COMPLIANCE OVERVIEW

Avoiding Common Open Enrollment Compliance Mistakes

Employers commonly make several mistakes during open enrollment, a busy and stressful period that comes with a high potential for errors. For employees, these mistakes can result in confusion and frustration, as well as missed opportunities to make the most of their benefit options. In addition to employee dissatisfaction, these mistakes can lead to potential legal liability for employers.

This Compliance Overview explains five common compliance mistakes employers should avoid making at open enrollment time, including:

1. Not communicating benefit changes clearly to eligible employees;
2. Failing to provide certain health plan notices;
3. Not distributing open enrollment materials to all eligible individuals, such as COBRA enrollees;
4. Underestimating the importance of election deadlines; and
5. Not describing the availability of a reasonable alternative standard for health-contingent wellness programs.

LINKS AND RESOURCES

- Revenue Procedure 2025-19, which includes the inflation-adjusted limits for health savings accounts (HSAs) for 2026
- Model notices for group health plans, including the Women's Health and Cancer Rights Act (WHCRA) notice
- Model COBRA notices for group health plans

Section 125 Election Rules

- Most employers allow employees to pay their premiums on a pre-tax basis through a Section 125 cafeteria plan.
- Participant elections under a Section 125 plan must be made before the first day of the plan year.
- Elections are generally irrevocable until the beginning of the next plan year, with limited exceptions.

Open Enrollment Notices

- Employers should provide certain health plan notices at open enrollment time.
- Some notices apply to all group health plans.
- Other notices only apply to certain group health plans, based on plan design and coverage.
- Federal agencies have provided model notices for many notice requirements.

1. Mistake: Not Communicating Benefit Changes Clearly

Employers frequently change their employee benefit offerings ahead of open enrollment to stay competitive and increase employee satisfaction. In addition to offering new benefit options, the terms of existing employee benefit plans can vary from year to year. Health plan cost sharing (e.g., deductibles, copayments and coinsurance) often changes from one year to the next, along with the plan's coverage for specific benefits. These changes may be the result of a plan design decision by the employer, a health insurance issuer or third-party administrator (TPA), or they may be mandated by federal or state laws. For example, federal law imposes cost-sharing limits on high deductible health plans that are compatible with HSAs and these limits are adjusted annually for inflation. Also, fully insured benefits must comply with changes to state insurance laws, which mandate coverage for certain benefits, providers and individuals.

Before the start of open enrollment, employers should ensure they have identified all important benefit changes for the upcoming plan year. These changes should be **clearly communicated to employees at open enrollment time** so they can make informed elections. Effective communication is critical to educate and inform employees about their benefit options. Some key strategies include starting early, selecting a mix of appropriate communication channels, keeping the information simple and digestible, and using real-world examples.

For benefits subject to the Employee Retirement Income Security Act (ERISA), these changes should be communicated through an **updated Summary Plan Description (SPD) or a Summary of Material Modifications (SMM)**. Also, following the written plan document in the day-to-day operations of the plan is a fiduciary duty under ERISA. Employers should be familiar with their written plan document and periodically review the document to make sure it remains current.

2. Mistake: Failing to Provide Required Health Plan Notices

Employers that sponsor health plans should provide certain benefit notices in connection with their plans' open enrollment periods. Some of these notices must be provided at open enrollment time, such as the Summary of Benefits and Coverage (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.

The following health plan notices are often provided in connection with annual open enrollment:

- **SBC**—This must be provided to participants who enroll or reenroll during an open enrollment period. More information on the SBC, including the SBC template, is available here;
- **SPD**—This must be provided to new health plan participants within 90 days of the date their plan coverage begins. Employers may include the SPD in their open enrollment materials to make sure employees who newly enroll receive the SPD on a timely basis. Also, an employer should include the SPD with its enrollment materials if it includes notices that are required to be provided at the time of enrollment, such as the WHCRA notice. In addition, an updated SPD must be provided to participants at least every five years, if material modifications have been made during that period. If no material modifications have been made, an updated SPD must be provided at least every 10 years;
- **Children's Health Insurance Program (CHIP) Notice**—Health plans covering residents in a state that provides a premium subsidy to low-income children and their families under a Medicaid plan or CHIP must send an annual 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 Notice**—COBRA applies to health plans sponsored by employers with 20 or more employees. 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;
- **WHCRA Notice**—Plans and issuers must provide notice of participants' rights to mastectomy-related benefits under WHCRA at the time of enrollment and on an annual basis. The notice is typically included in the plan's SPD or in the benefits summary provided by the issuer or TPA. Model language for this disclosure is available on the DOL's website;
- **Medicare Part D Notice**—Employers must disclose to individuals who are eligible for Medicare Part D whether the health plan's prescription drug coverage is creditable. 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 here;
- **Grandfathered Plan Notice**—Employers with grandfathered plans must 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;
- **Notice of Patient Protections**—Health plans that require participants to designate a participating primary care provider must provide a notice of patient protections whenever the SPD or similar description of benefits is provided to a participant. This notice is often included in the SPD or benefits summary provided by the issuer or TPA. The DOL has provided a model notice;
- **Health Insurance Portability and Accountability Act (HIPAA) Privacy Notice**—Self-insured health plans must maintain and provide their own Privacy Notices. (Note that special rules apply for fully insured plans. Under these rules, the health insurance issuer, and not the health plan itself, is primarily responsible for the Privacy Notice.) Self-insured health plans are required to send Privacy Notices at certain times, including to new enrollees at the time of enrollment. Thus, the Privacy Notice should be provided with the plan's open enrollment materials. 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. The Department of Health and Human Services has model Privacy Notices for health plans to choose from; and
- **HIPAA Special Enrollment**—At or prior to the time of enrollment, a group health plan must provide each eligible employee with a notice of their special enrollment rights under HIPAA. This notice should be included with the plan's enrollment materials. It is often included in the health plan's SPD or benefits summary provided by the plan's issuer or TPA.

Federal law allows employers to provide most health plan notices electronically, provided they comply with certain rules regarding electronic delivery that are designed to ensure actual receipt of the information.

3. Mistake: Not Distributing Open Enrollment Materials to All Eligible Individuals

Employers should ensure that open enrollment materials are provided to all individuals who are eligible to make benefit elections. Distributing open enrollment information to eligible active employees is typically straightforward, although employers should confirm they include any employees who are newly eligible for coverage, such as those moving from

part-time to full-time positions. Employers should also provide open enrollment materials to individuals who are eligible to make coverage elections but are not active employees, such as:

- Employees on leave or furlough who are benefits-eligible (e.g., employees on leave under the federal Family and Medical Leave Act, or FMLA); and
- COBRA qualified beneficiaries.

Eligible individuals should receive information on available benefits and costs, procedures for making elections and election deadlines. Employers can deliver open enrollment materials in a variety of ways, including delivery by hand in the workplace, mailing to a last-known address, emailing or posting to an internal company website. As a best practice, employers should implement a multichannel communication strategy to effectively distribute open enrollment information. Also, employers should maintain records showing when and how open enrollment information was provided to help avoid liability in the event a dispute over benefits arises.

4. Mistake: Underestimating the Importance of Election Deadlines

An employer's open enrollment period typically occurs sometime during the three-month period before the beginning of the plan year, and lasts two weeks or longer, depending on the employer's preferences. Open enrollment periods should end well before the upcoming plan year. This gives an employer time to take care of administrative tasks, including confirming elections, processing enrollments and performing preliminary nondiscrimination testing, if applicable, before the upcoming plan year starts.

Most employers allow their employees to pay their welfare benefit plan premiums on a pre-tax basis through a Section 125 cafeteria plan. Generally, elections under a Section 125 cafeteria plan must be effective on a prospective, not retroactive, basis. Thus, the elections that employees make during open enrollment should take effect for the upcoming plan year. Also, to comply with federal tax law, employees' elections generally must be **irrevocable** until the beginning of the next plan year. This means that employees ordinarily cannot make changes to their pre-tax elections during a plan year. Federal tax law permits employees to change their pre-tax elections during the year only when certain events occur, which are often referred to as "qualifying life events" (e.g., losing eligibility for other health coverage, getting married or having a baby).

Despite an employer's best efforts to ensure a successful open enrollment, employees may still miss the enrollment deadline or mistakenly select the wrong benefits. **Addressing these errors after the plan year begins is problematic due to the irrevocability requirement for Section 125 plans.** Informal guidance suggests that, in rare circumstances, the IRS may allow corrections under the "doctrine of mistake" with clear and convincing evidence. However, even if the employer determines an employee's election was truly an error, allowing the correction can be risky because of the high standard of "clear and convincing" evidence.

Allowing an employee to change their elections after the plan year starts without experiencing a qualifying life event can be problematic for reasons other than federal tax compliance. For example, it may create a precedent for the plan's administration and require the employer to make similar exceptions for other employees. Also, treating some employees differently or more favorably than others may raise concerns regarding impermissible discrimination or favoritism in the workplace. Moreover, health insurance issuers typically have enrollment restrictions and may not allow changes outside of designated enrollment periods. To minimize the need for post-open enrollment corrections, employers should encourage employees to enroll early and provide clear communication of election processes and deadlines.

5. Mistake: Not Describing the Availability of a Reasonable Alternative Standard for Health-contingent Wellness Programs

Health plans that impose a surcharge (or provide a reward) based on a health-related standard (e.g., not using tobacco or meeting a specific exercise target) must comply with HIPAA's nondiscrimination requirements for wellness programs. Among other HIPAA requirements, these health-contingent wellness programs must provide a **reasonable alternative standard** for qualifying for the full reward (or avoiding the surcharge) for anyone who does not meet the initial health-related standard. For example, if a health plan imposes a tobacco surcharge, it must provide a reasonable alternative standard for avoiding the surcharge for individuals who are tobacco users, such as attending a class on quitting tobacco use.

The availability of a reasonable alternative standard must be **disclosed in all plan materials describing the surcharge or reward**. This disclosure must also be included in any notice that an individual did not satisfy the wellness program's initial health-related standard. 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.

Numerous class-action lawsuits have been filed against employers alleging that health plan premium surcharges related to tobacco use violate HIPAA's nondiscrimination requirements. In general, the lawsuits assert that the health plans violated HIPAA's nondiscrimination rules by not offering a reasonable alternative standard to avoid the surcharge (or only applying the premium reduction on a prospective basis after completing the alternative standard) and not describing the availability of the alternative standard in all plan materials.

Given this increased scrutiny, employers that offer health-contingent wellness programs should ensure they comply with HIPAA's nondiscrimination requirements, including explaining to participants that a reasonable alternative standard is available for avoiding the surcharge (or qualifying for the reward).