AssuredPartners

# Plan Termination

**May 2025**

Terminating a health and welfare benefit plan midyear involves more than simply ending coverage; it triggers a range of compliance considerations under federal and, in some cases, state law. Employers must carefully navigate obligations under ERISA, the Internal Revenue Code, COBRA, and the Affordable Care Act, amongst others, while also managing practical concerns such as notice requirements, contractual obligations with carriers or administrators, and potential impacts on employees' access to alternative coverage. This summary outlines key legal and administrative issues employers should evaluate when contemplating midyear termination of a plan to help ensure a compliant and orderly transition.

## Plan Documentation – Authority to Terminate

### ERISA

ERISA §402 requires that the written plan document contain "a procedure for amending [the] plan, and for identifying the persons who have authority to amend the plan." Although the ability to amend the plan is generally considered to include the right to terminate the plan, employers should ideally include language in their ERISA plan document and SPD reserving the right and authority of the plan sponsor (employer) to terminate the plan at any time.

The termination should be written and formally adopted to officially terminate the plan. Then assuming plan termination provisions exist in the plan document, any termination procedures set forth in the documentation should be followed.

### Cafeteria Plans - Code §125

The employer's authority to amend or terminate a plan extends to the Code §125 cafeteria plan as well. In addition to the ERISA plan document and SPD, the employer's §125 cafeteria plan document should include language giving the employer the authority to terminate the plan at any time for any reason.

### Termination Timing - Why It Matters

Neither ERISA nor the Internal Revenue Code prohibits an employer from terminating a group health plan midyear. However, doing so can present a range of legal, administrative, and practical challenges. For instance, employers sponsoring a health FSA must assess how plan termination will impact participant forfeitures and potential compliance with applicable cafeteria plan rules. Applicable Large Employers (ALEs) that continue operations following a midyear termination must also evaluate their ongoing obligations under the Affordable Care Act's employer shared responsibility provisions. Additionally, terminating a plan midyear may give rise to

contractual complications with insurers or third-party administrators. Whenever feasible, employers should consider terminating group health plans at the end of the plan year to minimize disruption.

## General Notice Requirements

**ERISA Summary of Material Modifications (SMM)** - ERISA requires plan administrators to provide timely notice to plan participants when a material modification to the plan is made. Specifically, the plan administrator must distribute an SMM or an updated SPD no later than 60 days after the modification's adoption when the modification constitutes a material reduction in covered benefits or services which includes a termination of the group health plan itself.

**Summary of Benefits and Coverage (SBC)** - The ACA requires group health plans to provide a separate notice of material modifications when the plan is modified in a way that would affect the contents of the SBC. Unlike the SMM deadline addressed above, the SBC notice of material modification must be provided 60 days prior to the effective date of the change. An employer can satisfy both the SMM and SBC notification requirements by distributing a single complete notice that satisfies both deadlines (i.e., provided at least 60 days before the effective date of the modification).

### Notices – Recommended Approach

Employers should make every attempt to provide notice of an upcoming plan termination to participants as early as administratively practicable, but at least 60 days in advance of the effective date of termination. Not only does this help ensure legal compliance but it gives participants more time to secure other coverage and utilize any remaining funds in an HRA or health FSA prior to being forfeited.

## COBRA Continuation Coverage

The termination of a group health plan by an employer does not trigger a COBRA continuation right. When the group health plan terminates, there is no further plan under which to offer COBRA continuation. This is generally true for fully-insured plans and self-funded plans, as well as under both federal COBRA and state continuation.

When an employer stops providing any group health plan coverage, any qualified beneficiaries who are currently receiving COBRA coverage will lose their COBRA benefits upon termination of all group health plans. For this purpose, the term "employer" includes all related employers that are part of the same controlled group or affiliated service group. If another employer in the same controlled group or affiliated service group still offers group health plan coverage, existing COBRA participants must be offered COBRA under the remaining group health plan(s). Additionally, if a successor employer emerges following a merger, acquisition, or other restructuring, the successor employer may be required to continue COBRA coverage for any existing qualified beneficiaries.

Qualified beneficiaries receiving COBRA coverage who lose their COBRA following the termination of the group health plan must be issued a COBRA Termination Notice, which explains that their COBRA coverage is ending before the maximum coverage period expires.

## Claims Run-Out and Handling Remaining Plan Assets

Upon termination of the plan, the employer will need to offer a run-out period for claims that were incurred prior to plan termination, but submitted after the plan is terminated. The plan is obligated to pay out claims incurred during the coverage period in accordance with the plan's stated claims submission deadlines and ERISA claims and appeals procedures. For a health FSA, HRA or DCAP, the run-out period is often short (e.g., 60-90 days following the end of the plan year); but for other benefits, the plan may be required to process claims submitted within 12 months or more from the time the claim was incurred.

Once all claims or requested reimbursements have been processed, the employer must consider how it will handle any remaining plan assets, including leftover amounts attributable to participant contributions (e.g., any health FSA forfeitures remaining after plan termination may be plan assets). ERISA's exclusive benefit rule requires that plan assets be used for the exclusive purpose of providing benefits to plan participants and defraying reasonable administrative expenses. To the extent that all employee contributions were exhausted, the employer can likely keep any remaining amounts. However, to the extent that there are any remaining employee contributions, the plan is required to distribute the amounts back to plan participants, generally distributing the amounts on a uniform basis rather than based on participant utilization.

## Reporting and Disclosure Requirements

**Form 5500 & Summary Annual Report (SAR)** - Group health plans that are required to file Form 5500 must submit a final Form 5500 upon the plan's termination. The final Form 5500 is generally due at the regular time following the end of the plan year. In some situations, this may be a short plan year (i.e., less than 12 months). The final plan year concludes on the date when all plan assets (if any) have been distributed, or the date on which no participants remain covered under the plan, whichever is later. A terminated plan files a final Form 5500 by checking Part I, Box B of the Form 5500 main body and otherwise completes the main body as normal.

Additionally, plans that are subject to SAR requirements must distribute a final SAR in connection with the terminated plan.

**ACA Reporting** - Plans subject to §6055 ACA employer reporting (i.e., employers who offered a level-funded or self-funded group health plan) will be required to complete Form 1094/1095 reporting for the year in which the group health plan terminates. In addition, if an applicable large employer is involved, the employer will remain subject to §6055 ACA employer reporting on offers of coverage to full-time employees for the year as well as in subsequent years if the employer remains in business (regardless of whether the employer offers a group health plan).

**PCORI Fees** - For self-insured plans subject to the PCORI fee, the fee will apply to the year in which the plan terminates. The PCORI fee will be due on July 31 of the year following the calendar year in which the plan year ends.

**CMS Creditable Coverage** - CMS requires that a disclosure notice be provided to Part D eligible individuals when prescription drug coverage ceases to be offered, including when the group health plan is terminated. The regulations are not clear on the deadline to provide the disclosure to individuals, but best practice would be to provide notice within 30 days of the change or sooner if administratively practicable. Additionally, a separate disclosure must be submitted to CMS within 30 days after the termination of the prescription drug plan.

## Insurance Carriers and Third-Party Administrators

When terminating a plan midyear, agreements with insurance carriers, third-party administrators (TPAs), and stop-loss vendors will need to be reviewed, and any applicable service providers must be contacted in accordance with contractual terms.

Group policy contracts and ASO agreements may require written notice for early termination (often 30-90 days in advance). The employer should also be aware of potential penalty provisions for early termination (e.g., administrative fees, minimum participation guarantees, or early withdrawal fees). Employers should consider final claim submission deadlines, payment dates, and responsibility for denied/contested claims near the termination date.

Self-funded plans will need to notify the stop-loss carrier prior to the plan's termination. The employer should confirm with the stop-loss carrier that claims incurred prior to the plan's termination will be honored, even if they are submitted after the plan has terminated during a run-out period.