Q1 2026

Benefits Leader

Your Guide to Health & Welfare Compliance

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A SHORT PLAN YEAR ISN'T SHORT ON RISK

Michelle Barki, RN, Esq.
Senior Legal Counsel

When it comes to Health and Welfare (H&W) plans, a short plan year is more than just a calendar adjustment—it is a significant compliance event. Under ERISA and Section 125 rules, a plan year can be shorter than 12 months, but it can never exceed 12 months. This means any transition to a new cycle requires a "bridge" period known as a short plan year.

A short plan year occurs when a plan operates for a period of less than 12 consecutive months. In the world of welfare benefits, this is almost always triggered by a desire to align the ERISA plan year (the period for government reporting) with the policy year (the insurance contract period) or the calendar year. This short-plan year may be the bridge in the following circumstances:

A company currently running a plan on a non-calendar year basis wants to move to a calendar year plan to align with tax years and deductible resets.

After an acquisition, a parent company may end a subsidiary's plan early so both groups can join a consolidated plan on a single date.

A company starting a plan mid-year, such as in October, may use a short plan year to shift to a standard calendar year for the next year.

Sometimes a carrier may offer a one-time "early renewal" to lock in lower rates, necessitating a short bridge year.

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COMING SOON ON THE MEDCOM BRIDGE...

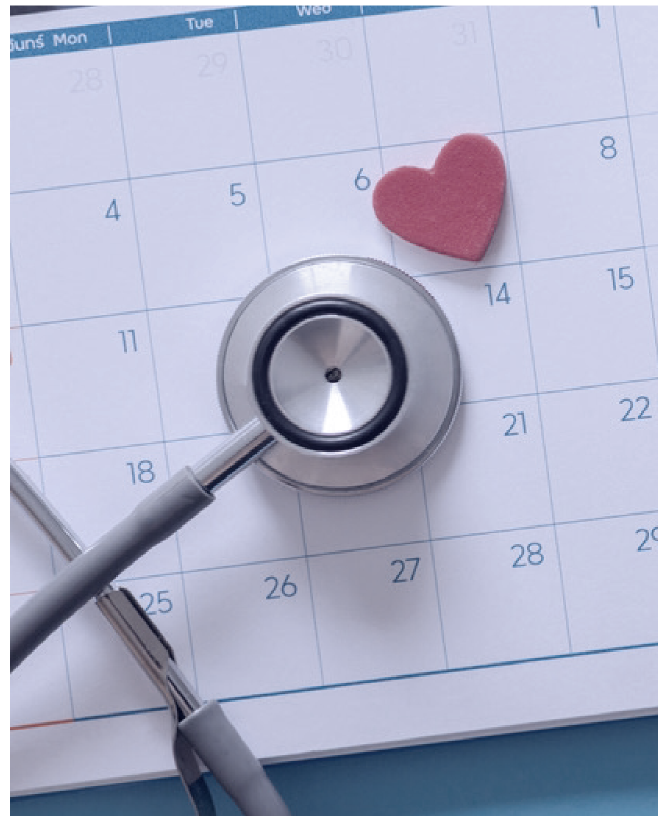
The Compliance Calendar is launching soon on the ***Medcom Bridge***! This new tool keeps you and your clients on top of key compliance dates. By answering just ten questions, you'll build a customized annual compliance timeline for each employer client, which will be securely stored right in your document vault.

Do not underestimate the impact on employees. Changing plan years often requires a "double open enrollment" (one for the short year and one for the subsequent full year), which can lead to fatigue and lower participation rates. In addition, most medical plans reset deductibles at the start of a new plan year. If an employer moves from a July 1 start to a January 1 start, employees who met their $3,000 deductible in August may be shocked to find it resets again in January. Efforts should be made to negotiate deductible credits or carryovers to minimize the impact on employees.

Compliance also needs to be addressed. Consider the following:

Form 5500	Must be filed 7 months after the end of the short-plan year.
PCORI Fees	Fees are still due for self-insured plans. Unlike other costs, PCORI fees for short years are not prorated, the full per-life fee applies.
SBCs & SPDs	Must issue a new Summary of Benefits and Coverage (SBC) and SMM (Summary of Material Modification) explaining the change in plan dates.
Medicare Part D	You must notify CMS of the plan's creditable coverage status within 60 days of the start of the short plan year.

In addition, the IRS requires a valid business purpose to change the plan year. While aligning with the corporate fiscal year is almost always accepted, resetting the clock to avoid a compliance failure is not.



Finally, if a plan sponsor changes the plan year more than once, it is a red flag, and the plan sponsor should have a clear and valid business purpose. Otherwise, the IRS may view it as an attempt to circumvent Section 125 rules.

In short, plan sponsors must be prepared to articulate a clear, legitimate business purpose, such as a corporate restructuring, a merger, or a permanent shift in the fiscal cycle, to justify the change to both the IRS and the Department of Labor. Simply seeking a "reset" to bypass unfavorable testing results or administrative errors is a compliance trap that can lead to plan disqualification or heavy penalties. By treating the short plan year as a strategic transition rather than a quick fix, you protect the plan’s tax-advantaged status and maintain the trust of your workforce.

HEALTH CARE FSA VS. DEPENDENT CARE FSA LIMITS

Mara Braunberg
Marketing Manager

HEALTH CARE FSA LIMITS: PLAN-YEAR DRIVEN

For Health Care FSAs, the IRS sets a flat annual dollar limit on employee salary reduction contributions. **For 2026, that limit is $3,400**.

HOW THE LIMIT APPLIES

- Health Care FSA limits apply on a plan-year basis, not the calendar year (specially important for non-calendar-year plans and short plan years)
- A full 12-month plan year allows the full annual limit
- A short plan year requires limit to be prorated based on the number of months in the plan year
- Employees who enter the plan mid-year are generally not subject to proration, as long as the plan year itself remains a full year
- Employers may not change from a calendar year to a fiscal year solely to delay limit application
- If the primary purpose of a plan year change is to avoid the cap, the IRS will not recognize it

WHAT COUNTS TOWARD THE LIMIT

- Limit applies **only to employee salary deferrals**
- Employer contributions, such as matching contributions, seed money, or flex credits, generally **do not count** toward the $3,400 cap

Important Note: If employees elect to receive employer contributions in cash or as a taxable benefit, the contributions will be treated as salary reductions and will count toward the limit if contributed to the health FSA.

WHO THE LIMIT APPLIES TO

- The limit is per employee, regardless of family size
- Employees cannot increase their contribution just because they cover a spouse or dependents
- If spouses each have access to their own employer-sponsored Health Care FSA, each spouse gets their own full limit, even if they work for the same employer

Important Exception: If an employee participates in multiple Health Care FSAs offered by employers within a controlled group or affiliated service group, the contributions are aggregated, and a single limit applies.

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DEPENDENT CARE FSA LIMITS: CALENDAR-YEAR & HOUSEHOLD-BASED

Dependent Care FSAs follow a different framework. **For 2026,** the maximum exclusion for married individuals filing a joint return or an unmarried parent is **$7,500** while married individuals filing separately are limited to **$3,750.**

In addition, the exclusion is limited to the lesser of the employee's or spouse's earned income.

HOW THE LIMIT APPLIES

- Dependent Care FSA limits apply on a calendar-year basis, tied to the participant's taxable year
- This is especially important for non-calendar-year cafeteria plans
- Contributions may span two calendar years but are still capped annually

WHAT COUNTS TOWARD THE LIMIT

- All contributions count toward the limit, including both employee and employer contributions

WHO THE LIMIT APPLIES TO

- Dependent Care FSA limits apply per household, not per employer
- If both spouses have access to a Dependent Care FSA, combined contributions across all plans cannot exceed the annual household limit

WHY THIS MATTERS

Not all FSA limits work the same way, and misunderstandings can quickly lead to compliance issues or employee frustration. When brokers clearly explain these differences, employers are better equipped to administer their plans correctly and employees avoid unexpected tax surprises.

Resource: ***Larry Grudzien, Attorney at Law***

COMING IN MARCH: NEW ERISA DOCUMENTATION SERVICES

We're expanding our ERISA documentation support to soon include EAP SPDs, Wellness Plan SPDs, as well as re-introducing Prescription Drug (Rx) SPDs. These services are designed to close common documentation gaps that can arise when employers add or enhance benefits subject to ERISA.

THE RISKS OF REIMBURSING MEDICAL EXPENSES VIA LIFESTYLE ACCOUNTS

Michelle Barki, RN, Esq.
Senior Legal Counsel

As the demand for Section 213(d) medical expenses—specifically GLP-1 medications like Ozempic, Wegovy, and Mounjaro—continues to grow, many employers are considering Lifestyle Accounts (LSAs) as a flexible way to help employees cover these costs. The following summary explains why these reimbursements are legally complex and how a tax-advantaged alternative may better serve your goals.

Lifestyle Accounts (LSAs) are designed for non-medical wellness benefits such as gym memberships or fitness equipment. However, the moment an LSA is used to reimburse a medical expense defined under Internal Revenue Code Section 213(d), it is legally transformed into a group health plan.

FEDERAL MANDATES TRIGGERED WHEN AN LSA COVERS MEDICAL EXPENSES:

ERISA & FORM 5500

The employer must maintain a formal Plan Document and Summary Plan Description (SPD). An annual Form 5500 filing is also likely required.

ACA VIOLATIONS

The Affordable Care Act (ACA) prohibits group health plans from imposing annual or lifetime dollar limits on "essential health benefits." Since LSAs are inherently capped (e.g., $1,500/year), they cannot comply with these market reforms, potentially exposing the employer to significant excise taxes ($100 per day, per affected individual).

DEPENDENT COVERAGE

Under the ACA, any health plan that offers dependent coverage must extend eligibility to adult children up to age 26.

Using an LSA for medical expenses also subjects the employer to HIPAA Privacy and Security Rules, which require strict protection of Protected Health Information (PHI). Furthermore, HIPAA nondiscrimination rules prohibit restricting eligibility or benefits based on a "health factor." Offering a benefit only for specific medications or conditions can be viewed as discriminatory without a careful (and often complex) legal structure.

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From a tax perspective, an LSA offers no tax-favored advantage for the employer or the employee. All reimbursements are treated as imputed income, meaning the employee is taxed on every dollar received. Additionally, it remains unsettled whether the choice to use LSA funds for medical versus non-medical items triggers the doctrine of constructive receipt, which could potentially make the entire account balance taxable the moment it is made available.

Employers can achieve the goal of supporting employee health, including GLP-1 coverage, more effectively by using a Health Reimbursement Arrangement (HRA). To remain compliant with the ACA and provide true tax advantages, the HRA should be "integrated" with the employer's primary group health plan. This structure offers several key benefits:

Tax-Free Benefits: *Unlike an LSA, contributions and reimbursements through an HRA are 100% tax-free for both employers and employees.*

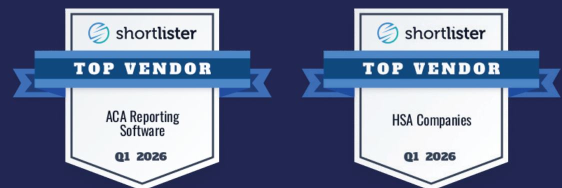
Regulatory Alignment: *By limiting the HRA to employees enrolled in the employer's major medical plan, the benefit is protected by the plan's existing ERISA and ACA compliance framework.*

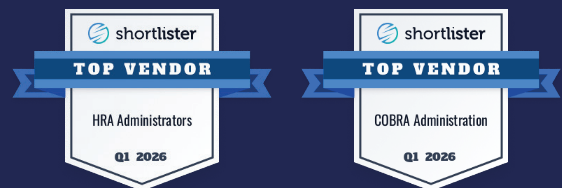
Controlled Spending: *The employer can still set specific annual caps on the HRA, but does so within a legally recognized "excepted benefit" or "integrated" framework that satisfies federal law.*

By shifting this support into an integrated HRA, employers can offer a meaningful, tax-free benefit that supports employee well-being while avoiding the significant legal risks of a "shadow" health plan.

MEDCOM IS A SHORTLISTER TOP VENDOR!

Shortlister is the #1 marketplace for employers and consultants to find and select providers in the benefits administration field. Medcom is excited to receive this recognition in several areas for Q1 2026!





MARKETPLACE PREMIUMS ON THE RISE: CAN EMPLOYEES SWITCH PLANS MID-YEAR?

Michelle Barki, RN, Esq., Senior Legal Counsel
Larry Grudzien, Attorney at Law

Because of the potential loss of enhanced federal subsidies, Marketplace premiums will increase in 2026. This will change financial calculations for employees and their families and generate many questions about whether employees and/or dependents can enroll in the employer's group health plan mid-year.

Whether this enrollment can occur lies in the strict regulations under Code Section 125. These regulations create a mechanism that allows employees to pay for group health plan premiums on a pre-tax basis. These plans operate under the fundamental rule that health coverage elections—the choice to enroll or waive coverage—must be irrevocable for the duration of the plan year. An exception can only be made if a Permitted Election Change Event (or Qualifying Event) occurs.

CAN EMPLOYEES AND THEIR DEPENDENTS ENROLL IN THEIR EMPLOYER'S GROUP HEALTH PLAN MID-YEAR IF MARKETPLACE PREMIUMS INCREASE SIGNIFICANTLY IN 2026?

The simple answer is no. The non-renewal of a federal subsidy or a significant increase in the Marketplace Qualified Health Plan (QHP) premium is a **change in cost**, not a change in eligibility or status. Because the individual or dependent retains the right to enroll in the Marketplace plan (even at a higher cost), this financial change does **not** trigger a permitted election change event under Code Section 125 that would allow them to enroll mid-year in the employer's group health plan.

To remain compliant with tax law, the plan must deny mid-year enrollment requests based on Marketplace cost increases alone.

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WHY COST CHANGES DON'T APPLY HERE

Section 125 does allow certain mid-year election changes when the employer’s own **group medical plan** experiences a significant cost change.

It is important to note that this cost-change rule does not extend to the cost of other external coverage, like the ACA Marketplace. Therefore, even a dramatic increase in the cost of a Marketplace plan has no bearing on the ability to change the election for the employer's group health plan outside of its scheduled annual open enrollment.

WHAT EMPLOYEES SHOULD PLAN FOR

As Marketplace premiums climb, employees will understandably look for more affordable options. But even in a shifting healthcare landscape, Section 125 rules stay firm. Marketplace cost increases alone do not open the door to mid-year changes, and employers must continue to follow their plan’s election rules to remain compliant.

The best approach is preparation. Employers should communicate these rules early, and employees should review their needs and plan ahead for the next open enrollment. Clear expectations now will help reduce confusion later and ensure everyone makes informed, timely decisions about their coverage.

MEDCOM'S TRAINING OPPORTUNITIES

ON THE ROAD TO COMPLIANCE: 5-PART ERISA TRAINING PROGRAM

Feb. 12 – Mar. 12 | Thursdays at 1:00 p.m. ET

A five-week virtual ERISA training for brokers that covers key rules, real-world challenges, and practical strategies to support clients with confidence. It's not too late to join! Session recordings are available when you register.

COMPLIANCE RECHARGE SERIES

Every other Thursday | 3:00 p.m. ET

A biweekly series designed for benefit brokers & consultants packed with timely insights, actionable guidance, and answers to your toughest compliance questions!

EMPLOYEE BENEFITS & COMPLIANCE TRAINING FOR HR PROFESSIONALS

Mar. 19 - Apr. 30 | Thursdays at 1:00 p.m. ET

A live, 7-part virtual series designed for HR professionals, focused on key topics in employee benefits compliance.

HIPAA PRIVACY & SECURITY TRAINING

24/7 On-Demand

This course helps meet annual HIPAA training requirements for any organization handling PHI, including providers, plan sponsors, business associates, third-party administrators, and brokers.

UPCOMING DEADLINES

FEB 28 — PAPER-FILING DEADLINE FOR ACA FORMS 1094-C & 1095-C

ALEs are required to report details about their health plan coverage to the IRS using Forms 1094-C and 1095-C. Paper-filing only applies to employers filing fewer than 10 information returns annually.

FEB 28 — PAPER-FILING DEADLINE FOR ACA FORMS 1094-B & 1095-B

Non-ALEs with self-insured health plans are required to report health plan coverage details to the IRS using Forms 1094-B and 1095-B. Paper-filing only applies to employers filing fewer than 10 information returns annually.

MAR 1 — HIPAA BREACH NOTIFICATIONS DUE TO OCR

Employers sponsoring group health plans must report any breach of PHI affecting <500 individuals to OCR within 60 days of the end of the plan year. Breaches affecting 500+ must be reported within 60 days of breach discovery.

MAR 2 — SUBMIT MEDICARE PART D DISCLOSURE TO THE CMS

Groups offering prescription drug coverage to Medicare Part D eligible individuals must report to CMS whether coverage is "creditable" within 60 days after the start of the plan year (March 2 for calendar-year plans).

MAR 2 — FURNISH ACA FORM 1095-C TO EMPLOYEES

ALEs are required to provide employees with health plan coverage info each year using IRS Form 1095-C.

MAR 2 — FURNISH ACA FORM 1095-B TO EMPLOYEES

Non-ALEs with self-insured health plans must provide employees with IRS Form 1095-B annually.

MAR 31 — ELECTRONICALLY FILE ACA FORMS 1094-C AND 1095-C

ALEs are required to report their health plan coverage information to the IRS using Forms 1094-C and 1095-C. The deadline for electronic filing is March 31 each year.

MAR 31 — ELECTRONICALLY FILE ACA FORMS 1094-B AND 1094-C

Non-ALEs with self-insured health plans must report information about their health plan coverage to the IRS using Forms 1094-B and 1095-B. The electronic filing deadline is March 31 each year.

APR 15 — LAST DAY FOR 2025 HSA CONTRIBUTIONS/CORRECTIONS

Employers and individuals have until the tax filing deadline to make HSA contributions and corrections for a given calendar year.

JUN 1 — SUBMIT PRESCRIPTION DRUG DATA COLLECTION REPORT

Health plans and health insurance issuers are required to report prescription drug info and healthcare spending to federal government on an annual basis. This process is known as the (RxDC) report.

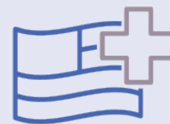
ACA EMPLOYER REPORTING

COBRA PREMIUM BILLING ADMINISTRATION

CONSUMER DRIVEN HEALTH PLANS

HEALTH & WELFARE COMPLIANCE

HIPAA PRIVACY & SECURITY



GOVERNMENT HEALTHCARE PROGRAMS

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