2024 plan year by Sept. 30, 2025. If the plan applied for an extension to the Form 5500 filing, the SAR is then due within two months after the filing. (Note that the SAR is only required if the plan includes fully-insured or funded (i.e. trust) component benefits.)

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Questions of the Month:

Can we have different eligibility and/or waiting periods?

ERISA generally gives employers the discretion to define their plan eligibility as long as they adhere to federal guidelines (e.g., no waiting period longer than 90 days under the ACA rules). This includes the ability to determine the length of waiting periods. However, IRS rules require that any classifications used to impose different waiting periods on different groups must exist for bona fide business purposes. In other words, classification cannot occur solely for the purpose of varying waiting periods (i.e. the employer must class the groups of employees together for other business reasons).

However, there are two areas of the tax code that might restrict the waiting period requirement an employer can implement:

- If any premium contributions are paid by participants with pre-tax salary reductions, Section 125 rules generally require uniform waiting periods within classifications established by the employer, which cannot "be discriminatory in favor of highly compensated employees". If that requirement is difficult for the employer to achieve, another option is to only offer coverage on a post-tax basis during a shorter waiting period (as that eliminates receiving pre-tax benefits that are subject to Section 125 rules).
- Additionally, if a plan is self-insured, providing a shorter waiting period for the top 25% paid employees is strictly prohibited. A self-insured plan with disparate waiting periods of this nature violates Section 105(h) non-discrimination rules and doing so would result in unfavorable tax consequences to all of the highly-compensated individuals covered under the plan.

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