Benefits BULLETIN

2024 Open Enrollment Checklist

• **September 25, 2024** •

For employers operating their group health and welfare plans beginning on or after January 1, 2025, now is the time of the year to prepare for open enrollment. Typically, the focus is on evaluating the services and performance of vendors, renewing rates, and considering design changes. In addition to these items, employers need to address various legal requirements. This Benefits Brief provides a checklist that covers these requirements for the 2025 plan year.

Inflation Adjustments in Annual Limits

Several annual limits apply to health plans and flexible spending accounts (FSAs), which may be adjusted each year to accommodate changes in the cost of living. The new amounts should be considered upon renewal.

	2025	2024
Health Plans *(Excluding HDHPs & Grandfathered Plans)*		
Annual Out-of-Pocket Maximum		
Single Coverage	$9,200	$9,450
Family Coverage	$18,400	$18,900
High Deductible Health Plans (HDHP)		
Minimum Deductible		
Single Coverage	$1,650	$1,600
Family Coverage	$3,300	$3,200
Annual Out-of-Pocket Maximum		
Single Coverage	$8,300	$8,050
Family Coverage	$16,600	$16,100

	2025	2024
Health Savings Accounts (HSA)		
Maximum Annual Contribution		
Individual Coverage	$4,300	$4,150
Family Coverage	$8,550	$8,300
Age 55 Catch-Up Contributions	$1,000	$1,000
Flexible Spending Accounts (FSA)		
Maximum Annual Contribution		
Medical	N/A	$3,200
Dependent Care	N/A	$5,000

The above limits must be followed except for the medical FSA limit, which is optional (employers can set a lower limit). Typically, the IRS doesn't publish the new FSA limits until November each year. There are some additional items to highlight, such as the maximum out-of-pocket limit for non-grandfathered health plans.

First, the limit can be divided so that a portion applies to the medical benefit and a portion applies to the prescription drug benefit. This may be needed if the plan has separate medical and prescription drug administrators.

Second, if a plan has a family maximum out-of-pocket that is greater than the individual maximum out-of-pocket, there must be an embedded individual maximum out-of-pocket within the family limit. An embedded out-of-pocket limit means no individual is subject to a maximum out-of-pocket greater than the individual amount. For an HDHP, however, the embedded maximum out-of-pocket can't be less than the minimum family deductible for HDHPs.

Participant Notices

As you prepare the open enrollment materials, remember the required participant notices. While only some of the notices below are required to be furnished annually, the other listed notices can be included in the employer's annual distribution of notices for ease of administration and to ensure compliance.

Annual Federal Notices

- **Summary of Benefits and Coverage (SBC).** The SBC is required for *all group health plans.* It is intended to provide information in a prescribed format to eligible individuals so they can easily compare the information to other plans for which they may be eligible, including coverage on the Exchange. The SBC must be provided with enrollment materials when individuals are initially eligible, upon special enrollment events, and annually. DOL's SBC Template & Instructions

- **Women's Health and Cancer Rights Act (WHCRA).** *All group health plans which provide coverage for mastectomy benefits* must disclose a woman's rights after a mastectomy. The plan is required to issue this notice upon an individual's (and dependents') enrollment and on an annual basis. DOL's Model Notice

- **Medicare Part D Notice of Creditable or Non-Creditable Coverage.** The Medicare Part D Notice (as it is commonly called) informs Medicare-eligible individuals as to whether the plan's prescription drug coverage is considered creditable coverage, meaning the plan is expected to pay, on average, as much as the standard Medicare Part D coverage. *All group health plans* must issue this notice to all Medicare-eligible individuals regardless of their plan enrollment status. Since it is difficult for most employers to determine who should receive the notice, providing it to all employees facilitates compliance. CMS' Model Notices

- **Children's Health Insurance Program (CHIP) Notice.** The CHIP notice informs individuals residing in a state that provides premium assistance subsidies under Medicaid or CHIP about the subsidies, their special enrollment rights, and whom to contact for more information. *All group health plans with eligible individuals (employees, dependents, COBRA participants, etc.) residing in these states* must distribute the notice annually. Since the model notice is updated twice a year, employers should check the DOL website for the latest version before distribution. DOL's Model Notice

Other Federal Notices to Consider

- **Notice of Grandfathered Status.** The Notice of Grandfathered Status is required of *all group health plans claiming grandfathered status* under the ACA. The notice must be included in the plan's Summary Plan Description (SPD) and any other plan materials describing the health coverage. DOL's Model Notice

- **HIPAA Notice of Privacy Practices.** The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires *all group health plans that create or receive protected health information* to provide a notice of their privacy practices to plan participants at least once every three years. HHS' Model Notices

- **HIPAA Special Enrollment Notice.** *All group health plans* must provide each eligible employee with a notice of their special enrollment rights under HIPAA at or before their initial enrollment. DOL's Model Notice *(see page 17)*

- **Primary Care Provider Designation Patient Protection Notice**. The ACA requires *all non-grandfathered health plans that require plan participants to designate a primary care provider (e.g., HMOs)* to distribute a notice of the terms of the plan and participant rights. The notice must be distributed to all plan participants when an SPD or other similar description of plan benefits is provided. DOL's Model Notice

- **Wellness Notices.** The Americans with Disabilities Act (ADA) and HIPAA require *all employers with specific wellness programs* to notify employees about the terms of the programs. Refer to our Benefits Brief for more information on these notices.

- **ACA Market Exchange Notice.** *All employers covered by the Fair Labor Standards Act (FLSA)* must provide employees with specific information about the existence of Health Insurance Exchanges (also known as Marketplaces). The notice must be provided to each new employee at the time of hiring or within 14 days of the employee's start date. DOL's Model Disclosure

- **COBRA Initial (General) Notice.** The Consolidated Omnibus Budget Reconciliation Act (COBRA) requires *all employers with 20 or more employees that sponsor group health plans* to 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 and enrollment materials. DOL's Model Notice

- **Michelle's Law Notice.** Under health care reform, group health plans and issuers are generally required to provide dependent coverage to age 26, regardless of the dependent's student status. However, Michelle's Law may apply in some circumstances, such as when a plan provides dependent coverage beyond age 26 or qualifies as a small employer group. *All group health plans that base eligibility for coverage on student status* must include this notice with any plan materials describing dependent eligibility. There is no model notice; however, some samples can be found online. For example, Thomson Reuters offers one if you sign up for a free trial.

- **Surprise Medical Billing Notice.** The No Surprises Act (NSA) requires *all group health plans and health insurance issuers* to make publicly available, post on a public website of the plan or issuer, and include on each applicable explanation of benefits, information in plain language on the restrictions against balance billing in certain circumstances, including any applicable state law balance billing protections, and information on contacting appropriate state and federal agencies. The Departments issued a model

notice that plans and issuers may use (but are not required to use) to meet these disclosure requirements related to surprise billing.

ADDITIONAL RESOURCES

Compliance Guide: Health Benefits Coverage under Federal Law
Source: Department of Labor,
Employee Benefits Security Administration (EBSA)

Health Benefits Advisor for Employers
Source: Department of Labor,
Employee Benefits Security Administration (EBSA)

Reporting and Disclosure Guide for Employee Benefit Plans
Source: Department of Labor,
Employee Benefits Security Administration (EBSA)