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Short Plan Year/Early Renewal Considerations

Health and welfare benefit plans operate on a plan year that is typically 12 months long. Plan years longer than 12 months are not permitted under IRS rules for cafeteria plans; although in some cases a plan year may be shorter than 12 months. Some common situations where an employer may have a plan year that is less than 12 months are:

- The employer implements a new plan in June, but wants the plan to operate on a calendar year basis.
- The employer is redesigning the current benefits in the middle of the year.
- As a result of a merger or acquisition the employer wants to combine two plans.
- The insurer is anticipating significant rate increases at the regular renewal date, but is implementing only modest increases for current renewals. Accepting an early renewal date can delay the more significant rate increase until a later date.

An important caveat to consider is that a short plan year is normally followed by a plan year that is 12 months in length. For example, a short plan year of June 1, 2019 to December 31, 2019 with the subsequent plan year being January 1, 2020 through December 31, 2020. Although possible, an employer will rarely have two short plan years in succession. An employer that is considering two short plan years in succession will need to have a solid business reason for doing so. *Note: IRS rules do not permit an employer to change a plan year in order to allow employees to change their cafeteria plan elections.*

A short plan year will affect the design, communication, and administration of a health and welfare benefit plan. A short plan year will primarily affect the design of health plans rather than the design of other benefits, such as life and disability insurance. Life insurance and disability benefit design are typically based on a relationship to compensation – such as life insurance coverage equal to one times salary or long term disability benefits equal to 60% of salary. Unless these plans use a definition of compensation that relates to the plan year, a short plan year is unlikely to affect the design of those plans. Health plans, however, that have deductibles and out-of-pocket limits, annual maximums (e.g., for dental and vision benefits), and medical plans that may be combined with an account-based benefit, such as a health Flexible Spending Account (”FSA”), will be impacted by a short plan year.

This whitepaper contains a brief discussion of the potential effect that a short plan year may have on health plans. However, before discussing short plan years, it is important to distinguish a short plan year from a short insurance policy year. The plan year is the period used to operate the plan itself – the cafeteria and/or the ERISA plan. The

insurance policy year is the period the insurer uses for determining premium rates and accounting if the plan uses experience accounting (sometimes called retrospective rating). Although most employers will align their insurance policy year and plan year, alignment is not required. An employer may, for example, maintain a calendar year plan year for its medical plan, but have an October 1 through September 30 insurance policy year.

The following discussion focuses on the potential impact of a short plan year for a health plan, not a short insurance policy year. The discussion covers the potential impact areas as it relates to design, communications, and administration, and assumes that the plan year and policy year are the same. At the end we include a brief discussion of the potential effect of having different plan and policy years. Our discussion focuses on possible compliance concerns, but does include a few general consulting comments.

Plan Design

Deductibles and out-of-pocket maximums under a medical plan are generally based on a 12-month period. Implementing a short plan year will usually result in a corresponding change in the plan's deductible. For example, if an employer starts a new medical plan on July 1, 2019 and wants to transition to a calendar year, the first year for the new plan will be 6 months – from July 1, 2019 through December 31, 2019. Because the employee will only have six months of expenses to use to satisfy the plan's deductible, the employer may want to use a lower deductible for the short plan year. For example, if the employer intends to offer a PPO with a $1,500 deductible, the employer might select a $750 deductible for the short plan year. If the employer uses the lower $750 deductible for the period July 1 2019 through December 31, 2019, employees (and their family members) will not be eligible to contribute to a Health Savings Account ("HSA") for that period, because the minimum statutory deductible for a qualified High Deductible Health Plan ("HDHP") for plan years that begin in 2019 is $1,350 for self-only coverage. IRS rules do not permit using a lower amount (i.e., prorating) for a coverage period of less than 12 months. The employee might be HSA-eligible in 2020 assuming the deductible matches the 2020 minimum statutory deductible. The family (i.e., other-than-self-only) deductible value would be similarly affected.

A short plan year may also affect the maximum out of pocket amount under a medical plan, but is unlikely to create a problem since the maximum for a short plan year is less likely to exceed the maximum permitted under an HSA-compatible HDHP ($6,750 for self-only coverage for 2019) or the maximum out-of-pocket limit for non-grandfathered plans under the Patient Protection and Affordable Care Act ("PPACA") ($7,900 for self-only coverage for 2019).

The above rules describe what may happen under a new plan with a short plan year. But what if the employer already has a plan and modifies the plan during the year as part of a plan redesign, combines two plans mid-year, or chooses an early renewal to delay a substantial rate increase? The change does not just affect the upcoming plan year, it also impacts the existing plan year.

When the current plan year is truncated and a new plan year starts, the shortened time frame for the current year will affect deductibles and out-of-pocket maximums. The magnitude of the effect can be expected to be reduced the closer the change is to the end of the current plan year. The impact on employees may be quite significant if it occurs earlier in the year. For example, if the current plan year is the calendar year and the employer makes the change on July 1, the 2019 plan year will be for six months from January 1, 2019 through June 30, 2019. If the plan has a $1,500 deductible, the employee will have only six months in which to accumulate expenses to satisfy the deductible rather than twelve months. Beginning on July 1, 2019 the employee may be facing another $1,500 deductible.

One way to lessen the impact of having a new deductible for a 12-month plan year that follows a short plan year is to permit some expenses incurred during the prior plan year to be applied to satisfy the deductible for the next plan year (often called a carryover deductible provision). If the plan carries forward and credits expenses incurred before the beginning the plan year toward the new deductible, it increases the deductibles required for a qualified HDHP. The statutory minimum deductible of $1,350 (2019 value, indexed annually) for self-only coverage is based on a twelve month coverage period. To the extent that the period used to accumulate expenses that count toward the deductible is lengthened, deductibles must be adjusted upward in order for the medical plan to be a qualified HDHP. The minimum statutory deductible for an 18-month accumulation period that begins in 2019 would be $2,025 ($1,350/12 x 18). It may also be possible to credit amounts from the prior plan year toward the out-of-pocket maximum.

In order to satisfy PPACA requirements, Health Reimbursement Arrangements (“HRAs”) must be integrated with a medical plan. Many employers design their HRAs to coordinate with the cost-sharing provisions of the medical plan. To the extent that those provisions are modified as the result of a short plan year, employers may want to make changes to the HRA to align with the medical plan. The employer may also want to modify its annual contribution – for example, by pro-rating the dollar amount – to accommodate the short plan year.

When the plan year starts will determine which indexed values must be used. Plan years that begin in 2019 must use the 2019 values. An employer that changes from a

calendar year plan to a July 1 through June 30 plan year on July 1, 2019 must use the 2019 values for the plan year July 1, 2019 through June 30, 2020.

A short plan year may also affect the design of other health plans such as dental and vision. However, as long as the dental and vision plans are separate (i.e., HIPAA excepted benefits) the effects on plan design will be primarily insurance or consulting issues rather than compliance concerns.

Plan Communications

Changing the plan year – even if there are no design changes – will require communications to employees, and in many cases, other individuals such as COBRA qualified beneficiaries. More extensive communications will be required if there are any plan design changes. First, the change in plan year will require a formal plan amendment, which must be communicated to employees if the plan is subject to ERISA, but should also be communicated by non-ERISA plans as well. The plan sponsor (typically the employer) must provide a Summary of Material Modification ("SMM") within 210 days after the end of the plan year when there is a material change in a plan subject to ERISA. A Summary of Material Reduction ("SMR") rather than an SMM must be used if there is a material reduction in benefits under the plan. The SMR must be provided no more than 60 days after the plan change **has been adopted and before the effective date of the change.** If the change involves the truncation of a plan year the change is a material reduction and an SMR must be distributed. Even if design features such as the level of the deductible and out-of-pocket are not changed, the time period during which they must be satisfied has been reduced. Similarly the cafeteria plan must be amended and the change communicated to employees

Required notices that are specifically based on the plan year include:

- Summary Annual Report for insured (or funded) plans subject to ERISA (due 9 months after the end of the plan year)
- Cafeteria Plan Automatic/Evergreen Election Notice (due before the plan year begins)
- HIPAA Opt-out Notice for Self-Insured Nonfederal Governmental Plans that have opted out of certain HIPAA portability requirements (due before the plan year begins)

The Summary of Benefits and Coverage ("SBC") must be provided any time there is a change in the plan that affects the content of the SBC. Because the coverage period is one of the plan provisions that is included in the SBC, a revised SBC must be provided for each plan year.

There are several notices that must be provided at annual enrollment:

- Grandfathered Status Notice*
- Wellness Program Notices – such as ADA, GINA, and HIPAA
- Women's Health and Cancer Rights Act Notice (Janet's Law)

*if there is a loss of grandfathered status, participants must be notified before the start of the plan year when the plan will no longer be grandfathered

There are two notices that are not plan-year based or required during annual enrollment, but which must be provided annually. Required notices include:

- CHIPRA State Premium Assistance Notice
- Prescription Drug (Part D) Certificate of Creditable/Non-creditable Status

In most cases, it will be easier for the employer to distribute these notices as part of the annual enrollment process.

More in-depth communications (i.e., more than an SMR, required notices, and a new SBC) are likely to be needed if design changes are involved. For example, if the current plan year will be truncated because of an early renewal, employees will also need to receive more detailed information such as what expenses, if any, may be applied toward the deductible for the upcoming plan year.

Plan Administration

A short plan year – with or without a major change in plan design – will affect the administration of a plan. COBRA administration is one area where a change in plan year will have a significant effect. The maximum COBRA premium that a qualified beneficiary may be charged is 102% (150% for a disability extension) of the premium, and the premium generally must remain in effect for a full 12 months. Under COBRA regulations, events that will permit a change in the COBRA premium in less than 12 months are very limited. In general, a new COBRA premium may be set if: (1) the new COBRA premium is less than the existing premium (unlikely for most health plans), (2) the employer is changing insurers and the new insurer charges different premium rates, or (3) there is a change in the premium based on a change in the design of the plan. An early renewal with increased rates (although less than the increase anticipated based on the normal renewal date) is not one of the events that would permit the employer to change the COBRA premiums. Starting a new plan mid-year with the intent to have a short first plan year followed by a 12-month plan year is also not on the list of events that would permit a change in the COBRA rate.

For example, assume the employer truncates the existing calendar year plan year as of September 30, 2019, but does not redesign the plan or change insurers. Although the insurance premium rates increase on October 1, 2019, the employer would not be permitted to change the COBRA rate for current qualified beneficiaries until January 1, 2020. If the employer increases the COBRA premium on January 1, 2020, it would not be permitted to make another change on October 1, 2020 for current qualified beneficiaries when the new premium rates are received. The result would be two different sets of COBRA rates in order to satisfy the requirement to keep COBRA rates unchanged for 12 months. The alternative would be to use the January 1, 2019 COBRA rates until October 1, 2020 for qualified beneficiaries whose COBRA coverage began before October 1, 2019.

Other elements of administration that will be affected are:

- For ERISA plans, the change in plan year will affect the filing requirements for Form 5500 and for insured or funded plans the timing for the distribution of the SAR.
- For ERISA plans, the change in the plan year is a material change to the terms of the plan which requires a formal plan amendment.
- The cafeteria plan document must be amended to reflect the change in the cafeteria plan year.
- If there is an HRA, the HRA plan document must be amended.
- The dollar amount that is used to calculate the Patient Centered Outcomes Research Institute (“PCORI”) fee, which is payable by self-insured medical plans, is based on the plan year.
- Nondiscrimination testing for cafeteria plans subject to Internal Revenue Code Section 125 and group term life insurance plans subject to Internal Revenue Code Section 79 are based on the plan year. Each plan year must be tested separately.
- Notice of the creditable/non-creditable status of the employer’s prescription drug benefit must be provided to the Centers for Medicare and Medicaid Services (“CMS”) within 60 days after the start of each plan year.

Cafeteria plan elections must be made before the period of coverage begins and remain in effect for the entire period of coverage. The coverage period is usually the plan year. When there is a short plan year, the employee will be making an election for a period

less than 12 months, followed by an election for a coverage period of 12 months.[1] For example, for a plan year of July 1, 2019 through December 31, 2019 following by plan year January 1, 2020 through December 31, 2020, the employer will need one election for July 1, 2019 through December 31, 2019 and a second election for the period January 1, 2020 through December 31, 2020. Even if the plan uses evergreen elections (i.e., once an employee makes an election it remains in effect until the employee affirmatively changes it), the employer must provide the annual cafeteria plan notice and give employees the opportunity to enroll in or waive coverage for each coverage period. PPACA also requires at least an annual opportunity for an employee to waive coverage (unless the coverage provides minimum value and is affordable using the Federal Poverty Line safe harbor) to avoid potential penalties under the Employer Shared Responsibility mandate.

Insurance Considerations

Plan years and policy years do not need to be the same, but if they are different it may create problems when coordinating the cafeteria plan and insurance policies. IRS rules for cafeteria plans require that elections be made before the **period of coverage** begins and must remain in effect until the end of the period of coverage unless there is a change in status that would permit a new election. The period of coverage is usually the plan year, but that is not a requirement. The primary reason that many employers align their cafeteria plan year with their insurance policy renewal date is to enable the employer to make decisions about required employee contributions once it has received the premium rates for the upcoming year. Changing employee contribution rates in the middle of a plan year when an insurance policy renews and the insurer provides new rates is more difficult. It is possible for the employer to change employee contributions mid-year, but the employee's ability to make new elections will be restricted. Under the IRS change in cost or coverage rules for cafeteria plans, only certain changes are permitted. Unlike annual enrollment, employees do not have an unrestricted ability to change their elections. For example, if there is a significant increase in the employee's required contribution toward the cost of medical coverage, IRS rules would permit the employee to pay the increased amount to maintain the same coverage, switch to a less expensive medical option, or drop medical coverage if there is no other medical option available.

Unfortunately, the employee may not be permitted to make other changes – such as decrease or drop coverage under a dental or vision plan – to offset the increased amount the employee must pay to continue the same medical coverage. (In addition,

[1] Except for separate dental and vision plans, IRS rules do not permit a period of coverage that exceeds 12 months. Based on informal guidance a 2-year election period may be permitted for separate dental and vision plans. Shorter periods of coverage – such as for a new plan with a short plan year or a newly hired or eligible employee – are permitted.

the cafeteria plan document must permit mid-year changes based on a change in cost or coverage.) The alternative for the employer is to wait until the beginning of the next coverage period to increase employee contributions. However, this disconnect between when insurer rates change and when employee contributions are determined will continue to be an issue as long as the plan and policy year are different.

The difference between the policy year and plan year does not create a problem for filing Form 5500 even though the Schedule A's provided by the insurers will be for the policy year, not the plan year. Filing instructions for Form 5500 specify which Schedule A's must be included in the filing.

Although outside the scope of this whitepaper, a change in the plan year may also be accompanied by a change in policy year for an insured plan which is likely to affect rates. A short plan year will also affect any stop loss coverage.

Special Concerns for Health FSAs

The maximum permitted salary reduction contribution for a health FSA ($2,700 for 2019) is based on the plan year. Thus, starting a new plan year on July 1, 2019 means that the $2,700 maximum in effect on July 1, 2019 must be used for the July 1, 2019 through June 30, 2020 plan year even if the indexed value for 2020 is greater than $2,700.

If the health FSA is a new plan which will have a short plan year following by a 12-month plan year, the employer's main concern may be what salary reduction maximum to use for the short plan year and whether to include either a grace period or a carry-over for the short plan year and subsequent 12-month plan years. The salary reduction maximum of $2,700 (2019 value, indexes annually) or a lesser amount may be used for a health FSA with a plan year beginning at any time in 2019. There is no requirement that the maximum be adjusted to reflect a short plan year. If the employer's first plan year for the health FSA is July 1, 2019 through December 31, 2019, the employer may use a maximum salary reduction amount of $2,700. The employer is not required, but many will choose to prorate that amount for the short plan year to avoid potential problems such as increased forfeitures.

One of the most difficult areas to address occurs when the current plan year is truncated. The first effect is that unless the plan has a grace period or carry-over provision, employees have fewer months in which to incur expenses that may be reimbursed (of course there are also fewer salary reductions taken). If the plan year was a calendar year plan, but the employer changed to a July 1 through June 30 year on July 1, 2019, employees have only six months from January 1, 2019 through June 30, 2019 in which to incur expenses to be reimbursed, rather than the twelve months

available when they made their decisions. Unless employees have already incurred expenses, or are able to incur expenses before the end of the short plan year, they will forfeit unused amounts. Although probably less likely, there is the potential for a shortfall if employees submit expenses in January through June 30 which exceed salary reduction amounts for those months.

Any difference between the insurance policy year and plan year also makes it more difficult for employees to make health FSA elections. Most employees will make health FSA elections based on what types of health care they envision needed during the upcoming year plus the level of cost-sharing in the health plan(s). It is easier for employees to make health FSA elections if they have information about any changes in annual deductible and out-of-pocket amounts and other plan provisions such as coinsurance and copayments plus information about their required contributions for medical and other benefits before they make their elections.

The change in cost or coverage rules are not available to a health FSA. If the deductible is increased under the medical plan mid-year, the employee might reasonably want to increase his health FSA election. Unfortunately, he may not be permitted to do so. Similarly, if the cost of medical coverage increases mid-year, an employee who must pay more for the same coverage may want to reduce his health FSA election in order to avoid having a significant reduction in his take-home pay. IRS rules also prohibit this change.

If the short plan year is very short – e.g., one to three months in length – it may be unattractive to most employees and may increase the risk for adverse selection. An employee who does not anticipate receiving medical care in the next one to three months is far less likely to enroll in the health FSA than an employee who is getting ready to schedule a surgical procedure. Employees are more likely to enroll when they have a longer time period in which to incur expenses that can be reimbursed by a health FSA. A grace period may help, but it is limited to 2 ½ months. Alternatively, a carryover may help, but must be limited to $500. In addition, the plan may have either a grace period or a carryover, but not both. (Note: including a grace period or carryover will affect the employee's HSA eligibility.)

The intent of this analysis is to provide general information regarding the provisions of current federal laws and regulation. It does not necessarily fully address all your organization's specific issues. It should not be construed as, nor is it intended to provide, legal advice. Your organization's general counsel or an attorney who specializes in this practice area should address questions regarding specific issues.

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