Brown & Brown

EMPLOYEE BENEFITS

Health & Welfare Benefit Plans: Plan Year Change Considerations

June 2023

From the Brown & Brown Regulatory and Legislative Strategy Group

Health & Welfare Benefit Plans: Plan Year Change Considerations

When a plan sponsor decides to change the plan year for their health and welfare benefit programs, numerous compliance items should be considered, including but not limited to those issues identified in the chart below. Plan sponsors should consult with their employee benefits attorney before making such a decision and for specific recommendations on compliance considerations related to plan year changes.

Plan Sponsor Name: _____ FEIN: _____

Original Plan Year: _____ New Plan Year: _____ Effective Date: _____

Item	Action	Deadline/Completion Dates		Notes
ERISA Compliance[1]				
Plan documents[2]	Under ERISA, plan documents must be adopted and maintained for any health and welfare plan(s) adopted by a plan sponsor. Plan documents must be amended to reflect any changes to plan terms, including a plan year shift. Amendments must be formally adopted by signature of an authorized agent or via Board Resolution.	No specified deadline under ERISA for changes that need to be made to a plan's plan documents, but a conservative approach would be to adopt the formal plan amendment prior to its effective date.	Due: _____ Completed: _____	Each policy or line of coverage may be a stand-alone document, or plan sponsor may adopt and maintain a consolidated health & welfare benefit (wrap) plan document.

[1] Applies to health & welfare benefit plans sponsored by entities that are subject to ERISA – i.e., the plan sponsor is not a governmental entity or a church.
[2] Non-ERISA healthcare benefit plan sponsors should also maintain plan documents and amendments to preserve non-taxable nature of benefits for participants and beneficiaries and to provide a roadmap by which the plan is administered.

Item	Action	Deadline/Completion Dates		Notes
ERISA Compliance[1]				
Summary of Material Modification and/ or Summary Plan Description (SMM)[3]	When an ERISA health or welfare benefit plan is materially modified, an SMM or amended SPD must be distributed to all plan participants.	Generally, the disclosure deadline for material changes to the plan, as evidenced by an SMM/SPD, is due to plan participants within 210 days after the end of the plan year in which the amendment was adopted. However, if the change constitutes a material reduction in coverage, the disclosure deadline of a material reduction in coverage evidenced within an SMM/SPD must be distributed to plan participants within 60 days after adoption of the amendment.	Due: Completed:	SMM may be a stand-alone document incorporated by reference as part of the Summary Plan Description (SPD), or the plan sponsor may distribute an amended and restated SPD that reflects the material changes to the plan that also serves as the SMM.
Form 5500 Annual Return/Report	Annual return/report (Form 5500) must be filed for a short plan year. Under ERISA, a plan year cannot exceed 12 months, so there is no ability to extend the plan year to avoid filing Form 5500 for a short plan year.	Unless an extension applies, by the end of the seventh month following the last day of the short plan year.	Due: Completed:	Subsequent annual filings (after the short plan year filing) will be based on the end of the ***new*** full plan year due at the end of the seventh month following the last day of the ***new*** plan year.
	Example: Employer A previously maintained its health plan under an ERISA plan year that ended October 31. Beginning 1/1/2024, they are adopting a calendar year plan year to coincide with their plan's benefit year for determining deductibles and out-of-pocket expenses. To make the change, Employer A must run a short plan year from 11/1/2023 to 12/31/2023. • By 5/31/2024, they must file Form 5500 for the plan year 11/1/2022-10/31/2023. • By 7/31/2024, they must file Form 5500 for the short plan year 11/1/2023-12/31/2023. • Beginning with the 2024 calendar year plan year, they will file on a 1/1-12/31 basis, with their 5500 due 7/31 of the following year. • A 2 ½ -month extension to the deadline to file Form 5500 is available if the plan sponsor files Form 5558 Extension Application by the initial filing deadline.[4]			
Summary Annual Report (SAR)	SAR must be distributed to all plan participants.	Two months after the Form 5500 filing deadline (including applicable extensions).	Due: Completed:	SAR is required for funded plans and fully insured plans.

[3] Participants covered by plans sponsored by non-ERISA employers are generally provided with a benefits summary and receive written notice of material changes affecting coverage.
[4] Automatic extension to file Form 5500 may apply if plan year and sponsor's tax fiscal year are the same and sponsor has filed an application for extension to file corporate tax return(s).

Item	Action	Deadline/Completion Dates		Notes
Affordable Care Act (ACA) Compliance[5]				
Open Enrollment for Minimum Essential Health Coverage	Under the ACA's employer shared responsibility penalty (ESRP) provision, Applicable Large Employers (ALEs) have offered coverage only if they provide full-time employees with at least an annual opportunity to enroll in or decline minimum essential health coverage.[6] Plan sponsor may wish to offer additional open enrollment opportunity to employees for the short plan year to minimize the risk of ESRPs.	Prior to start of applicable (short) plan year.	Due: Completed:	Plan sponsor may choose to administer a default or passive enrollment or require all eligible employees to make an active election. These enrollment rules should be reflected in the plan documentation and may require an amendment to the plan document and distribution of an SMM or amended SPD.
Full-time Employee Status	Under the ACA, minimum value, affordable coverage must be offered to full-time employees to avoid ESRPs. If an ALE uses the look-back measurement method to determine the full-time status of its employees (or a class of employees), changing the plan year of the medical plan likely will necessitate a modification to the employer's look-back measurement policies.[7]	No deadline for adopting a change to the look-back measurement policy is specified in the ESRP regulations, but employers are allowed to change their look-back measurement period once a year.	Due: Completed:	The employer should follow the guidance provided by the IRS regarding the transition rules that apply when an ALE changes the duration or start date of its measurement period(s).[8]
Uniform Summary of Benefits and Coverage (SBC)	A new SBC must be distributed for both the short plan year and the ***new*** full plan year.	• Whenever there is a material plan change that affects the content of the SBC[9], • At the time renewal materials are distributed, • If renewal is automatic ("evergreen" election), within 30 days prior to the start of the new plan year, or • If renewal policy was not received 30 days hprior to the start of the new plan year, as soon as practicable, no more than seven days after the start of the plan year.	Due: Completed:	Subsequent annual SBCs (after the short plan year SBC) must be distributed to plan participants in the ***new*** full plan year.

[5] *These issues generally will arise only when a change is made to the plan year of the group medical plan.*
[6] *Treas. Reg. §54.4980H-4 Assessable payments under section 4980H(a).*
[7] *Employers typically set the stability period for ongoing employees to match the medical plan's plan year.*
[8] *IRS Notice 2014-49.*
[9] *"If a group health plan or health insurance issuer makes any material modification in any of the terms of the plan or coverage involved (as defined for purposes of section 102 of the Employee Retirement Income Security Act of 1974) that is not reflected in the most recently provided summary of benefits and coverage, the plan or issuer shall provide notice of such modification to enrollees not later than 60 days prior to the date on which such modification will become effective." (Public Health Service Act §2715 [42 USC §300gg-15]).*

Item	Action	Deadline/Completion Dates		Notes
Affordable Care Act (ACA) Compliance[5]				
Patient-Centered Outcomes Research Institute (PCORI) Fee	PCORI fee is based on the average number of covered lives enrolled in the self-insured health plan during the plan year. Average covered lives are determined, and PCORI fees are payable for, short and full plan years that ended within the preceding calendar year. No proration applies for less than a full 12-month plan year.[10]	July 31 of the calendar year following the calendar year in which the plan year ended.	Due: Completed:	Applies to all (regardless of the number of plan participants) self-insured health plans (including HRAs integrated with fully insured major medical).
	Example: Employer B has a self-insured health plan and has changed their plan year from 4/1-3/31 to a calendar year beginning 1/1/2023. • The next PCORI fee is payable for all plan years ending in the calendar year 2022, with payment due 7/31/2023. • On the Form 720 Excise Tax return due 7/31/2023, average covered lives will be reported for both the full plan year ending 3/31/2022 and the short plan year ending 12/31/2022, and the PCORI fee will be remitted with that return. • For the 12-month plan year beginning 4/1/2021 and ending 3/31/2022, the PCORI fee is equal to their average covered lives during the period 4/1/2021-3/31/2022, multiplied by $2.79 (applicable fee for all plan years ending on or after October 1, 2021, and before October 1, 2022). • For the plan year 4/1/2022-12/31/2022, the PCORI fee is equal to their average covered lives during the period beginning 4/1/2022-12/31/2022, multiplied by $3.00 (applicable fee for all plan years ending on or after October 1, 2022, and before October 1, 2023).			

[10] *Patient-Centered Outcomes Research Trust Fund Fee (IRC 4375, 4376 and 4377): Questions and Answers. (Q/A-12).*

Item	Action	Deadline/Completion Dates	Notes
High Deductible Health Plans (HDHPs) and Health Savings Accounts (HSAs)			
Calendar Year Deductible for HDHP	Ensure the HDHP annual deductible and OOP limits are appropriate for the short plan year. If the period during which the member's claims apply toward the deductible exceeds 12 months, the statutory minimum annual deductible also proportionally increases.[11] **Example:** • Before the plan year change, Employer C's HDHP required members to pay an annual deductible of $1,500 for individual or $3,000 per family contract (non-embedded) before the health plan paid medical expenses other than for preventive care. The annual deductible accumulated over the employer's plan year, 7/1-6/30. • Effective 1/1/2024, they are switching their plan year to operate on a calendar year basis. A short plan year runs from 7/1 through 12/31/2023. In conjunction with the change in a plan year, their health insurer has agreed to permit members to receive credit for deductibles incurred from 7/1-12/31/2023 toward their 2024 deductibles rather than requiring members to start over with deductible accumulations for the 2024 plan year. • For plan years beginning in 2024, the HDHP minimum annual deductible is $1,600/$3,200. However, because members have 18 months (rather than 12) in which to incur their 2024 annual deductible, the minimum annual deductible becomes $2,400 ($1,600÷12x18=$2,400) per individual contract or $4,800 ($3,200÷12x18=$4,800) per family contract. *Note: If, instead of a deductible credit, the employer makes an additional HSA contribution to offset member out-of-pocket expenses for the plan year, those employer contributions will reduce affected HSA participants' calendar year contribution limits.*		

[11] *IRS Notice 2004-50, Q&A 24.*

Item	Action	Deadline/Completion Dates		Notes
Flexible Spending Accounts (HCFSAs/DCFSAs)				
Dependent Care FSAs	Employees can make new elections for the short plan year unless the plan sponsor suspends participant elections/ participation and allows participants to make new elections only at the start of the next full plan year.	Amendments should be adopted **prior** to the start of the short plan year.	Due: Completed:	Consider how the change in plan years will impact the application of the limit under IRC Section 129 on the amount of DCFSA reimbursements excluded from income, which applies on a calendar year basis.[12] Any excess reimbursements during a calendar year will be taxable.
Health Care FSAs	Employees can make new elections for the short plan year unless the plan sponsor suspends participant elections/ participation and allows participants to make new elections only at the start of the next full plan year.	Amendments should be adopted **prior** to the start of the short plan year.	Due: Completed:	The statutory annual limit on salary reduction contributions is prorated for short plan years.
	Example: Prior to implementing a plan year change, Employer D maintains a health care FSA with a plan year of 1/1-12/31. To coincide with their medical plan, they amend the plan year to 7/1-6/30, beginning 7/1/2023. • For a full 12-month plan year beginning in 2023, the annual contribution limit is $3,050. • Because the plan year is six, rather than 12, months, the contribution limit for the 2023 short plan year 1/1/2023-6/30/2023 is $1,525 ($3,050÷12x6=$1,525). • For the full plan year 7/1/2023-6/30/2024, the contribution limit is $3,050.			
Forfeitures (HCFSA/ DCFSA)	Determine the impact of the timing of the decision to run a short plan year on potential forfeitures under HCFSA and DCFSA. Subject to the plan's provisions regarding claims run-out, grace periods, and carryovers, any account balances remaining at the end of the short plan year will be forfeited. Whenever possible, employers should inform employees in advance of running a short plan year so that employees may account for any associated deadlines applicable to that short plan year.	N/A	N/A	N/A

[12] *Statutory maximum Dependent Care FSA annual benefit limit per calendar year is:*
- $5,000 for head-of-household or married couple filing joint tax return, or
- $2,500 for married couple filing separate returns.

Item	Action	Deadline/Completion Dates		Notes
Flexible Spending Accounts (HCFSAs/DCFSAs)				
Claims Submission Deadline Decision (HCFSA/DCFSA)	Determine the length of run-out (claims substantiation) for the short plan year. Will participants have a full standard run-out period, or will a shorter run-out apply?	**Prior** to start of short plan year.	Due: Completed:	
Grace Period (HCFSA/DCFSA)	If the plan has up to a 2 ½ -month grace period to incur claims after the end of the plan year, will the grace period apply to the short plan year? Or will the grace period be suspended?	**Prior** to start of short plan year.	Due: Completed:	
Carryover Provision (HCFSA)	If the plan allows for a carryover of unreimbursed account balances to the next plan year, will the carryover apply to participants' short plan year elections?	**Prior** to start of short plan year.	Due: Completed:	
Cafeteria Plan Documents	Cafeteria plan, HCFSA and DCFSA documents may require amendment to reflect plan year change, decisions regarding short plan year elections, and decisions regarding claims submission deadlines, grace periods, and carryovers. Amendments must be formally adopted by signature of an authorized agent or via Board Resolution prior to the end of the plan year in which the change occurs.	Amendments to change the plan year or to address short plan year elections should be made prior to the start of the short plan year and plan year change. Amendments to make changes to the claims submission deadline and/or the availability of a grace period or carryover generally should be made no later than the last day of the plan year to which the claims submission deadline, grace period, and/or carryover will apply.	Due: Completed:	

Item	Action	Deadline/Completion Dates		Notes
Flexible Spending Accounts (HCFSAs/DCFSAs)				
Notification of Changes to HCFSA/ DCFSA	SMMs/SPDs must be distributed to all plan participants describing any material changes to the HCFSA. Changes to the DCFSA should be communicated to eligible employees.[13]	Generally, an SMM/SPD evidencing a material change in the plan must be distributed to HCFSA plan participants within 210 days after the end of the plan year in which the amendment was adopted. However, if the change constitutes a material reduction in coverage, the HCFSA SMM/SPD must be distributed to HCFSA plan participants within 60 days after adoption of the amendment. Section 129 does not specify a deadline for communicating changes made to a DCFSA.	Due: Completed:	
COBRA Continuation Coverage				
COBRA Rate Determination[14]	COBRA rates must be determined in advance of each determination period.	Reasonable notice of COBRA rates must be provided to qualified beneficiaries.	Due: Completed:	In general, COBRA rates must be set for a 12-month determination period, except in certain limited circumstances.[15]

[13] *RS §129(d)(6) indicates that "Reasonable notification of the availability and terms of the program shall be provided to eligible employees."*

[14] *Treas. Reg. §54-4980(b)-8 Paying for COBRA continuation coverage, Q&A 2.*

[15] *There are three instances in which a plan may increase the COBRA premium charged to a qualified beneficiary during the 12-month determination period:*

- *it may implement the increase permitted during a disability extension (from 102% of the premium to 150% for the 11-month extension);*
- *if it is requiring payment of less than the maximum permissible amount (i.e., less than 102% or, if permitted, 150% of the applicable premium), then it may increase the COBRA premium up to that level; and*
- *if a qualified beneficiary changes coverage from one benefit package or coverage unit to another, and a higher applicable premium was fixed for the new benefit package or coverage unit before the determination period began, then the plan may increase the qualified beneficiary's COBRA premium to up to 102% (or, if permitted, 150%) of the applicable premium for the new benefit package or coverage unit.*

While there might be a plan modification exception that can be applied if the plan is changed for similarly situated active employees for reasons unrelated to COBRA, the conservative approach would be to hold the COBRA rate for a period of at least 12 months.

How Brown & Brown Can Help

Connect with your Brown & Brown service team to learn more about how we can help find solutions to fit your unique needs.

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