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End-of-2024 Health Plan Reminders and a Look Towards 2025

Introduction

For many employers and plan sponsors offering benefits to employees, it's a perfect time to review some end-of-year action items and reminders as 2024 ends and before the onset of 2025.

In addition, this end-of-year missive includes some general refreshers regarding general compliance requirements of Internal Code § 125 cafeteria plans, nondiscrimination testing, Form 5500 filing obligations, and updated Patient-Centered Outcome Research Institute or Clinical Effectiveness Research (PCORI) fees and San Francisco Health Care Expenditure Rates.

DOL and Treasury Extend Certain ERISA-Related Deadlines for Areas Impacted by Hurricanes Helene and Milton

On November 7, 2024, the Department of Labor (DOL) Employee Benefits Security Administration (EBSA) announced compliance guidance and further relief for employee benefit plans, qualified beneficiaries, and other plan members impacted by Hurricanes Helene and Milton.[1]

On November 14, 2024, the Department of Health and Human Services (HHS) commented that it concurred with the DOL and Treasury and will adopt a non-enforcement policy to extend similar timeframes to non-federal governmental group health plans and health insurance issuers offering coverage in connection with a group health plan.[2]

These disasters brought with them a number of temporary suspensions to certain ERISA health and welfare plan benefit deadlines that fall during specified relief periods, which are for specific periods designated by the Federal Emergency Management Agency (FEMA) as eligible for Individual Assistance because of Hurricane Helene, Tropical Storm Helene, and Hurricane Milton:

- Designated areas in Florida
    - Hurricane Helene[3] – September 23, 2024 – May 1, 2025
    - Hurricane Milton[4] – October 5, 2024 – May 1, 2025
- Designated areas in Georgia[5]: September 24, 2024 - May 1, 2025.
- Designated areas in North Carolina,[6] South Carolina,[7] and Virginia:[8] September 25, 2024 - May 1, 2025.

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[1] US Department of Labor announces guidance, relief for employee benefit plans, participants, beneficiaries affected by hurricanes Helene, Milton | U.S. Department of Labor

[2] https://www.hhs.gov/guidance/sites/default/files/hhs-guidance-documents/Hurrican%20Helen%20Disaster%20Relief%20Bulletin.pdf

[3] https://www.fema.gov/disaster/4828/designated-areas#individual-assistance

[4] https://www.fema.gov/disaster/4834/designated-areas#individual-assistance

[5] https://www.fema.gov/disaster/4830/designated-areas#individual-assistance

[6] https://www.fema.gov/disaster/4827/designated-areas#individual-assistance

[7] https://www.fema.gov/disaster/4829/designated-areas#individual-assistance

[8] https://www.fema.gov/disaster/4831/designated-areas#individual-assistance

- Designated areas in Tennessee:[9] September 26, 2024 - May 1, 2025.

These extensions apply to all group health plans, disability and other employee welfare benefit plans and employee pension benefit plans subject to ERISA and the Internal Revenue Code (the "Code"). HHS similarly "encourages" non-federal government plans and health insurance issuers offering group or individual health insurance coverage to also extend participant deadlines.

For an individual to be eligible for this relief, they must have resided or worked in one of the FEMA-designated disaster areas at the time of the corresponding hurricane or tropical storm or have been covered under a plan that was directly impacted.

EBSA Disaster Relief Notice 2024-01 extends the time for plans to furnish ERISA-required notifications (e.g., Summary Plan Descriptions [SPDs], Forms 5500) during the applicable relief period, as long as there is a good faith effort to furnish the documents as soon as administratively practicable.

The applicable relief period is disregarded in determining the following provisions:

- COBRA Election Notices to Qualified Beneficiaries – The 14-day (44 days in instances in which the employer is the plan administrator) deadline for a plan administrator of a group health plan affected[10] by Hurricane Helene, Tropical Storm Helene, or Hurricane Milton to provide COBRA Election Notices under ERISA § 606(c) and Code § 4980B(f)(6)(D).
- HIPAA Special Enrollment Period – The 30-day period (or 60-day period, in some instances) to exercise special enrollment rights in a group health plan following certain events (that is, birth, adoption, or placement for adoption of a child; marriage; loss of other health coverage; or eligibility for a state premium assistance subsidy);
- COBRA Qualifying Event and Disability Extension Notices – The 60-day deadline by which qualified beneficiaries must notify the plan of certain qualifying events (for example, divorce or legal separation, a dependent child ceasing to be a dependent under the terms of the plan), or a Social Security disability determination used to extend COBRA coverage;
- COBRA Elections – The 60-day deadline in which to elect COBRA continuation coverage;
- COBRA Premium Payments – The 45-day (for the initial premium payment) and 30-day (for subsequent monthly payments) deadlines to pay COBRA premiums;
- Benefit Claims and Appeals – The deadline under the plan by which participants may file a benefit claim (under the terms of the plan) and the 180-day (for group health plans) and 60-day (for other welfare benefit plans) deadlines for appealing an adverse benefit determination.

First-Dollar Telehealth Cost-Sharing Set to Extend

Included in the Coronavirus Aid, Relief, and Economic Security Act (CARES Act), signed into law on March 27, 2020, was the provision allowing high-deductible health plans (HDHPs) compatible with Health Savings Accounts (HSAs) to cover telemedicine and other remote care service expenses before the deductible was met and with no effect to a participant's ability to continue to contribute to their HSA for plan years beginning on or before December 31, 2021. The Consolidated Appropriations Act, 2022 and Consolidated Appropriations Act, 2023 further extended this relief to allow plan sponsors offering HSA-qualified HDHPs to pay for these telemedicine and remote care service expenses before the deductible is met for plan years beginning after December 31, 2022 and before January 1, 2025 and such services will continue to be

[9] https://www.fema.gov/disaster/4832/designated-areas#individual-assistance

[10] Generally, if the principal place of business of the employer that maintains the plan, the principal place of business of employers that employ more than 50 percent of the active participants covered by the plan, or the office of the plan or the plan administrator, or the office of the primary recordkeeper serving the plan, was located in one of the disaster areas at the time of the hurricane or tropical storm.

disregarded coverage during those plan years (meaning payment for such services will not cause a loss of eligibility to contribute to an HSA).

The Further Continuing Appropriations Act, 2025"[11] is set to again extend this regulatory relief for two years (for plan years beginning on or before January 1, 2027 (i.e., through 2026 for calendar year plan years). This act is expected to pass before the end of 2024. Without this extension, participants in an HDHP that includes no-cost sharing telehealth services will no longer be eligible to make contributions to an HSA for plan years beginning on or after January 1, 2025.

IRS Notices on Preventive Care and Medical Care

On October 17, 2024, the IRS issued IRS Notices 2024-71[12] and 2024-75[13] allowing the cost of condoms to be treated as Code § 213(d) medical care expense and clarifying the list of preventive care services that an HSA-compatible HDHP can cover before a deductible is met.

In IRS Notice 2024-71, the IRS classified male condoms as medical expenses under Code § 213(d), making them eligible for reimbursement through health Flexible Spending Arrangements (health FSAs), Archer Medical Savings Accounts (MSAs), Health Reimbursement Accounts (HRAs), or HSAs.

IRS Notice 2024-75 expands the list of preventive care benefits permitted to be provided by an HDHP under Code § 223(c)(2)(C) without a deductible, or with a deductible below the applicable minimum deductible for the HDHP, to include:

- over-the-counter oral contraceptives (including emergency contraceptives) and male condoms;
- breast cancer screening for individuals who have not been diagnosed with breast cancer;
- continuous glucose monitors for individuals diagnosed with diabetes; and
- a new safe harbor for certain insulin products that applies without regard to whether the insulin product is prescribed to treat an individual diagnosed with diabetes or prescribed for the purpose of preventing the exacerbation of diabetes or the development of a secondary condition

Code § 223 permits eligible individuals to establish HSAs but - among the requirements to qualify for an HSA - the individual must be covered under an HDHP and have no other disqualifying health coverage.

Generally, an HDHP is not permitted to provide benefits for any year until the IRS minimum deductible for that year has been satisfied. However, Code § 223(c)(2)(C) provides a safe harbor for the absence of a deductible for preventive care. Therefore, an HDHP may provide preventive care benefits without a deductible or with a deductible below the minimum annual deductible otherwise required by Code § 223(c)(2)(A). To be a preventive care benefit, the benefit must either be described as preventive care in Social Security Act § 1861 or be determined to be preventive care in guidance issued by the Department of the Treasury and the IRS.

New Indexed PCORI Fees Issued

Under the Affordable Care Act, (ACA), a fund for a nonprofit corporation to assist in clinical effectiveness research was created. To aid in the financial support for this endeavor, certain health insurance carriers and health plan sponsors are required to pay fees based on the average number of lives covered by welfare benefits plans.

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[11] https://docs.house.gov/billsthisweek/20241216/CR.pdf
[12] N-2024-71
[13] N-2024-75

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On December 2, 2024, the IRS published Notice 2024-83[14] updating the amount of the PCORI fees that must be paid by self-insured health plans for plan years ending on or after October 1, 2024, and before October 1, 2025.

For plan years ending on or after October 1, 2024, and before is increased to $3.47, up from $3.22.

Fees are reported and paid annually through IRS Form 720 (Quarterly Federal Excise Tax Return). These fees are due by July 31 of the year following the end of the plan year along with IRS Form 720.

Indexed each year, the fee amount is determined by the value of national health expenditures. The fee phases out for plan years ending after September 30, 2029.

As a reminder, fees are required for all group health plans including Health Reimbursement Arrangements (HRAs) but are not required for Health FSAs that are considered excepted benefits. To be an excepted benefit, Health FSA participants must be eligible for their employer's group health insurance plan and may include employer contributions in addition to employee salary reductions. However, the employer contributions may only be $500 per participant or up to a dollar-for-dollar match of each participant's election.

HRAs exempt from other regulations would be subject to the PCORI fee. For instance, an HRA that only covered retirees would be subject to this fee, but those covering dental or vision expenses only would not be, nor would Employee Assistance Programs (EAPs), disease management programs and wellness programs be required to pay PCORI fees.

2025 San Francisco Healthcare Expenditure Rates

The San Francisco Office of Labor Standards Enforcement recently released updated Health Care Security Ordinance (HCSO)[15] required health expenditure rates for 2025.

Updated Rates

The 2025 Healthcare Expenditure Rates – and previous year's rate history – are as follows:

Employer Size	Rate Per Hour	
	2025	2024
Large employers (≥ 100 employees)	$3.85	$3.51
Medium employers (20-99 employees); Non-profit (50-99 employees)	$2.56	$2.34
Small employers (≤ 19 employees); Non-profit (≤ 49 employees)	Exempt	

Nondiscrimination Testing

Nondiscrimination testing rules are generally designed by and specified within the IRC to ensure that plans are not designed in such a way that they discriminate in favor of highly paid employees

[14] https://www.irs.gov/irb/2024-49_IRB#NOT-2024-83

[15] Health Care Security Ordinance | San Francisco

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(HCEs)[16] or certain key employees[17] within the organization. These tests, in turn, help make sure the contributions made by and for non-highly compensated employees (NHCEs) are proportional to contributions made for HCEs.

These tests, which apply to employer clients who offer plans governed by IRC §§ 125, 129, and/or 105 (such as cafeteria plans, Health Flexible Spending Accounts [Health FSAs], Dependent Care FSAs, Health Reimbursement Arrangements [HRAs], and Health Savings Accounts [HSAs] with contributions made through a Section 125 cafeteria plan), can best be organized into three basic groupings:

- *Eligibility.* If too many NHCEs are excluded from participation in the plan, then it will be discriminatory.
- *Availability of Benefits.* The plan will not pass the nondiscrimination tests if the HCEs/key employees can access more or better benefits than NHCEs.
- *Utilization.* A plan will not pass the nondiscrimination tests if the HCEs/key employees actually elect more benefits under the plan.

What are Nondiscrimination Tests?

The overall Key Employee "25% Concentration Test" compares all the pre-tax benefits elected by key employees with all the pre-tax benefits elected by non-key employees. Not more than 25% of the total benefits elected by all employees may be attributed to key employees.

Example:

All elections to the cafeteria plan add up to $35,000. Of those total elections, key employee elections equal $5,000. Key employee elections are about 14% of the total elections to the plan (i.e., $5,000 / $35,000 = 14.3%). In this example, the cafeteria plan passes the 25% Concentration Test.

The "55% Average Benefits Test" involves only the Dependent Care portion of the cafeteria plan. The average dollar amount of benefits elected by NHCEs must be at least 55% of the average dollar amount of benefits elected by HCEs.

Example:

Assume that HCEs' elections are $10,000 to the Dependent Care portion of the plan and there are five HCEs in the company. NHCEs elect $19,500 to the Dependent Care portion of the plan and there are 13 NHCEs. The highly compensated average dollar amount is $2,000 (= $10,000 / 5). The non-highly compensated average dollar amount is $1,500 (= $19,500 / 13). The average dollar amount of benefits elected by NHCEs is 75% of the average dollar amount of

[16] Highly compensated means any individual or participant who – for the prior plan year or the current plan year in the case of that individual's first year of employment – had annual compensation from the employer greater than an amount specified by the IRC (i.e., $155,000 for 2024; $150,000 for 2023; $135,000 for 2022) and is in the top 20 percent of employees when ranked by compensation.

[17] A key employee is a participant who, at any time during the plan year, is one of the following: (1) an officer of the company with annual compensation greater than an indexed dollar amount (i.e., $220,000 for 2024; $215,000 for 2023; $200,000 for 2022); (2) a five-percent owner of the employer; or (3) a one-percent owner of the employer with annual compensation greater than $150,000.

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benefits elected by HCEs ($1,500 / $2,000). In this example, the Dependent Care portion of the cafeteria plan passes the 55% Average Benefits test.

The "More-Than-5% Owner Concentration Test" compares the Dependent Care benefits elected by more-than-5% owners of a company with Dependent Care benefits elected by non-owners. Not more than 25% of the total Dependent Care benefits elected by everyone in the Dependent Care benefit may be attributed to more-than-5% owners.

Example:

Assume a $5,000 election to the Dependent Care portion of the plan by a more-than-5% owner and elections in the amount of $19,500 made by all non-owners. The more-than-5% owner's election is 20% of the total benefits elected to the Dependent Care portion of the plan.

$$20\% = \frac{\$5{,}000}{\$24{,}500}$$

[i.e., More-than-5% Owner election]

[= $5,000 + $19,500 (non-owner election)]

In this case, the Dependent Care portion of the plan passes the More-Than-5% Owner test because only 20% of the Dependent Care benefits were elected by the more-than-5% owner.

The "Eligibility," "Benefits Available," and "Contributions and Benefits" Tests ensure that employers offer all benefits to an adequate number of employees and benefits do not discriminate in favor of highly compensated or key employees.

In the event the plan does not meet all the nondiscrimination requirements, employers may need to change benefit elections and payroll amounts to bring the plan into compliance. It is important to test prior to the end of the plan year. If testing is completed after the end of the plan year, it's too late to take corrective action. Instead of reducing key or highly compensated elections to pass the nondiscrimination test(s), the affected employees would be taxed on their total election amount.

When should Nondiscrimination Testing be conducted?

Nondiscrimination testing must occur as of the last date of the current plan year, taking into account all non-excludable employees (or former employees) who were employees on any day during the plan year.

As a best practice, employers should consider performing nondiscrimination testing several months before the end of the current plan year.

This will allow the employer to take into account changes to employment and enrollment and will allow time to make necessary corrections before the end of the plan year if it appears the plan will not pass nondiscrimination testing.

Be aware that corrections cannot be made after the end of the applicable plan year.

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Form 5500 Obligation

A frequently overlooked responsibility for plan sponsors is Form 5500 filings under certain circumstances. Generally, Forms 5500 must be filed for ERISA health and welfare plans offered under a cafeteria plan.

What is a welfare benefit plan?

Welfare benefit plans provide benefits such as medical, dental, life insurance, apprenticeship and training, scholarship funds, severance pay and disability. FSAs contained inside cafeteria plans and HRAs qualify as welfare benefit plans.

Who must file a Form 5500?

Employers that sponsor welfare benefit plans covered by Title I of the Employee Retirement Income Security Act of 1976 (ERISA), with 100 or more participants at the beginning of the plan year, are required to file a Form 5500 for those plans. However, there are a couple of exceptions that apply, depending on the type of employer sponsoring the plan.

A general exception applies to:

- a governmental plan ERISA § 4(b)(1); or
- a church plan under ERISA § 4(b)(2).

The plan *may* not be exempt from filing if:

- it is deemed to have plan assets;
- plan funds are separated from the employer's general assets;
- plan funds are held in trust; or
- plan funds are forwarded to a Third-Party Administrator.

Most non-exempt employer plans will complete all questions on Form 5500. Depending on the funding arrangement or payments from the plan, attaching Schedules may be applicable.[18]

Since 2009, however, the "Instructions for Form 5500" have been modified to make clear that plans that are paid from the general assets of the employer need not file Schedule C.

When does a welfare benefit plan need to file a Form 5500?

Forms must be filed by the last day of the seventh calendar month after the end of the plan year. A plan may obtain a one-time extension of time to file. Form 5558 must be sent by the original due date to gain a 2½ month extension of time in which to complete and file the Form 5500.

Failure to Timely File the Form 5500

Failure to timely file a Form 5500 may result in ERISA penalties, which may be assessed not just for late or unfiled Forms 5550, but also for incomplete or otherwise deficient Forms 5500. Under ERISA, the Department of Labor (DOL) may assess a civil penalty against a plan administrator of

[18] Refer to specific Form 5500 instructions for complete information on filing requirements (e.g., *Who Must File* and *What To File*). See 2023 Instructions for Form 5500 at pages 3 and 8 for more information.

up to $2,760 per day for 2024 (subject to annual index increases after 2024)[19] from the date of the plan administrator's failure or refusal to file the Form 5500.

However, under the DOL's Delinquent Filer Voluntary Compliance (DFVC) program, employers that voluntarily submit late or unfiled Forms 5500 prior to being notified in writing by the DOL of the failure to timely file may be allowed to pay significantly reduced penalties.[20]

2025 Index Figures

On October 22, 2024**,** the Internal Revenue Service issued the 2025 annual inflation adjustments for many tax provisions of the IRS Code[21]. These adjusted amounts will be used to prepare tax year 2025 returns in 2026.

Also, on November 1, 2024, the IRS released the dollar limitations for qualified retirement plans for tax year 2025, including 401(k) plans.[22]

Indexed Compensation Levels

For highly compensated and Key Employee definitions:

	2025	**2024**
Highly Compensated Employee	$160,000	$155,000
Key Employee	$230,000	$220,000

401(k), 403(b), or 457 Plans

	2025	**2024**
Maximum Employee Contribution	$23,500	$23,000
Maximum Catch-Up Allowed 50+	$7,500	

Health Flexible Spending Account (FSA)[23]

	2025	**2024**
Annual Salary Reduction Limit	$3,300	$3,200

[19] Federal Register: Federal Civil Penalties Inflation Adjustment Act Annual Adjustments for 2024

[20] https://www.dol.gov/agencies/ebsa/employers-and-advisers/plan-administration-and-compliance/correction-programs/dfvcp

[21] RP 24

[22] Notice 2024-80, 2025 Amounts Relating to Retirement Plans and IRAs, as Adjusted for Changes in Cost-of-Living

[23] As a reminder, Healthcare FSAs that permit the carryover of unused amounts, the maximum carryover amount is increased to an amount equal to 20 percent of the maximum health FSA salary reduction contribution for that plan year (i.e., $660 [= $3,300 * .2]).

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Dependent Care Assistance Program (DCAP)

Maximum DCAP Amount	2025	2024
Unless Married Filing Separately	$5,000	
If Married Filing Separately	$2,500	
Deemed Income of Spouse Incapable of Self-Care or Full-Time Student		
With 1 Qualifying Individual	$250/month	
With 2 or More Qualifying Individuals	$500/month	

There are adjustments to some of the general tax limits that are relevant to the federal income tax savings under a DCAP. These include the 2025 tax rate tables, earned income credit amounts, and standard deduction amounts. The child tax credit limits are also relevant when calculating the federal income tax savings from claiming the dependent care tax credit (DCTC) versus participating in a DCAP.

Commuter Accounts

	2025	2024
Parking – Monthly Limit	$325	$315
Transit and Vanpooling – Monthly Limit	$325	$315

Adoption Assistance Exclusion and Adoption Credit

	2025	2024
Phase Out (modified Adjusted Gross Income)	$259,190 - $299,190	$252,150 - $292,150
Maximum Exclusion for Employer- Provided Adoption Assistance	$17,280	$16,810
Adoption Tax Credit Limit	$17,280	$16,810

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Health Savings Account (HSA)[24]

	2025	2024
Minimum deductible amounts for the qualifying high-deductible health plan (HDHP)		
Individual Coverage	$1,650	$1,600
Family Coverage	$3,300	$3,200
Maximum Contribution Levels		
Individual Coverage	$4,300	$4,150
Family Coverage	$8,550	$8,300
Catch-Up Allowed for Those 55+	$1,000	
Maximums for HDHP Out-of-Pocket Expenses (excluding premiums)		
Individual Coverage	$8,300	$8,050
Family Coverage	$16,600	$16,100

Excepted Benefit Health Reimbursement Arrangement (EBHRA)

	2025	2024
Maximum Newly Available Benefit Amount	$2,150	$2,100

Qualified Small Employer Health Reimbursement Arrangement (QSEHRA)

	2025	2024
Individual Coverage	$6,350	$6,150
Family Coverage	$12,800	$12,450

Archer Medical Savings Account (MSA)

	2025	2024
Minimum/Maximum Deductible Amounts for the Qualifying High-Deductible Health Plan (HDHP)		
Individual Coverage	$2,850 - $4,300	$2,800-$4,150
Family Coverage	$5,700 - $8,500	$5,550-$8,350
Annual out-of-pocket expenses required to be paid (other than for premiums) for covered benefits do not exceed		
Individual Coverage	$5,700	$5,550
Family Coverage	$10,500	$10,200

[24] RP-2024-25 (irs.gov)

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Conclusion

These are but a few of the specific year-end deadlines and requirements that were required to have been completed or are quickly approaching.

Compliance becomes clearer for employers through knowledge. It's as easy as contacting HealthEquity for more information about its services, and your own accounting or legal sources for additional guidance.
