CRC BENEFITS

A Midyear Compliance Check Can Protect the Plan and the Client Relationship

Some compliance questions keep showing up because the rules are technical, the situations are messy, and employer groups are usually trying to do the right thing.

A missed notice, an undocumented leave arrangement, a compensation disclosure that never made it into the renewal file, or a Section 125 plan that has been pre-taxing premiums all year without testing can all create avoidable risk. Most of these issues do not start with bad intent but when someone is trying to help an employee, or move too quickly.

Compliance does not run on good intent. It runs on written policies, consistent administration, accurate documentation, and knowing when a legal or tax professional needs to be involved. And, midyear is the perfect time to revisit the questions that come up again and again before they become bigger plan problems.

START WITH THE MARKETPLACE MODEL NOTICE

The Marketplace Model Notice is one of those requirements many employer groups forget about or assume does not apply to them. It applies to small groups, large groups, fully insured plans, level-funded plans, and self-funded plans. If the employer offers a group health plan, the notice should be part of the new hire process.

Every new hire should receive the notice within 14 days of hire. The form explains that Marketplace coverage may be available and helps employees understand how employer-sponsored coverage may affect eligibility for premium tax credits.

The government provides a template, so this is not something that needs to be recreated. Part A is required and includes general Marketplace information. Part B is optional, but it is strongly recommended because it gives employees plan-specific information, including whether the employer's coverage meets minimum value and whether it is intended to be affordable.

Skipping the plan-specific section may feel easier, but it can create more questions for employees. The cleaner approach is to provide the notice, complete the information that helps employees understand their options, and keep a record that the process is being followed.

MAKE COMPENSATION DISCLOSURE PART OF THE RENEWAL PROCESS

Broker compensation disclosure has been around since the Consolidated Appropriations Act of 2021, but it still gets missed.

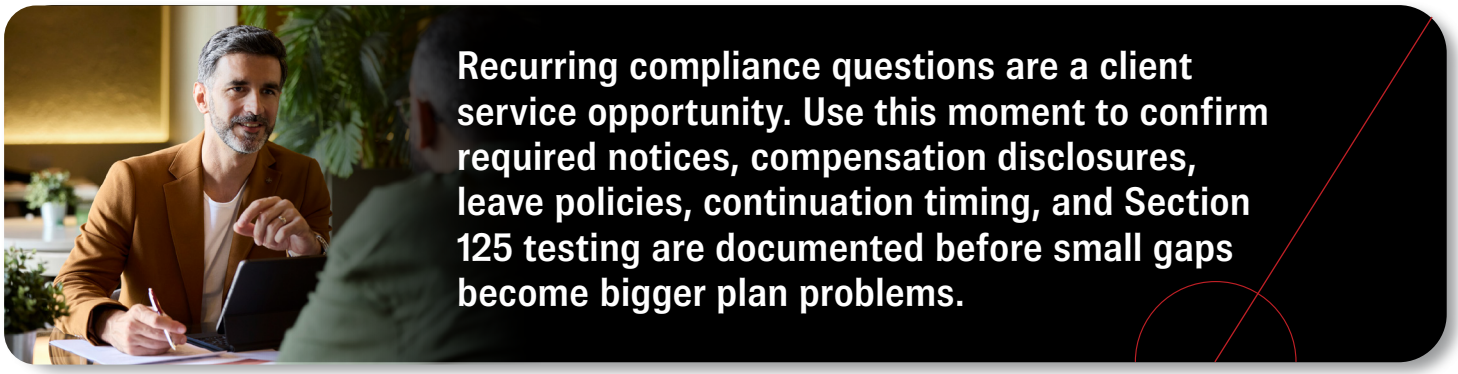
If compensation is expected to reach at least $1,000 annually, whether direct or indirect, it needs to be disclosed. That can include commissions, consulting fees, bonuses, finder's fees, prepaid commissions, third-party payments, incentives, or other compensation tied to the plan.

The disclosure is not filed with the Department of Labor, CMS, or the IRS. The employer keeps it in the plan file.

This requirement is often made harder than it needs to be. The disclosure does not need to show the exact total paid

every month as enrollment changes. It can show the compensation structure, such as a per employee per month amount, percentage, flat fee, or other arrangement.

Medical, dental, vision, life, disability, COBRA services, consulting work, RFP support, census work, and other compensated services should all be reviewed. Split commissions should be handled based on what each party receives. The goal is simple: disclose clearly, make it part of the renewal or new business process, and keep it documented.

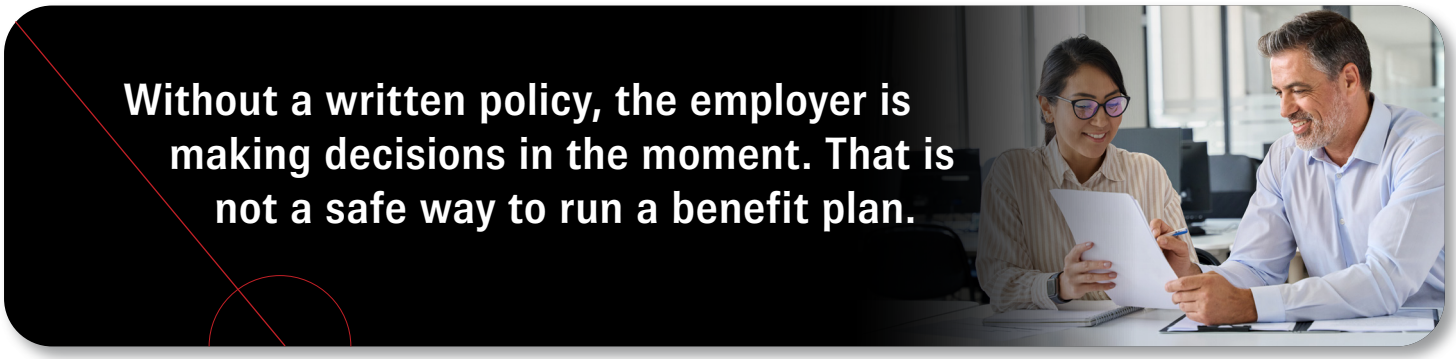


PUT GUARDRAILS AROUND GOODWILL

Employer groups often want to help employees through difficult situations. That is understandable, but informal exceptions can create real problems when there is no written policy behind them.

Keeping someone on the plan "just this once," extending coverage without checking the carrier contract, or handling one employee's leave differently from another's can create precedent. What is done for one employee may need to be done for another similarly situated employee. Inconsistent treatment can also create discrimination concerns.

Generosity needs guardrails. Leave of absence policies should be written. Benefit termination rules should be written. Premium payment expectations during leave should be written. The employee handbook should explain what happens when someone goes out on leave, when benefits continue, when benefits terminate, and how employee contributions are handled.



SEPARATE BENEFIT TERMINATION FROM EMPLOYMENT TERMINATION

Benefits can terminate even when employment has not formally ended. An employee may be on leave, no longer actively working, or outside the allowed leave period. The employment relationship may still exist, but active benefit eligibility may not.

That means the employer needs to know what the carrier contract says, what the employee handbook says, what the stop loss contract says, and what federal or state continuation rules require.

Termination timing can vary. Some contracts terminate coverage on the last day worked. Others terminate at the end of the month. Medical, dental, and vision may follow one rule, while life and disability follow another.

FMLA adds another layer. Covered employers generally must continue medical benefits as though the employee is still actively at work. Employer contributions continue, and employee contribution obligations need to be clearly explained in writing. If the employee does not pay their portion according to the written policy, the employer may be able to terminate coverage and offer COBRA.

State leave laws can create similar obligations, especially when job protection is involved. Level-funded and self-funded plans need even tighter discipline because COBRA timing and stop loss requirements can directly affect claim liability. Stop loss carriers can deny claims when the employer keeps someone on the plan outside the policy or fails to offer COBRA on time.

Workers' compensation should be treated as a caution flag. The employer needs to talk to the workers' comp carrier or attorney before terminating benefits in those situations.

DO NOT WAIT ON SECTION 125 TESTING

Section 125 nondiscrimination testing is often pushed aside until year-end, if it gets addressed at all. If an employer is pre-taxing premiums through a Section 125 plan, testing is required.

The test does not get filed with the government, but the employer should keep a copy on hand. If there is an audit, the employer needs to show that testing was completed and that the plan passed or was handled correctly.

The purpose is to make sure pre-tax benefits do not disproportionately favor owners, highly compensated employees, or key employees. A failed test does not usually disqualify the entire plan or take benefits away from the whole workforce. The impact is more targeted. The favored group may lose the pre-tax advantage, which makes those benefits taxable for that group.

That is still a problem, but it is much easier to manage when it is caught early. Preliminary testing at the beginning or middle of the plan year can help identify red flags before year-end. Employers need to know who counts as an owner, highly compensated employee, or key employee, and the rules can vary based on entity type.

Benefit type matters too. Health FSAs have testing concerns because the full annual election is available at the start of the plan year. Dependent Care FSAs are often the hardest to pass because testing is based on utilization, not just elections. Employer HSA contributions also need attention because comparability rules may apply unless contributions are routed through a cafeteria plan.

This is not usually something a tax accountant handles. The vendor that provides the Section 125 document is often the better starting point for testing support.

BOTTOM LINE

Required notices should be provided. Compensation should be disclosed clearly. Leave rules should be in writing. Carrier and stop loss contracts should be followed. COBRA and state continuation should be offered on time. Section 125 plans should be tested before year-end becomes a fire drill.

The rules are manageable when the process is clear. The risk grows when employers rely on memory, one-time exceptions, or "we have always done it this way."

CRC Benefits helps you bring the right compliance resources, market intelligence, and value-added support to client conversations before small gaps become bigger plan problems. Connect with your CRC Benefits representative or visit crcgroup.com/compliance to access the latest compliance resources.

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