OPEN ENROLLMENT CHECKLIST 2024

2024 Open Enrollment Checklist

To get ready for open enrollment, employers who sponsor group health plans should be aware of the legal changes affecting the design and administration of their health plans for plan years beginning on or after Jan. 1, 2024. These changes include limits that are adjusted for inflation each year, such as the Affordable Care Act's (ACA) affordability percentage and cost-sharing limits for high deductible health plans (HDHPs). Employers should review their health plan's design to confirm that it has been updated, as necessary, for these changes.

In addition, any changes to a health plan's benefits for the 2024 plan year should be communicated to plan participants through an updated summary plan description (SPD) or a summary of material modifications (SMM).

Health plan sponsors should also confirm that their open enrollment materials contain certain required participant notices, when applicable, such as the summary of benefits and coverage (SBC). Some participant notices must also be provided annually or upon initial enrollment. To minimize costs and streamline administration, employers should consider including these notices in their open enrollment materials.

LINKS AND RESOURCES

- Revenue Procedure 2023-23, which includes the inflation-adjusted limits for health savings accounts (HSAs) and HDHPs for 2024
- Model notices for group health plans, including the Women's Health and Cancer Rights Act (WHCRA) notice
- Model COBRA notices for group health plans

Plan Design Issues

- Applicable large employers (ALEs) should confirm that at least one of their health plans offered to full-time employees satisfies the ACA's affordability standard.
- For HDHPs, employers should confirm that the plan's deductible and out-of-pocket maximum comply with the 2024 limits.
- Employers should communicate plan design changes to employees as part of the open enrollment process.

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PLAN DESIGN CHANGES

ACA Affordability Standard

Under the ACA's employer shared responsibility rules, ALEs are required to offer affordable, minimum value health coverage to their full-time employees (and dependent children) or risk paying a penalty. The employer shared responsibility requirements are also known as the "pay or play" rules.

Under the ACA, an ALE's health coverage is considered affordable if the employee's required contribution to the plan does not exceed a certain percentage of the employee's household income for the taxable year (as adjusted annually). The adjusted percentage is **8.39%** for 2024. **This is a substantial decrease from 2023 and is the lowest that this percentage has ever been set. As a result, many employers may have to significantly lower their employee contribution for 2024 to meet the adjusted percentage.**

- ☑ If you are an ALE, confirm that at least one of the health plans providing minimum value offered to full-time employees satisfies the ACA's affordability standard.

Out-of-Pocket Maximum Limits

Non-grandfathered health plans are subject to limits on cost sharing for essential health benefits (EHB). The annual limits on total enrollee cost sharing for EHB for plan years beginning on or after Jan. 1, 2024, are **$9,450** for self-only coverage and **$18,900** for family coverage. With this in mind, employers should consider these next steps:

- ☑ Review the out-of-pocket maximum limits for your health plan to ensure they comply with the ACA's limits for the 2024 plan year.
- ☑ Keep in mind that the out-of-pocket maximum limits for HDHPs compatible with HSAs must be lower than the ACA's limits. For the 2024 plan year, the out-of-pocket maximum limits for HDHPs are **$8,050** for self-only coverage and **$16,100** for family coverage.
- ☑ Group health plans with a family out-of-pocket maximum that is higher than the ACA's self-only out-of-pocket maximum limit must embed an individual out-of-pocket maximum in family coverage so that no individual's out-of-pocket expenses exceed $9,450 for the 2024 plan year.

Preventive Care Benefits

The ACA requires non-grandfathered health plans to cover certain preventive health services without imposing cost-sharing requirements (e.g., deductibles, copayments or coinsurance) when the services are provided by in-network health care providers. The recommended preventive care services covered by these requirements include the following:

- Evidence-based items or services that have a rating of A or B in the current recommendations of the United States Preventive Services Task Force (USPSTF);
- Immunizations for routine use in children, adolescents and adults that are currently recommended by the Centers for Disease Control and Prevention;
- Evidence-informed preventive care and screenings included in the Health Resources and Services Administration (HRSA) guidelines for infants, children and adolescents; and
- Evidence-informed preventive care and screenings included in HRSA-supported guidelines for women.

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Health plans are required to adjust their first-dollar coverage of preventive care services based on the latest preventive care recommendations. In general, coverage must be provided for a newly recommended preventive health service or item for plan years beginning on or after the one-year anniversary of when the recommendation was issued. More information on the recommended preventive care services is available at www.HealthCare.gov.

Impact of Ongoing Litigation

Currently, a key portion of the ACA's preventive care mandate is the subject of a legal dispute. On March 30, 2023, the U.S. District Court for the Northern District of Texas ruled that preventive care coverage requirements based on an A or B rating by the USPSTF on or after March 23, 2010, violate the U.S. Constitution and blocked enforcement of those requirements. However, the 5th Circuit Court of Appeals has put enforcement of the District Court's ruling on hold pending the case's appeal. The 5th Circuit is expected to issue a decision on the merits of the case by the end of 2023. It is uncertain whether the District Court's ruling will be reversed or upheld by the 5th Circuit. For now, non-grandfathered health plans and issuers should continue to cover, without cost sharing, the full range of preventive care services required by the ACA, including items or services that have an A or B recommendation by the USPSTF.

Considering these developments, employers should consider taking the following steps:

- ☑ Confirm that non-grandfathered health plans cover the latest recommended preventive care services without imposing any cost sharing.
- ☑ Monitor future developments for the 5th Circuit's decision regarding the ACA's preventive care mandate, which is expected by the end of 2023. If the 5th Circuit rules that a portion of the mandate is unconstitutional, employers should consult their advisors to determine the potential impacts on their health plans.

Coverage for COVID-19 Vaccines, Testing and Treatment

Because the COVID-19 public health emergency has ended, health plans are no longer required to cover COVID-19 diagnostic tests and related services without cost sharing or other medical management requirements. Health plans are still required to cover recommended preventive services, including COVID-19 immunizations, without cost sharing, but this coverage requirement can now be limited to in-network providers.

Also, for plan years ending after Dec. 31, 2024, an HSA-compatible HDHP is no longer permitted to provide benefits for COVID-19 testing and treatment without a deductible (or with a deductible below the minimum deductible for an HDHP). As such, employers should take these steps:

- ☑ Determine whether health plans will impose cost-sharing requirements, prior authorization or other medical management requirements on COVID-19 testing for the upcoming plan year.
- ☑ Determine whether health plans will continue covering COVID-19 immunizations, without cost sharing, from all health care providers or whether this first-dollar coverage will be limited to in-network providers.
- ☑ Confirm that HDHPs that do not have a calendar year as the plan year will not pay benefits for COVID-19 testing and treatment before the annual minimum deductible has been met for plan years ending after Dec. 31, 2024.
- ☑ Notify plan participants of any changes for the 2024 plan year regarding COVID-19 testing and vaccines through an updated SPD or SMM.

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Health FSA Contributions

The ACA imposes a dollar limit on employees' pre-tax contributions to a health FSA. This limit is indexed each year for cost-of-living adjustments. An employer may set their own dollar limit on employees' contributions to a health FSA, as long as the employer's limit does not exceed the ACA's maximum limit in effect for the plan year. For plan years beginning in 2023, the health FSA limit is **$3,050**. For plan years beginning in 2024, **the health FSA limit has not been released yet**.

In addition, the IRS recently issued a memorandum on FSAs that provides helpful reminders about the strict substantiation requirements for these tax-advantaged accounts. This memorandum clarifies that health FSA expenses are not considered properly substantiated if employees self-certify expenses, if the plan uses sampling, if only amounts over a certain level are substantiated or if charges from favored providers are not substantiated. Moving forward, employers should consider these next steps:

- ☑ Monitor future developments for the release of the health FSA limit for 2024.
- ☑ Confirm that health FSAs will not allow employees to make pre-tax contributions in excess of the 2024 limit.
- ☑ Communicate the health FSA limit to employees as part of the open enrollment process.
- ☑ Review health FSA substantiation procedures to make sure they comply with IRS rules.

HDHP and HSA Limits for 2024

Employers offering HDHPs compatible with HSAs to employees should confirm that the HDHP's minimum deductible and out-of-pocket maximum comply with the 2024 limits. The IRS limits for HSA contributions, HDHP minimum deductibles and HDHP maximum out-of-pocket expenses will all increase for 2024. The HSA contribution limits will increase effective Jan. 1, 2024, while the HDHP out-of-pocket limit will increase effective for plan years beginning on or after Jan. 1, 2024. Looking ahead, employers should follow these steps:

- ☑ Check whether HDHP cost-sharing limits need to be adjusted for the 2024 limits.
- ☑ Communicate HSA contribution limits to employees as part of the enrollment process and update these enrollment materials to reflect the increased limits that apply for 2024.

The following table contains the HDHP and HSA limits for 2024 as compared to 2023. It also includes the catch-up contribution limit that applies to HSA-eligible individuals age 55 and older, which is not adjusted for inflation and stays the same from year to year.

Type of Limit		2024	2023	Change
HSA Contribution Limits	Self-only	$4,150	$3,850	**Up $300**
	Family	$8,300	$7,750	**Up $550**
HSA Catch-up Contributions	Age 55 and older	$1,000	$1,000	**No change**
HDHP Minimum Deductibles	Self-only	$1,600	$1,500	**Up $100**
	Family	$3,200	$3,000	**Up $200**

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Type of Limit		2024	2023	Change
HDHP Maximum Out-of-Pocket Expense Limits *(deductibles, copayments and other amounts, but not premiums)*	Self-only	$8,050	$7,500	**Up $550**
	Family	$16,100	$15,000	**Up $1,100**

HDHP Design Option – Telehealth

At the beginning of the COVID-19 pandemic, Congress temporarily relaxed the rules for HDHPs to allow them to provide benefits for telehealth or other remote care services before plan deductibles were met without jeopardizing HSA eligibility. This relief has been repeatedly extended and currently applies for plan years beginning before Jan. 1, 2025. This means that HDHPs may waive the deductible for any telehealth services for plan years beginning in 2023 and 2024 without causing participants to lose HSA eligibility. This provision is optional; HDHPs can continue to choose to apply any telehealth services toward the deductible. Going forward, employers can take these steps:

- ☑ Determine whether HDHPs will waive the deductible for telehealth services for the plan year beginning in 2024.
- ☑ Communicate any plan changes for the upcoming year to participants through an updated SPD or SMM.

Mental Health Parity – Required Comparative Analysis for NQTLs

The Mental Health Parity and Addiction Equity Act (MHPAEA) requires parity between a group health plan's medical/surgical benefits and its mental health or substance use disorder (MH/SUD) benefits. These parity requirements apply to financial requirements and treatment limits for MH/SUD benefits. In addition, any nonquantitative treatment limitations (NQTLs) placed on MH/SUD benefits must comply with MHPAEA's parity requirements. For example, NQTLs include prior authorization, step therapy protocols, network adequacy and medical necessity criteria.

MHPAEA requires health plans and issuers to conduct comparative analyses of the NQTLs used for medical/surgical benefits compared to MH/SUD benefits. This analysis must contain a detailed, written and reasoned explanation of the specific plan terms and practices at issue and include the basis for the plan's or issuer's conclusion that the NQTLs comply with MHPAEA. Plans and issuers must make their comparative analyses available upon request to specific federal agencies or applicable state authorities. Considering this information, employers should take the following steps:

- ☑ Reach out to health plan issuers (or third-party administrators) to confirm that comparative analyses of NQTLs will be updated, if necessary, for the plan year beginning in 2024.

ACA EMPLOYER MANDATE REQUIREMENTS

Applicable Large Employer Status (ALE)

Under the ACA's employer penalty rules, applicable large employers (ALEs) that do not offer health coverage to their full-time employees (and dependent children) that is affordable and provides minimum value will be subject to penalties if any full-time employee receives a government subsidy for health coverage through an Exchange.

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To qualify as an ALE, an employer must employ, on average, **at least 50 full-time employees, including full-time equivalent employees (FTEs)**, on business days during the preceding calendar year. All employers that employ at least 50 full-time employees, including FTEs, are subject to the ACA's pay or play rules.

- ☑ Determine your ALE status for 2024.
- ☑ Calculate the number of full-time employees for all 12 calendar months of 2023. A full-time employee is an employee who is employed on average for at least 30 hours of service per week.
- ☑ Calculate the number of FTEs for all 12 calendar months of 2023 by calculating the aggregate number of hours of service (but not more than 120 hours of service for any employee) for all employees who were not full-time employees for that month and dividing the total hours of service by 120.
- ☑ Add the number of full-time employees and FTEs (including fractions) calculated above for all 12 calendar months of 2023.
- ☑ Add up the monthly numbers from the preceding step and divide the sum by 12. Disregard fractions.
- ☑ If your result is 50 or more, you are likely an ALE for 2024.

Identify Full-time Employees

All full-time employees must be offered affordable minimum value coverage. A full-time employee is an employee who was employed on average at least 30 hours of service per week. The final regulations generally treat 130 hours of service in a calendar month as the monthly equivalent of 30 hours of service per week. The IRS has provided two methods for determining full-time employee status—the **monthly measurement method** and the **look-back measurement method.**

- ☑ Determine which method you are going to use to determine full-time status
- ☑ Monthly measurement method involves a month-to-month analysis where full-time employees are identified based on their hours of service for each month. This method is not based on averaging hours of service over a prior measurement method. Month-to-month measuring may cause practical difficulties for employers, particularly if there are employees with varying hours or employment schedules, and could result in employees moving in and out of employer coverage on a monthly basis.
- ☑ Look-back measurement method allows an employer to determine full-time status based on average hours worked by an employee in a prior period. This method involves a measurement period for counting/averaging hours of service, an administrative period that allows time for enrollment and disenrollment, and a stability period when coverage may need to be provided, depending on an employee's average hours of service during the measurement period.

Offer of Coverage

An ALE may be liable for a penalty under the pay or play rules if it does not offer coverage to "substantially all" **(95%)** full-time employees (and dependents) and any one of its full-time employees receives a premium tax credit or cost-sharing reduction for coverage purchased through an Exchange. Employees who are offered health coverage that is **affordable** and provides **minimum value** are generally not eligible for these Exchange subsidies.

- ☑ Offer minimum essential coverage to all full-time employees

- ☑ Ensure that at least one of those plans provides minimum value (**60%** actuarial value)
- ☑ Ensure that the minimum value plan offered is affordable to all full-time employees by ensuring that the employee contribution for the lowest cost single minimum value plan does not exceed **8.39%** of an employee's earnings based on the employee's W-2 wages, the employee's rate of pay, or the federal poverty level for a single individual.

Reporting of Coverage

The ACA requires ALEs to report information to the IRS and to employees regarding the employer- sponsored health coverage on Form 1095-C. The IRS will use the information that ALEs report to verify employer-sponsored coverage and to administer the employer shared responsibility provisions (**Code Section 6056).**

In addition, the ACA requires every health insurance issuer, ***sponsor of a self-insured health plan***, government agency that administers government-sponsored health insurance programs and any other entity that provides minimum essential coverage (MEC) to file an annual return with the IRS and individuals reporting information for each individual who is provided with this coverage (**Code Section 6055).**

Beginning in 2024, employers that file at least 10 returns during the calendar year must file their ACA returns electronically. Reporting entities must aggregate most information returns, such as Forms W-2 and 1099, to determine if they meet the 10-return threshold for mandatory electronic filing. The previous threshold was 250 returns. **Due to the lowered threshold, only the smallest employers will be permitted to file using paper returns. As a result, employers that are subject to the ACA reporting rules should begin to explore options for filing ACA reporting returns electronically beginning in 2024.**

- ☑ Determine which reporting requirements apply to you and your health plans (depending if fully insured or self-funded)
- ☑ Determine the information you will need for reporting and coordinate internal and external resources to help compile the required data for the 1094-C and 1095-C
- ☑ Complete the appropriate forms for the 2023 reporting year. Furnish statements to individuals on or before March 2, 2024, and file returns with the IRS on or before February 28, 2024 (March 31, 2024, if filing electronically).

Comparative Effectiveness Research Fee (PCORI)

Sponsors of self-funded plans and health insurance issuers of fully insured plans are required to pay a fee each year, by July 31st, to fund comparative effectiveness research. Fees will increase to $3.00 per covered life in 2024 and are next due July 31, 2024.

W-2 Reporting

Healthcare Reform requires employers to report the aggregate cost of employer-sponsored group health plan coverage on their employees' Forms W-2. This reporting requirement was originally effective for the 2011 tax year. However, the IRS later made reporting optional for 2011 for all employers.

The IRS further delayed the reporting requirement for small employers (those that file fewer than 250 Forms W-2) by making it optional for these employers until further guidance is issued. For the larger employers, the reporting requirement was mandatory for the 2012 Forms W-2 and continues.

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Open Enrollment Notices

Employers who sponsor group health plans should provide certain benefits notices in connection with their plans' open enrollment periods. Some of these notices must be provided at open enrollment time, such as the SBC. Other notices, such as the WHCRA notice, must be distributed annually. Although these annual notices may be provided at different times throughout the year, employers often choose to include them in their open enrollment materials for administrative convenience.

In addition, employers should review their open enrollment materials to confirm that they accurately reflect the terms and cost of coverage. In general, any plan design changes for 2024 should be communicated to plan participants either through an updated SPD or an SMM.

Summary of Benefits and Coverage

The ACA requires health plans and health insurance issuers to provide an SBC to applicants and enrollees each year at open enrollment or renewal time. Federal agencies have provided a template for the SBC, which health plans and issuers are required to use. With this in mind, employers should consider these next steps:

- ☑ Include an updated SBC with open enrollment materials.
- ☑ Take note that for self-funded plans, the plan administrator is responsible for providing the SBC. For insured plans, the issuer usually prepares the SBC. If the issuer prepares the SBC, an employer is not required to also prepare an SBC for the health plan, although the employer may need to distribute the SBC prepared by the issuer.

Medicare Part D Notices

Group health plan sponsors must provide a notice of creditable or non-creditable prescription drug coverage to Medicare Part D-eligible individuals covered by, or who apply for, prescription drug coverage under the health plan. This creditable coverage notice alerts the individuals about whether their prescription drug coverage is at least as good as the Medicare Part D coverage. The notice generally must be provided at various times, including when an individual enrolls in the plan and each year before **Oct. 15** (when the Medicare annual open enrollment period begins). Model notices are available on the Centers for Medicare and Medicaid Services' website.

Annual CHIP Notices

Group health plans covering residents in a state that provides a premium subsidy to low-income children and their families to help pay for employer-sponsored coverage must send an annual CHIP notice about the available assistance to all employees residing in that state. The U.S. Department of Labor (DOL) has provided a model notice.

Initial COBRA Notices

COBRA applies to employers with 20 or more employees who sponsor group health plans. Group health plan administrators must 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. A model initial COBRA notice is available from the DOL.

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SPDs

Plan administrators must provide an SPD to new participants within 90 days after plan coverage begins. Any changes made to the plan should be reflected in an updated SPD booklet or described to participants through an SMM. Also, an updated SPD must be furnished every five years if changes are made to SPD information or if the plan is amended. Otherwise, a new SPD must be provided every 10 years.

Notices of Patient Protections

Under the ACA, group health plans and issuers that require the designation of a participating primary care provider must permit each participant, beneficiary and enrollee to designate any available participating primary care provider (including a pediatrician for children). Additionally, plans and issuers that provide obstetrical/gynecological care and require a designation of a participating primary care provider may not require preauthorization or referral for such care. If a health plan requires participants to designate a participating primary care provider, the plan or issuer must provide a notice of these patient protections whenever the SPD or similar description of benefits is provided to a participant. If an employer's plan is subject to this notice requirement, they should confirm that it is included in the plan's open enrollment materials. This notice may be included in the plan's SPD. Model language is available from the DOL.

Grandfathered Plan Notices

If an employer has a grandfathered plan, they should make sure to include information about the plan's grandfathered status in plan materials describing the coverage under the plan, such as SPDs and open enrollment materials. Model language is available from the DOL.

Notices of HIPAA Special Enrollment Rights

At or before the time of enrollment, an employer's group health plan must provide each eligible employee with a notice of their special enrollment rights under HIPAA. This notice may be included in the plan's SPD. Model language for this disclosure is available on the DOL's website.

HIPAA Privacy Notices

The HIPAA Privacy Rule requires covered entities (including group health plans and issuers) to provide a Notice of Privacy Practices (or Privacy Notice) to each individual who is the subject of protected health information (PHI). Health plans are required to send the Privacy Notice at certain times, including to new enrollees at the time of enrollment. Also, at least once every three years, health plans must either redistribute the Privacy Notice or notify participants that the Privacy Notice is available and explain how to obtain a copy.

Self-insured health plans are required to maintain and provide their own Privacy Notices. However, special rules apply for fully insured plans, where the health insurance issuer, not the plan itself, is primarily responsible for the Privacy Notice.

Special Rules for Fully Insured Plans

The plan sponsor of a fully insured health plan has limited responsibilities with respect to the Privacy Notice, including the following:

- If the sponsor of a fully insured plan has access to PHI for plan administrative functions, they are required to maintain a Privacy Notice and to provide the notice upon request.
- If the sponsor of a fully insured plan does not have access to PHI for plan administrative functions, they are not required to maintain or provide a Privacy Notice.

A plan sponsor's access to enrollment information, summary health information and PHI that is released pursuant to a HIPAA authorization does not qualify as having access to PHI for plan administration purposes.

Model Privacy Notices are available through the Department of Health and Human Services.

WHCRA Notices

Plans and issuers must provide a notice of participants' rights to mastectomy-related benefits under the WHCRA at the time of enrollment and on an annual basis. The DOL's compliance assistance guide includes model language for this disclosure.

NMHPA Notice

Plan administrators must include a statement within the Summary Plan Description (SPD) timeframe describing requirements relating to any hospital length of stay in connection with childbirth for a mother or newborn child under the Newborn's Mother's Health Protections Act. Model language for this disclosure is available on the DOL's website.

SARs

Plan administrators required to file a Form 5500 must provide participants with a narrative summary of the information in the Form 5500 called a summary annual report (SAR). A model notice is available from the DOL.

Group health plans that are unfunded (that is, benefits are payable from the employer's general assets and not through an insurance policy or trust) are not subject to the SAR requirement. The plan administrator generally must provide the SAR within nine months of the close of the plan year. If an extension of time to file the Form 5500 is obtained, the plan administrator must furnish the SAR within two months after the close of the extension period.

Wellness Program Notices

Group health plans that include wellness programs may be required to provide certain notices regarding the program's design. As a general rule, these notices should be provided when the wellness program is communicated to employees and before employees provide any health-related information or undergo medical examinations. These notices are required in the following situations:

- ☑ **HIPAA Wellness Program Notice**—HIPAA imposes a notice requirement on health-contingent wellness programs that are offered under group health plans. Health-contingent wellness plans require individuals to satisfy standards related to health factors (e.g., not smoking) to obtain rewards. The notice must disclose the availability of a reasonable alternative standard to qualify for the reward (and, if applicable, the possibility of waiver of the otherwise applicable standard) in all plan materials describing the terms of a health-contingent wellness program. The DOL's compliance assistance guide includes a model notice that can be used to satisfy this requirement.
- ☑ **Americans with Disabilities Act (ADA) Wellness Program Notice**—Employers with 15 or more employees are subject to the ADA. Wellness programs that include health-related questions or medical exams must comply with the ADA's requirements, including an employee notice requirement. Employers must give participating employees a notice that tells them what information will be collected as part of the wellness program, with whom it will be shared and for what purpose, as well as the limits on disclosure and the way information will be kept confidential. The U.S. Equal Employment Opportunity Commission has provided a sample notice to help employers comply with this ADA requirement.