2024 End-of-year compliance checklist

Several new (2024/2025) employee benefit compliance requirements for 2024 and 2025 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 2025

1 **Telehealth, HSAs and HDHPs: Application of the Deductible.**

One of the last safe harbors of federal government COVID-19 modified employee benefit compliance is set to expire on December 31, 2024: the ability of participants with a Health Savings Account (HSA) and High-Deductible Health Plan (HDHP) to utilize free telehealth services without the need to first satisfy their health plan's deductible. Historically, telemedicine (virtual primary care or virtual specialty care) is disqualifying

coverage for HSA purposes unless the telemedicine is only available once the participant meets the applicable deductible, or if the participant pays 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.

As of this date, there has been no Congressional activity to extend the safe harbor. Employers currently offering free telemedicine for HDHP participants before satisfying the plan deductible *should phase this out before January 1, 2025 (for calendar year plans) or before their 2025 plan year renewal (for non-calendar year plans) as a best practice.* HDHP participants should pay fair market value for telemedicine appointments.

2 Calculate Your 2025 ACA Plan Year Affordability

ACA Affordability Percentage for 2025 Increases to 9.02%

The ACA affordability percentage for 2025 has been increased from 8.39% (2024) to 9.02%.

- For calendar year groups, the new 2025 Poverty Line Safe Harbor will be:
  - $113.20 for the 48 contiguous states and the District of Columbia;
  - $141.39 for Alaska;
  - $130.11 for Hawaii.
- These calculations are based on the 2024 federal poverty levels, the 2025 levels will be announced in late January 2025.

Applicable large employers (ALEs) — generally those with 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.

3 2025 PLAN YEAR BENEFIT LIMITS

HSA	2024 AMOUNT	2025 AMOUNT
Max Contribution Level	$4,150/$8,300	$4,300/$8,550
Min Deductible for HDHP (non-embedded)	$1,600/$3,200	$1,650/$3,300
Max OOP Expenses for HDHP	$8,050/$16,100	$8,300/$16,600

FSA	2024 LIMIT	2025 LIMIT
FSA Contribution Limit	$3,200	$3,300
Max Carryover Amount	$640	$660

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Medicare Part D Creditable Coverage Change for 2025.

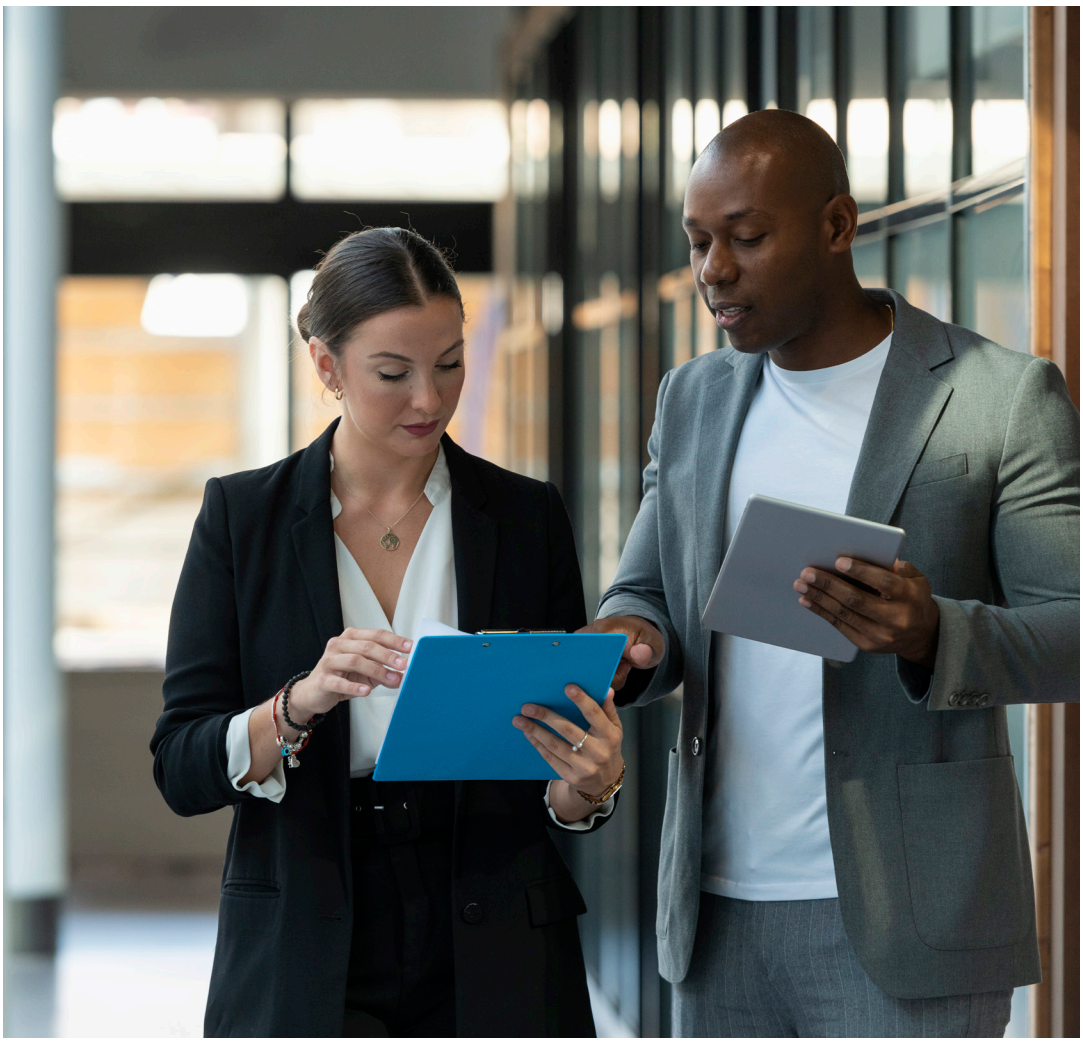
Creditable prescription drug coverage means that an employer-sponsored health plan offers prescription drug coverage to its Medicare-eligible population that is at least as good as the new Medicare Part D drug benefit. Creditable prescription drug coverage allows an employer's Medicare-eligible population to continue to get the high quality care they have now as well as avoid higher payments if they sign up later for the Medicare drug benefit. Prescription drug coverage is creditable if the actuarial value of the coverage equals or exceeds the actuarial value of standard prescription drug coverage under Medicare Part D, as demonstrated through the use of generally accepted actuarial principles and in accordance with CMS actuarial guidelines.

Plan sponsors need to be familiar with new changes that will dramatically impact Medicare Part D benefits effective beginning in 2025. The Centers for Medicare and Medicaid Services (CMS) released Final Redesign Program Instructions for the Medicare Part D program that will be effective starting January 1, 2025.

The 2025 updates include:

- The lower annual out-of-pocket (OOP) threshold, reduced from $8,000 to $2,000;
- The sunsetting of the Coverage Gap Discount Program (CGDP) and establishment of the Manufacturer Discount Program (Discount Program);
- Changes to the liability of enrollees, sponsors, manufacturers and CMS in the new standard Part D benefit design.

This does not mean that a group health plan will not be considered creditable if it has an out-of-pocket (OOP) limit over $2,000. Plans will still need to determine creditability based on an actuarial determination. Employers should confer with their carriers/third-party administrators (TPAs) to know whether their coverage will retain creditability status when they renew in 2025. If the carrier/TPA is unable to make this determination for the plan and the plan does not meet the safe harbor requirements, our Alera Group actuarial team can help make the determination for a fee.



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Cyber Security Guidance: Employee Benefit Plan Fiduciary Requirements

The Department of Labor (DOL) recently released guidance stating that employee benefit plan sponsors have a fiduciary duty to make sure all necessary steps are taken to protect their employee benefit plans and their participants from cyber events. Specifically, plan sponsors, fiduciaries and service providers of employee benefit plans all have a duty to safeguard plan data, personal information and plan assets. Plan fiduciaries should see to it that they and any plan service providers partner with their technology teams:

1. Have a formal, well documented cybersecurity program;
2. Conduct prudent annual risk assessments;
3. Have a reliable annual third-party audit of security controls;
4. Clearly define and assign information security roles and responsibilities;
5. Have strong access control procedures;
6. Ensure that any assets or data stored in a cloud or managed by a third-party service provider are subject to appropriate security reviews and independent security assessments;
7. Conduct periodic cybersecurity awareness training;
8. Implement and manage a secure system development life cycle (SDLC) program;
9. Have an effective business resiliency program addressing business continuity, disaster recovery and incident response;
10. Encrypt sensitive data, stored and in transit;
11. Implement strong technical controls in accordance with best security practices;
12. Appropriately respond to any past cybersecurity incidents.

The failure of an employee benefit plan fiduciary to take the steps could create financial exposure for the plan sponsor and personal exposure for the fiduciary.

As best practice, plans as part of their year-end wrap-up should ensure that they are meeting the DOL cybersecurity guidelines and make changes to their plan providers/administrators/ vendors as necessary.

Resources:

- Cybersecurity compliance assistance release 2024
- Cybersecurity best practices document

6 New HIPAA Reproductive Rights Attestation and Amendment of Notice of Privacy Practices

The Department of Health and Human Services (HHS) recently issued a final rule titled "HIPAA Privacy Rule to Support Reproductive Health Care Privacy" and issued guidance directing entities covered under the Health Insurance Portability and Accountability Act (HIPAA), such as an employer-sponsored health plan or its business associate, that if they receive a request for protected health information (PHI) that is potentially related to reproductive healthcare, it must obtain a signed attestation from the requesting party that clearly states that the requested use or disclosure of PHI is not for any of the following prohibited purposes: (1) To conduct a criminal, civil or administrative investigation into any person for the mere act of seeking, obtaining, providing or facilitating lawful reproductive healthcare; (2) To impose criminal, civil or administrative liability on any person for the mere act of seeking, obtaining, providing or facilitating lawful reproductive healthcare; (3) To identify any person for any purpose described in (1) or (2).

The recently issued HHS guidance also requires plan sponsors and health plans to revise their Notice of Privacy Practices (NPP) provided to plan participants to make sure the NPP supports reproductive health care privacy.

This rule went into effect June 25, 2024, and requires covered entities and their business associates to comply with these requirements by December 23, 2024. Covered entities, including self-funded plans, need to update their HIPAA privacy policies and procedures to reflect these changes no later than December 23, 2024. This includes updating the privacy policies and procedures to ensure that the covered entity obtains a signed, written attestation from the requester related to any request for use or disclosure of PHI potentially related to reproductive healthcare requested for health oversight, judicial or administrative proceedings, law enforcement purposes or disclosures to coroners or medical examiners. The new model attestation form is linked here.

An updated Notice of Privacy Practices will need to be provided to participants by February 16, 2026.

Resources:

- Insights legal alert HIPAA privacy-rules
- HIPAA final rule fact sheet
- Model attestation document

7 Mental Health Parity Addiction Equity Act: The Final Rules

Several federal departments issued final rules regarding the Mental Health Parity Addition Equity Act (MHPAEA) regulations. Some of these final rules will take effect in 2025, others in 2026. The final rules aim to further MHPAEA's fundamental purpose — to ensure that individuals in group health plans or with group or individual health insurance coverage who seek treatment for covered mental health (MH) conditions or substance use disorders (SUDs) do not face greater burdens on access to benefits for those conditions or disorders than they would face when seeking coverage for the treatment of a medical condition or a surgical procedure (M/S). This includes ensuring that quantitative treatment limits (QTL) such as deductibles, copayments and coinsurance are comparable, 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.

a. Comparative Analysis Content Requirements

Plans that cover both M/S benefits and MH/SUD benefits and impose NQTLs on MH/SUD benefits must perform and document a comparative analysis of the design and application of each applicable NQTL. The final rules require the comparative analysis to contain, at a minimum, six content elements:

1. A description of the NQTL, including identification of benefits subject to the NQTL;
2. Identification and definition of the factors and evidentiary standards used to design or apply the NQTL;
3. A description of how factors are used in the design or application of the NQTL;
4. A demonstration of comparability and stringency, as written;
5. A demonstration of comparability and stringency, in operation, including the required data, evaluation of that data, explanation of any material differences in access, and description of reasonable actions taken to address such differences;
6. Findings and conclusions.

b. **Plan Sponsor NQTL Comparative Analysis Production Timelines**

The final rules set forth the steps and aggressive timelines that must be satisfied when there is a request to review a plan's comparative analysis of an NQTL.

1. After an initial request for a comparative analysis, the plan must submit it to the relevant secretary within 10 business days (or an additional period of time specified by the relevant secretary).
2. If the secretary determines the comparative analysis is insufficient, the secretary will specify the necessary additional information, which must be provided by the plan or issuer within 10 business days (or an additional period of time specified by the relevant secretary).
3. If the secretary makes an initial determination of noncompliance, the plan has 45 calendar days to specify the actions it will take to comply and provide additional comparative analyses.
4. If the secretary makes a final determination of noncompliance, the plan must notify all participants, beneficiaries, and enrollees enrolled in the plan or coverage not later than seven business days after the secretary's determination. The final rules set forth specific content for this notice and require that a copy of the notice be provided to the secretary and to relevant service providers and fiduciaries.

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.

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

8 Reoccurring Year-End Employee Benefit Compliance Considerations

a. ACA Reporting

- ALEs should plan to get their Form 1095s created, reviewed and ready to distribute to employees prior to the deadline of March 3, 2025.
- The deadline to submit paper copies of Form 1094 to the IRS is February 28, 2025.
  - Since 2024, all filers submitting more than 10 forms are required to file electronically. This means that virtually all ALEs will be required to file electronic Forms 1094 and 1095.
- The deadline to electronically submit Form 1094 to the IRS is March 31, 2025.
- Remember that the IRS no longer provides "good faith effort" penalty relief. It is vital that these forms be 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, 2024. 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 Section 125 plan. Section 125 requires nondiscrimination testing 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.

d. Self-Funded Plans and Section 105(h) Nondiscrimination Testing

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

e. Imputed Income on Life Insurance and Domestic Partners

The IRS considers the value of Group Term Life Insurance in excess of $50,000 as income to an employee, and imputed income must be calculated and paid for amounts over $50,000 (common with 1x or 2x salary plan designs).

If Dependent Life Insurance exceeds $2,000, taxes are due 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 the Federal Insurance Contributions Act (FICA) and Federal Unemployment Tax Act (FUTA).

f. 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.

g. 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]

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).

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.

50 OR MORE EMPLOYEES

Family and Medical Leave Act (FMLA), MHPAEA and the ACA Employer Responsibility rules (including penalties if Form 1095 is not distributed to employees and Form 1094 is not submitted to the IRS).

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 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 2025.

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. Telehealth, HSAs and HDHPs: Application of the Deductible
2. Calculate Your 2025 ACA Plan Year Affordability
3. 2025 Plan year benefit limits
4. Medicare Part D Creditable Coverage Change for 2025
5. Cyber Security Guidance: New Employee Benefit Plan Fiduciary Requirements
6. New HIPAA Reproductive Rights Attestation and Amendment of Notice of Privacy Practices
7. Mental Health Parity Addiction Equity Act: The Final Rules
8. Reoccurring Year-End Employee Benefit Compliance Considerations

   ACA Reporting

   Gag Clause Attestation

   Year-End Nondiscrimination Testing

   Self-Funded Plans and Section 105(h) Nondiscrimination Testing

   Imputed Income on Life Insurance and Domestic Partners

   Update and Distribute Plan Documents

   A Change In Employer Size May Create New Compliance Responsibilities.