



The Compliance Gray Areas That Keep Showing Up

WHY THE GRAY AREAS STILL MATTER

Most compliance issues do not start with “What is the rule?” They start with “What if we just...?”

By this time of year, renewals are wrapping up and employers are shifting focus to next year’s goals. The compliance questions do not stop when the ink dries on new plans though. In fact, some of the biggest mistakes surface after renewal season when employers begin to implement what they just sold.

These are the gray zones, the tricky in-between areas where intent does not always line up with regulation. They are not headline-grabbing violations, but they can still lead to penalties, audits, or messy cleanups later. Here are the top gray areas we continue to see and how to help employers avoid them before 2026.

THE “VOLUNTARY” TRAP

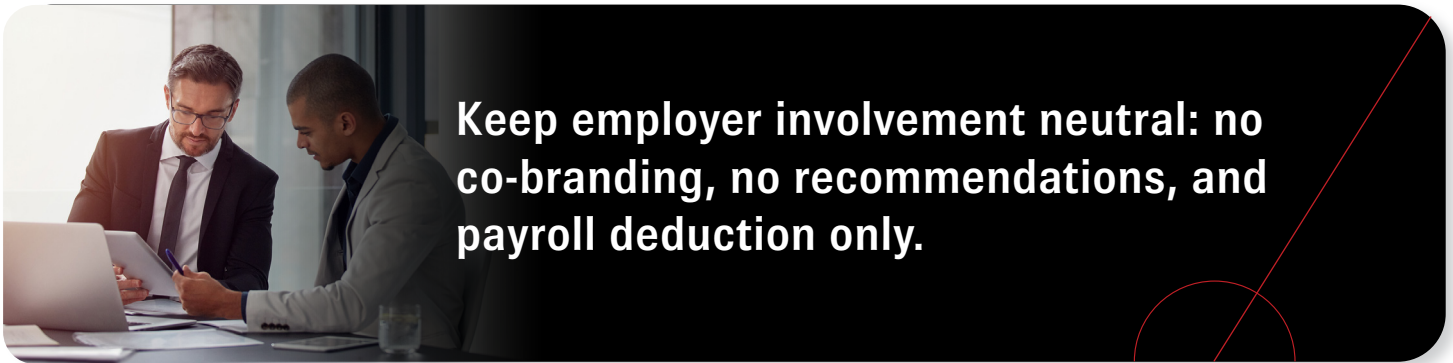
It sounds simple. If a benefit is voluntary, it should be outside ERISA rules, right? That is not always true. The Department of Labor outlines a four-part safe harbor for voluntary plans (defined under 29 C.F.R. § 2510.3-1(j)):

1. The employer does not contribute.
2. Employee participation is completely voluntary.
3. The employer’s role is limited to allowing payroll deduction and collecting premiums.
4. The employer does not endorse the program.

That last point is where most employers slip. Under Department of Labor guidance, “endorsement” goes beyond simply approving a product. It can include using the company name or logo on materials, recommending the product, or helping employees enroll. Once it appears that the employer is sponsoring or promoting the program, it may be treated as an ERISA plan. To stay within the safe harbor, the employer’s role should remain purely administrative and limited to collecting premiums through payroll deduction.

This mistake often shows up with voluntary life or supplemental health products. The intent is good. The goal is to help employees access more benefits, but it can unintentionally create a compliance obligation.

The solution is straightforward: keep voluntary benefits separate, avoid marketing them as part of a group plan, and make sure employees understand participation is entirely their choice.



Keep employer involvement neutral: no co-branding, no recommendations, and payroll deduction only.

CARVE-OUTS, CLASSES, AND DISCRIMINATION RISK

Creating different benefit classes can make sense on paper. Employers may want to reward executives with richer plans or offer hourly workers a limited option to manage costs. The problem is that not all classes are treated equally under the law, and small plan design choices can create big compliance issues.

Sections 125 and 105(h) of the Internal Revenue Code restrict how employers can structure benefits. Section 105(h) applies to self-funded medical plans, while Section 125 governs cafeteria plans that let employees pay premiums pre-tax. Both sets of rules are designed to keep plans from favoring highly compensated employees. The intent is simple, but the application can be complicated.

For example, an employer might separate management and staff into different medical plan tiers. That can be allowed if the distinction is based on bona fide job classifications and the benefits are available on the same terms to all employees within each class. It becomes a problem if access or contribution levels vary in a way that benefits leadership more than everyone else. For self-funded plans, that kind of variation can cause a failure under Section 105(h). Even for fully insured plans, if employee contributions are handled pre-tax through a Section 125 arrangement, discrimination testing under that section can still create exposure.

Another common issue is documentation. Employers may say a carve-out applies only to executives but forget to define who qualifies as an executive in their plan documents. Inconsistencies like that can cause compliance problems during an audit.

A good way to check for risk is to ask a few simple questions:

- + Is this class based on job function or pay level?
- + Are all similarly situated employees treated the same?
- + Do the plan documents clearly match how benefits are being offered?

If the answer to any of these is “no,” it is time to review the plan design. It is always better to adjust a class now than to defend it later.



Agent tip: For self-funded plans, pre-check 105(h). For any plan using pre-tax, confirm Section 125 testing with the contribution setup.

DOCUMENTATION DRIFT

One of the most common compliance problems happens quietly. It starts when plan documents say one thing, but day-to-day practice says another. Over time, the two drift apart.

An employer might update benefits midyear and forget to amend the Summary Plan Description (SPD). HR may use old eligibility rules when onboarding new employees. Or someone might promise a benefit verbally that does not actually exist in writing. Each of these situations creates exposure if the Department of Labor ever reviews the plan. Employers are also required to issue a Summary of Material Modifications (SMM) within 210 days after the end of the plan year when changes occur, or within 60 days if the change reduces benefits.

Documentation drift is rarely intentional. It usually happens when multiple people manage benefits or when a renewal change never makes it back into the plan file. The risk is that in an audit or employee complaint, the DOL and IRS will look at what is documented, not what was intended.



Agent tip: Calendar SMM timing for any midyear change and run a quick “document vs. reality” check quarterly.

A simple “plan document reality check” can prevent most of these problems. Review plan summaries and wrap documents against current practice. Make sure eligibility, waiting periods, and benefit descriptions are consistent across all materials. When in doubt, update the documents and store a signed copy.

Compliance is not about paperwork for its own sake. It is about ensuring that what you promise and what you provide are the same thing.

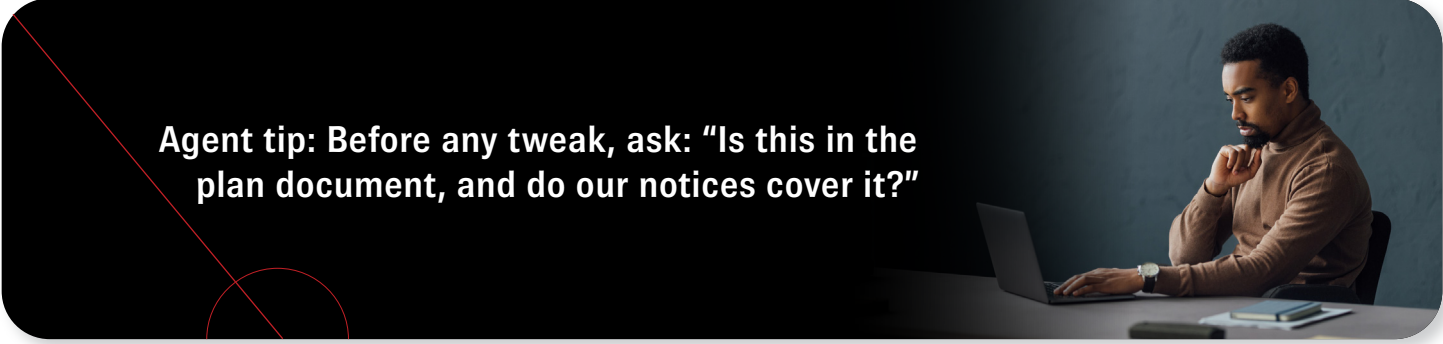
INTENT VS. IMPACT

Most compliance mistakes do not come from cutting corners. They come from trying to do the right thing without checking every detail. Employers rely on carriers, vendors, and internal habits that have “always worked,” assuming they are compliant because no one has raised a flag.

The problem is that compliance does not weigh intent. Regulators look at what is documented, when actions were taken, and whether the plan was operated according to its written terms. A good-faith mistake still counts as a violation if the

paperwork and practice do not match. Common examples include offering special benefits to a favored group, skipping notices because “everyone knows,” or making plan decisions based on a conversation instead of written guidance. These may seem harmless, but they can create audit triggers or participant claims that take months to resolve.

The best prevention is clarity. Employers should pause before making changes and confirm that each step is supported by both the law and the plan language. Brokers can help by asking the right questions and reviewing materials together.



Agent tip: Before any tweak, ask: “Is this in the plan document, and do our notices cover it?”

WRAP-UP: STAYING OUT OF THE GRAY

Compliance gray areas will always exist, but employers do not have to stay stuck in them. Each plan year, small assumptions can quietly turn into bigger risks if no one checks them. A quick review of voluntary plans, class structures, and documentation now can prevent much larger problems later.

Treat compliance as an ongoing process, not a once-a-year task. The rules themselves do not shift often, but how they are interpreted and applied certainly does. Even a small midyear change can trigger new notice or documentation requirements, so building a short “plan check-in” into your renewal cycle keeps everything aligned and defensible.

THE BOTTOM LINE

Gray areas in compliance are where good intentions meet real consequences. Knowing when to pause and ask for guidance can make the difference between a small correction and a costly cleanup.

A short review today can prevent months of rework tomorrow. Connect with your CRC Benefits team to confirm that every plan detail is aligned before 2026 begins.

CONTRIBUTORS

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