COMPLIANCE OVERVIEW

Common Health Plan Compliance Mistakes to Avoid

Employers that sponsor group health plans are subject to many different compliance requirements under federal law. Keeping track of these various requirements can be challenging, even for the most attentive employers. Mistakes can easily occur, which may trigger penalties, excise taxes, enforcement action or lawsuits, depending on the type of mistake. To help avoid these potential consequences, employers should regularly review their compliance with employee benefits laws and implement strategies to address any compliance gaps.

There are some mistakes that employers commonly make when it comes to health plan compliance, which include the following:

- Not having an official plan document or providing participants with a summary plan description (SPD);
- Allowing pre-tax contributions without a Section 125 plan document;
- Failing to file a Form 5500; and
- Not offering affordable health plan coverage to full-time employees.

LINKS AND RESOURCES

- U.S. Department of Labor self-compliance tool, which addresses compliance with select federal laws
- IRS questions and answers on the ACA's pay-or-play rules
- DOL's Reporting and Disclosure Guide for Employee Benefit Plans, which covers basic requirements under ERISA

Employee Benefits Laws

Employers are subject to numerous employee benefits laws, including the following:

- ERISA (applies to all private-sector employers, except churches);
- Section 125 (applies to all employers that allow pre-tax contributions);
- COBRA (applies to employers with 20 or more employees); and
- ACA's pay-or-play rules (applies to employers with 50 or more full-time employees, including full-time equivalents).

Common Mistakes

- Forgetting to provide annual notices, such as the CHIP notice;
- Overlooking nondiscrimination testing;
- Failing to send a separate COBRA election notice to a spouse residing at a different address; and
- Not disclosing the availability of an alternative standard for qualifying for a reward under a health-contingent wellness program.

1. Not having an official plan document or providing plan participants with an SPD

ERISA sets minimum standards for employee benefit plans maintained by private-sector employers. Among other requirements, ERISA requires employers to maintain an official plan document for their employee benefit plans and provide plan participants with an SPD. Employers often overlook these requirements or mistakenly think documents provided by an insurance carrier or third-party administrator (TPA) will satisfy ERISA's requirements on their own. There are no specific penalties under ERISA for failing to adopt an official plan document or provide participants with an SPD. However, not having these documents can have serious consequences for an employer, including the following:

- An employer may be charged up to **$110 per day** if it does not provide the SPD or other plan documents within 30 days after an **individual's request**. These penalties may apply even where a plan document or SPD does not exist;
- Failure to have a plan document (or failing to distribute an SPD) may **put an employer at a disadvantage if a participant brings a lawsuit for benefits under the plan**. Without these documents, it may be difficult for an employer to prove that the plan's terms support benefit decisions; and
- The U.S. Department of Labor (DOL) will almost always ask to see a copy of the plan document and SPD, in addition to other plan-related documents, if it selects an employer's health plan for audit. If an employer cannot respond to the DOL's document requests, then additional document requests, interviews, on-site visits or even DOL enforcement actions may be triggered. Also, the DOL may charge a plan administrator up to **$195 per day (up to a maximum of $1,956 per request) if it does not provide plan documentation to the DOL upon request**.

2. Allowing pre-tax contributions without a Section 125 plan document

Internal Revenue Code (Code) Section 125 allows employers to establish a type of tax savings arrangement, called a Section 125 plan or cafeteria plan, for their employees. A Section 125 plan provides employees with an opportunity to pay for certain benefits on a pre-tax basis, allowing them to increase their take-home pay. To avoid taxation, the Section 125 plan must meet the specific requirements of Code Section 125 and underlying IRS regulations. One of these requirements is that a Section 125 plan must be maintained pursuant to a **written plan document that is adopted by the employer on or before the first day of the plan year.**

According to the IRS' 2007 proposed regulations, if there is no written plan document in place (or if the written plan document does not comply with the IRS' content or timing requirements), employees' elections between taxable and nontaxable benefits will result in **taxable income to the employees**.

3. Overlooking nondiscrimination testing

The Code imposes nondiscrimination requirements on certain types of employee benefits to ensure employers do not impermissibly favor their highly compensated employees. These rules currently apply to **self-insured health plans** and **Section 125 plans**. The nondiscrimination requirements for fully insured health plans have been delayed indefinitely.

In general, a plan will not have problems passing any applicable nondiscrimination test when the employer treats all its employees the same for purposes of plan coverage (for example, all employees are eligible for the plan, and the plan's eligibility rules and benefits are the same for all employees). However, treating employees differently may make it more difficult for a plan to pass the applicable nondiscrimination tests. The following are examples of plan designs that may cause problems with nondiscrimination testing:

- Only certain groups of employees are eligible to participate (for example, only salaried or management employees);
- The plan has different employment requirements for eligibility (for example, waiting periods and entry dates) for different employee groups;
- The employer's contribution varies based on employee group; and
- The employer maintains separate health plans for different groups of employees.

Employers often overlook nondiscrimination testing when considering a potentially problematic plan design. If a self-insured health plan or Section 125 plan is discriminatory, highly compensated employees will lose certain tax benefits under the plan.

4. Failing to file a Form 5500

Employers that are subject to ERISA must file an annual report (Form 5500) with the DOL for their employee benefit plans. The Form 5500 must be filed by the last day of the seventh month following the end of the plan year unless the employer requests an extension. For health plans that operate on a calendar-year basis, the nonextended deadline is July 31. Small welfare benefit plans (i.e., fewer than 100 participants) that are unfunded or fully insured (or a combination of unfunded and insured) are exempt from the Form 5500 filing requirement.

The DOL can assess penalties of up to **$2,739 per day** for each day an administrator fails or refuses to file a complete Form 5500. However, the penalties may be waived if the noncompliance was due to reasonable cause. Also, the DOL maintains a voluntary correction program for late or missing Forms 5500. If an employer has not been notified by the DOL of a failure to file Form 5500, it can use this program to correct its Form 5500 noncompliance and pay a reduced penalty.

5. Not offering affordable health coverage to full-time employees

The Affordable Care Act (ACA) requires applicable large employers (ALEs) to offer affordable, minimum-value health coverage to their full-time employees (and their dependents) or potentially pay a penalty to the IRS. This coverage mandate is also known as the "pay-or-play" rules. Small employers that are not ALEs (i.e., those with fewer than 50 full-time employees, including full-time equivalent employees) are not subject to the ACA's pay-or-play rules.

An ALE may be subject to a pay-or-play penalty if at least one full-time employee receives a premium tax credit for purchasing individual health coverage through an Exchange and the ALE:

- Did not offer health plan coverage to at least 95% of full-time employees and their dependents;
- Offered health plan coverage to at least 95% of full-time employees but not to the specific full-time employee receiving the credit; or
- Offered health plan coverage to full-time employees that was unaffordable or did not provide minimum value.

Common mistakes that ALEs make when it comes to the ACA's pay-or-play rules include **not following the** IRS' rules for identifying full-time employees **and offering coverage that is unaffordable.** An ALE's health coverage is considered affordable if the employee's required contribution for the lowest-cost self-only coverage that provides minimum value does not exceed 9.5% (as adjusted) of the employee's household income for the taxable year. For plan years beginning in 2025, the adjusted affordability percentage is **9.02%**.

Depending on the circumstances, one of two penalties may apply under the pay-or-play rules: the 4980H(a) penalty or the 4980H(b) penalty. These penalties are as follows:

1. The 4980H(a) penalty applies when an ALE does not offer coverage to substantially all full-time employees. In this case, the monthly penalty assessed on the ALE is equal to the ALE's number of full-time employees (excluding 30) multiplied by one-twelfth of $2,000 (as adjusted). For 2025, the adjusted penalty amount is **$2,900**; and
2. The 4980H(b) penalty may apply if an ALE offers coverage to substantially all full-time employees but does not offer coverage to all full-time employees or if it offers coverage that is unaffordable or does not provide minimum value. The monthly penalty assessed on an ALE for each full-time employee who receives a subsidy is one-twelfth of $3,000 (as adjusted) for any applicable month. For 2025, the adjusted penalty amount is **$4,350**. However, the total penalty for an ALE is limited to the 4980H(a) penalty amount.

6. Failing to send a separate COBRA election notice to a spouse living at a different address

COBRA requires employers with 20 or more employees to offer continuation coverage to covered employees, spouses and dependent children when their health coverage would otherwise end due to certain events, called qualifying events. COBRA also requires employers to provide specific notices to employees and their covered family members at certain times, one of which is the COBRA election notice. This notice must be provided to each qualified beneficiary after an employer learns that a qualifying event has occurred. It informs qualified beneficiaries of their right to elect COBRA coverage, how to elect and pay for the coverage, and the duration of COBRA coverage.

An employer may use a single COBRA election notice for qualified beneficiaries who reside at the same address. However, if an employer knows that a spouse lives at a different address (based on the most recent information available), the employer must **send a separate COBRA election notice to the spouse.** Employers often overlook this detail and fail to send a separate COBRA election notice to a spouse living at a different address.

Failing to provide a COBRA election notice carries a potential penalty of **$110 per day** under ERISA. It could also trigger an **excise tax of $100 per day** for each qualified beneficiary impacted by the failure during the noncompliance period. If a legal dispute arose, a court would most likely view the spouse as still having a 60-day window for electing COBRA. The court could also award attorney fees and other relief, such as liability for any medical expenses incurred.

7. Offering a health-contingent wellness program but not disclosing the availability of an alternative standard for qualifying for the program's reward

A workplace wellness program that is provided as part of an employer's group health plan must comply with HIPAA's nondiscrimination requirements. These requirements mainly apply to health-contingent wellness programs, which require individuals to satisfy standards related to health factors to obtain rewards (e.g., complete an exercise program, refrain from smoking or vaping, or attain certain results on biometric screenings).

Under HIPAA, a health-contingent wellness program's reward must be available to all similarly situated individuals. To meet this requirement, health-contingent wellness programs must provide a reasonable alternative standard (or waiver of the otherwise applicable standard) in certain circumstances. Employers are required to disclose the availability of a reasonable alternative standard (or, if applicable, waiver of the otherwise applicable standard) to qualify for the reward in all plan materials describing the terms of a health-contingent wellness program. The disclosure must include contact information for obtaining the alternative standard and a statement that recommendations of an individual's personal physician will be accommodated. For health-contingent wellness programs that require individuals to meet a health outcome to obtain a reward, this notice must also be included when an individual is informed that they did not satisfy the program's outcome-based standard.

Violations of HIPAA can trigger **excise taxes of $100 per day** for each individual impacted by the failure, as well as possible DOL enforcement action and civil penalties. Additionally, in the event of a lawsuit, a court may require the employer to reimburse impacted plan participants for any extra expenses they incurred as a result of the employer's failure to offer an alternative standard.

8. Taking into account employees' (or spouses') Medicare coverage

When individuals have Medicare coverage and employer-sponsored health coverage, each type of coverage is called a "payer." Medicare's coordination of benefits rules decide which payer pays first on a health care claim (that is, pays primary). For example, health plans sponsored by employers with 20 or more employees are typically the primary payers for individuals who are entitled to Medicare due to age. The Medicare Secondary Payer rules include requirements for employers that sponsor group health plans that are primary to Medicare. These requirements are intended to protect Medicare's secondary payer status. For example, when an employer's group health plan is the primary payer, Medicare-eligible employees and spouses cannot be excluded from health plan coverage or discouraged from enrolling in coverage. Also, employers cannot offer any financial or other incentive for an individual entitled to Medicare to not enroll (or terminate enrollment) in a health plan that would pay primary. A violation of these restrictions can trigger financial penalties of up to **$11,524**.

9. Forgetting the Medicare Part D disclosures

Employers with group health plans that provide prescription drug coverage to Medicare Part D eligible individuals are subject to disclosure requirements under Medicare Part D. Each year, employers must disclose to individuals who are eligible for Medicare Part D and to the Centers for Medicare and Medicaid Services (CMS) whether the health plan's prescription drug coverage is "creditable" (i.e., its actuarial value equals or exceeds the actuarial value of the standard Medicare Part D prescription drug coverage). The disclosure to individuals must be made by **Oct. 15 each year**, which is the start of the Medicare Part D annual election period. The disclosure to CMS must be made within **60 days of the beginning of the plan year**.

There are **no specific penalties** associated with these annual notice requirements (except for employers that are claiming a retiree drug subsidy). However, failing to comply with the individual notice requirement may be **detrimental to employees**. This is because knowing whether an employer's coverage is creditable helps employees make informed decisions regarding their Medicare enrollment. Medicare beneficiaries who are not covered by creditable prescription drug coverage and do not enroll in Medicare Part D when first eligible will likely pay higher premiums if they enroll at a later date.

10. Not providing the annual Children's Health Insurance Program (CHIP) notice

The Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) permits states to offer eligible low-income children and their families a premium assistance subsidy to help pay for employer-sponsored group health coverage. CHIPRA imposes an annual notice requirement on employers that maintain group health plans in states that provide premium assistance subsidies under a Medicaid plan or a CHIP plan. An employer is subject to this annual notice requirement if its group health plan covers participants who reside in a state that provides a premium assistance subsidy, regardless of the employer's location. Employers that fail to send the required notice may be subject to penalties of **$145 per day**.