2024 Annual Employee Benefits Compliance Checklist
Administrators of Governmental and Church Plans

Considerations for Administrators of Governmental and Church Plans

Administrators of governmental plans and church plans that are not subject to the Employee Retirement Income Security Act of 1974 (ERISA) should review the following actions to be taken before the end of 2024 and address what to expect for 2025. The following checklist addresses plan amendments and other considerations for qualified plans, welfare plans, and executive compensation. A chart showing benefit and contribution limits for 2025 is on page 7.

Amendments and Considerations for All Qualified Retirement Plans

☐ **SECURE, SECURE 2.0 and CARES Act Amendments**: Amendments to conform to the SECURE Act of 2019 (SECURE Act), the Coronavirus Aid, Relief, and Economic Security Act of 2020 (CARES Act), and the SECURE 2.0 Act of 2022 (SECURE 2.0) must be adopted by ***December 31, 2026, for qualified plans or by December 31, 2029, for governmental plans.*** Plan administrators should carefully document changes implemented under the SECURE Act, CARES Act, and SECURE 2.0 so that amendments adopted later will accurately reflect administration.

☐ **Discretionary Plan Amendments**: Plan amendments reflecting discretionary changes that became effective in the current plan year (other than the SECURE Act, CARES Act, and SECURE 2.0 changes discussed above) must be ***adopted by the last day of the plan year*** (*e.g.,* December 31, 2024, for a calendar year plan). An increase in benefits, the addition of a new participating employer, and the addition of a new type of contribution are examples of discretionary changes that would need to be documented in plan amendments adopted by the end of the year. For defined benefit plans, advance participant notice may be required if an amendment significantly reduces the rate of future benefit accruals, such as a pension plan freeze.

☐ **Determination Letter Procedures**: The Internal Revenue Service (IRS) determination letter program permits determination letter requests only for initial plan qualification, plan termination, or in the case of a merged plan. The application for determination on a merged plan must generally be submitted before the end of the plan year following the year of the plan merger. For instance, if a merger occurred in 2023, the determination letter request must be submitted ***no later than December 31, 2024***, for a calendar year plan.

☐ **Determination Letter Procedures for 403(b) Plans**: The IRS expanded its determination letter program and will now issue determination letters on individually designed 403(b) plans. The IRS will accept determination letter applications for initial review based on the last digit of the plans sponsor's EIN as follows:

Last digit of plan sponsor EIN:	Determination letter application may be submitted starting:
1, 2, or 3	June 1, 2023

4, 5, 6, or 7	June 1, 2024
8, 9, or 0	June 1, 2025

☐ **Fiduciary Procedures**: Any entity sponsoring a retirement plan is a fiduciary of the plan. Best practice for investment fiduciaries responsible for selecting and monitoring plan investments is to meet on a regular basis (preferably quarterly) to review the performance of the plan's investments and the reasonableness of investment-related fees that are paid directly from plan assets. Minutes of such meetings recording the fiduciaries' decisions should be maintained and approved by the committee. Such fiduciaries should report annually to the corporate board or its delegate.

☐ **Forfeiture Accounts**: The IRS issued proposed regulations in February 2023 to address the timing and use of forfeitures that accumulate in a retirement plan, as follows:

- Forfeitures arising in a **defined contribution plan** may be used to pay plan administrative expenses, reduce employer contributions, or increase benefits to other participants' accounts. The regulations generally require that plan administrators use forfeitures no later than 12 months after the close of the plan year in which the forfeitures are incurred. The plan document must provide for the treatment of forfeitures. It is recommended that the plan provide more than one use of forfeitures, in the event that the amount of forfeitures exceeds the need under one option.

- Forfeitures arising in a **defined benefit plan** cannot be used to increase the benefits of any employees. However, the anticipated amount of forfeitures can be used in determining funding under the defined benefit plan.

- The proposed regulations will be effective after the IRS issues final regulations but can be relied on now. It is anticipated that final regulations will be effective on or after January 1, 2025. The proposed regulations offer a transition rule so that forfeitures incurred prior to January 1, 2025, are treated as having occurred in the first plan year on or after January 1, 2025.

Notices for Defined Contribution Plans

☐ **Default Investment Notice – Best Practice**: Many defined contribution plans that permit participant-directed investments also have a default investment alternative for participants who do not affirmatively elect how their account will be invested. For such plans, best practice is to provide a notice to participants and beneficiaries identifying the default investment alternative and informing them that their contributions will be allocated to such investment if they do not make an investment election in accordance with the plan's investment procedures. Generally, a notice should be provided before a participant's first investment into the default investment alternative. Plan administrators should also provide an annual notice prior to each subsequent plan year. For plans subject to ERISA, such notices must be provided ***at least 30 days before***

the initial investment and the start of each subsequent year. We recommend that administrators of non-ERISA plans also adopt such practice.

☐ **EACA Notice – Action Required 30 Days Before Plan Year**: An Eligible Automatic Contribution Arrangement (EACA) is an automatic enrollment plan that specifically permits a participant to withdraw automatic contributions made within 90 days after the first automatic contribution. Plan administrators must issue an EACA notice to participants at least 30 days before the beginning of the plan year.

Considerations for Health and Welfare Benefit Plans

☐ **Gag Clause Prohibition Compliance Attestation due December 31:** Group health plans may not enter into an agreement with a third-party administrator, a provider, a network of providers, or an entity offering access to a network of providers that includes a "gag clause." A "gag clause" is a contractual term that restricts a health plan from sharing specific information with another party. Generally, plans may not enter into agreements that would prevent the disclosure of data or cost, quality of care, or certain other information to active or eligible participants, beneficiaries, enrollees, plan sponsors, or referring providers, or would restrict the plan from sharing such information with a business associate. Plans must submit an annual attestation of compliance with this requirement to the Departments of Labor, Health and Human Services, and Treasury. The attestation is due ***by December 31*** of every year. The attestation is made online here.

☐ **Cafeteria Plan Amendments**: Amendments to Code section 125 cafeteria plans must be prospective. Any changes to a calendar year plan for the 2025 plan year, such as benefit options, must be adopted by December 31, 2024.

☐ **Nondiscrimination Testing**: Nondiscrimination testing should be performed. Such testing includes:

- Code section 125 testing for cafeteria plans;
- Code section 129 testing for dependent care assistance flexible spending arrangements; and
- Code section 105(h) testing for self-insured health plans.

☐ **Mental Health and Substance Use Disorder Benefit Parity**: The Departments of Labor, Treasury, and Health and Human Services recently finalized regulations under the Mental Health Parity and Addiction Equity Act of 2008. Action is required by group health plans offering mental health and/or substance use disorder benefits to comply with the regulations in 2025. Significant changes include the following:

- Plan fiduciary certification that the fiduciary prudently selected and monitored the service provider performing the plan's nonquantitative treatment limitations (NQTL) analysis.

- Revision of the NQTL analysis requirements, including a requirement to collect data to identify any material differences in access to mental health and substance use disorder (MH/SUD) benefits as compared to medical and surgical benefits. Immediate action is required to ensure that plans comply with the NQTL analysis requirement in 2025.

- Requirement that plan definitions of MH/SUD be consistent with the most current World Health Organization's International Classification of Diseases adopted by the Department of Health and Human Services and/or the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders.

- New standard for "meaningful benefits" for MH/SUD conditions.

☐ **Prescription Drug Data Collection (RxDC) and Health Care Cost Reporting**: Pharmacy Benefit and Drug Costs Reporting (RxDC Reporting) is a reporting requirement implemented under the Consolidated Appropriations Act, 2021 (CAA). Group health plans and health insurance issuers offering group, individual, and self-funded health insurance coverage, as well as student health plans, must report information about prescription drugs and healthcare spending to the Departments of Labor, Health and Human Services, and Treasury. Reporting instructions are found here.

☐ **Reporting Health Plan Coverage to the IRS and Employees**: Code section 6056 requires Applicable Large Employers to report information about employer-sponsored health coverage to the IRS and employees. An Applicable Large Employer is an employer that employs at least 50 full-time employees, including full-time equivalent employees. In addition, sponsors of self-insured health plans that provide minimum essential coverage must file an annual return with the IRS and provide statements to employees. Returns are due to the IRS ***by March 31, 2025,*** and **must be filed electronically**. Statements to employees are generally due January 31, 2025 (no later than March 1, 2025).

☐ **Patient-Centered Outcomes Research Institute (PCORI)**: The PCORI fee applicable to health insurers and self-insured health plan sponsors is paid using IRS Form 720 and is due by July 31 of the calendar year following the last day of the plan year.

☐ **Transparency in Coverage**: Group health plans and issuers must disclose (i) cost-sharing information for a covered item or service from specific providers to participants and beneficiaries through an internet self-service tool, and (ii) pricing information to the public through three machine-readable files. Disclosure must include payment rates between plans or issuers and providers, the unique allowed amounts a plan or issuer used and associated billed charges for out-of-network providers, and pricing information for prescription drugs. Sponsors of self-insured plans should coordinate compliance with their third-party administrators.

☐ **Fee Disclosure**: Under the CAA, "covered service providers" to group health plans must disclose to the plan's fiduciary the direct and indirect compensation that the covered service provider expects to receive from providing services to the plan. Covered service providers include persons who provide "brokerage services" or "consulting" to ERISA-covered group health plans and reasonably expect to receive $1,000 or more in direct or indirect compensation

in connection with providing those services. Before entering into, extending, or renewing a service agreement with a covered service provider, plan fiduciaries should ask to see the ERISA section 408(b)(2) disclosure.

☐ **Notice for No Surprises Act**: Group health plans and insurers were required to provide the initial notice regarding patient rights under the No Surprises Act by January 1, 2022. The annual notice must be made publicly available, posted on the plan's website, and included in explanations of benefits. The government provided a model notice to meet the disclosure requirements that can be used to ensure good-faith compliance with the disclosure requirement. The model notice can be found here.

☐ **ACA Affordability Requirements**: The IRS increased the ACA affordability percentage for 2025 to 9.02%. To meet the ACA affordability requirement in 2025, Applicable Large Employers must offer at least one health plan option where employee-only coverage is less than 9.02% of the employee's household income.

☐ **Medicare Part D Notices**: Employers offering group health plans providing prescription drug coverage to individuals who are eligible for Medicare must provide a notice of creditable or non-creditable coverage to such individuals ***before October 15*** of each year. Such employers are also required to disclose to the Centers for Medicare and Medicaid Services (CMS) whether their prescription drug coverage is creditable within ***60 days after the beginning of the plan year***. Disclosure to CMS is made through the CMS creditable coverage disclosure webpage.

☐ **Student Loan Repayment Plans**: The CAA included a provision allowing employers to make tax-free payments on their employees' student loans of up to $5,250 per year through January 1, 2026. This is a five-year extension of a provision originally enacted in the CARES Act. The student loan repayment plan must be operated pursuant to a written plan document.

☐ **Summary of Benefits and Coverage**: Insurers and group health plans must provide a Summary of Benefits and Coverage (SBC) for each coverage option offered by the insurer or plan. Participants who enroll mid-year must be provided an SBC within 90 days of enrollment. Calendar year plans have already complied, or are in the process of complying, with this requirement. The SBC should be provided at the beginning of open enrollment each year if renewal is not automatic or at least 30 days before the beginning of each plan year if renewal is automatic. Plans also must provide 60 days' notice of changes to the content of an SBC.

☐ **Annual Notices for Group Health Plans**: In addition to the notices described above, employers must continue to provide participants with the following annual group health plan notices:

- Children's Health Insurance Program Reauthorization Act Notice
- Women's Health and Cancer Rights Act Notice
- Newborns' and Mothers' Health Protection Act Notice
- Primary Care Provider Patient Protection Notice
- ADA Wellness Program Notice
- HIPAA Special Enrollment Notice

Stock-Based, Executive, and Director Compensation

☐ **For Deferred Compensation That Vests in 2025 or Later Years, Review and Correct any Code section 409A Violations**: Employers should review all nonqualified deferred compensation plans or agreements, under which compensation vests in 2025 or later years, to ensure that there are no Code section 409A violations. If employers identify the violation ***before the end of 2024***, then documentary violations with respect to unvested amounts generally can be corrected by ***December 31, 2024***, without penalties. Code section 409A corrections should correspond to methods described in formal guidance and should be reviewed by legal counsel.

☐ **For Tax-Exempt* and Governmental Entities That Have Code section 457(f) Arrangements**: Such employers should review all employment agreements and Code section 457(f) arrangements for deferrals of compensation that vest in 2024 to confirm whether such amounts have been included in the employee's wages for 2024 and whether applicable FICA and income tax withholding occurred. If inclusion and withholding for any deferrals of compensation that vested in 2024 (or prior years) have not already occurred, action should be taken ***by December 31, 2024,*** in consultation with legal counsel.

*Churches, conventions or associations of churches, and elementary and secondary schools that are controlled, operated, or principally supported by a church, or convention or association of churches are not eligible to maintain Code section 457(f) arrangements.

Contribution and Benefit Limits for 2025		
Description	**2024 Limit**	**2025 Limit**
Compensation Cap	$345,000	$350,000
Elective Deferral Limit for 401(k) plans, SEPs, 403(b) plans, and 457(b) plans	$23,000	$23,500
Catch-Up Contributions for Individuals Age 50 and Above	$7,500	$7,500
Catch-Up Contributions for Individuals Who Attain Age 60, 61, 62, or 63 in 2025	N/A	$11,250
Defined Benefit Maximum Annual Accrual	$275,000	$280,000
Defined Contribution Maximum Annual Addition	$69,000	$70,000
Highly Compensated Employee Threshold	$155,000	$160,000
Key Employee in Top-Heavy Plans Threshold	$220,000	$230,000
ESOP Threshold for determining maximum account balance subject to 5-year distribution period Regular Limit Additional Amount to Lengthen 5-Year Period	 $1,380,000 $275,000	 $1,415,000 $280,000
SEP Compensation Threshold for Participation	$750	$750
SIMPLE IRA Salary Reduction Contribution	$16,000	$16,500
Catch-Up Contributions for SIMPLE IRAs or SIMPLE 401(k) plans for Individuals Age 50 and Above	$3,500	$3,500
Social Security Taxable Wage Base	$168,600	$176,100
Health Flexible Spending Account Maximum (Cafeteria Plans) Carryover Limit	$3,200 $640	$3,300 $660
Health Savings Account Maximum Contribution Self-only Coverage Family Coverage	 $4,150 $8,300	 $4,300 $8,550
Annual Out-of-Pocket Maximum for Marketplace Plans Self-only Coverage Family Coverage	 $9,450 $18,900	 $9,200 $18,400
Annual Minimum Deductible for High-Deductible Health Plans Self-only Coverage Family Coverage	 $1,600 $3,200	 $1,650 $3,300
Annual Out-of-Pocket Maximum for High-Deductible Health Plans Self-only Coverage Family Coverage	 $8,050 $16,100	 $8,300 $16,600

If you have any questions regarding this checklist, please contact any member of the Employee Benefits & Executive Compensation Section at Williams Mullen.

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