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Determining a Health Plan's "Plan Year"

Employer-sponsored health plans are subject to a variety of compliance requirements, including those included in the Affordable Care Act (ACA). Many of these requirements are linked to a health plan's "plan year."

Examples

- The ACA's prohibition on pre-existing condition exclusions for all enrollees is effective for **plan years beginning on or after Jan. 1, 2014.**
- Health plan sponsors that provide prescription drug coverage to Medicare Part D eligible individuals must provide a disclosure notice to the Centers for Medicare & Medicaid Services (CMS) on an annual basis, **within 60 days after the beginning of the plan year**.
- If a health plan is required to file a Form 5500, the deadline (without extensions) is the **last day of the seventh month following the end of the plan year**.

It is important for an employer to identify its health plan's "plan year" for purposes of monitoring its compliance obligations under the ACA and other federal laws.

PLAN YEAR OVERVIEW

Section 3(39) of the Employee Retirement Income Security Act (ERISA) defines "plan year" as the calendar, policy or fiscal year on which the records of the plan are kept. Although short plan years are permitted in some limited situations, a plan year is generally the **12-month period** that was established when the health plan became effective.

Many employers operate their health plans on a calendar year basis, from Jan. 1 through Dec. 31 of each year. Other employers operate their plans on a non-calendar year basis, which may be consistent with the company's taxable year or with an insured plan's policy year.

IDENTIFYING THE PLAN YEAR

To determine a health plan's plan year, an employer should first review the documents governing the plan. ERISA requires a health plan's summary plan description (SPD) to specify the plan year. Also, for a plan that files a Form 5500, the plan year is disclosed on the form.

If the plan document does not designate a plan year or if there is no plan document, federal regulations issued under HIPAA (and amended pursuant to the ACA) provide guidance on determining the plan year:

- The plan year is the **deductible or limit year** used under the plan;
- If the plan does not impose deductibles or limits on a yearly basis, the plan year is the **policy year**;
- If the plan does not impose deductibles or limits on a yearly basis, and either the plan is not insured or the insurance policy is not renewed on an annual basis, the plan year is the **employer's taxable year**; or
- In any other case, the plan year is the **calendar year**.

Thus, if an insured plan is not required to file a Form 5500 or is not required to have (or has failed to prepare) an SPD, the plan year will generally be the policy year, presuming that the plan is administered based on that policy year. However, if the plan's deductible is administered on a basis other than the policy year (for example, the calendar year), the plan year will be the year used for administering the deductible.

Plan sponsors should take care to appropriately document their plans and their plan years to avoid any questions regarding compliance with plan year requirements.

PLAN YEAR COMPLIANCE

The following table outlines examples of select compliance requirements that are linked to a health plan's plan year.

EFFECTIVE DATE/DEADLINE	PROVISION
ACA REFORMS	
Plan years beginning on or after Jan. 1, 2014	**Employer Wellness Programs** The potential incentive for health-contingent wellness programs increases to 30 percent (50 percent for programs designed to prevent or reduce tobacco use) of the premium.
	Annual Limits Prohibited Plans and issuers may not impose annual limits on the coverage of essential health benefits.
	Pre-existing Condition Prohibition Group health plans and health insurance issuers may not impose pre-existing condition exclusions on coverage for anyone.
	Nondiscrimination Based on Health Status Group health plans and health insurance issuers offering group or individual health insurance coverage (except grandfathered plans) may not establish rules for eligibility or continued eligibility based on health status-related factors.
	Excessive Waiting Periods Prohibited Group health plans and health insurance issuers cannot require a waiting period of more than 90 days.
	Coverage for Clinical Trial Participants Non-grandfathered group health plans and insurance policies will not be able to terminate coverage because an individual chooses to participate in a clinical trial for cancer or other life-threatening diseases, nor will they be able to deny coverage for routine care that they would otherwise provide just because an individual is enrolled in the clinical trial.

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Plan years beginning on or after Jan. 1, 2014	**Comprehensive Benefits Coverage** Health insurance issuers that offer health insurance coverage in the individual or small group market will be required to provide the essential benefits package required of plans sold in the health insurance exchanges. This requirement does not apply to grandfathered plans.
	Limits on Cost-sharing Non-grandfathered group health plans will be subject to limits on cost-sharing or out-of-pocket costs. The ACA's annual deductible limit applies *only* to insured health plans offered in the small group market, whereas the ACA's out-of-pocket maximum limit applies to *all* non-grandfathered health plans.
DISCLOSURE AND REPORTING	
Last day of the seventh month following the end of the plan year, unless an extension applies	**Form 5500** A plan administrator must file an annual Form 5500, which is the annual return/report for an employee benefit plan. Small health plans (less than 100 participants) that are fully insured or unfunded or a combination of insured and unfunded are generally exempt from the Form 5500 filing requirement.
Nine months after the end of the plan year (or two months after the due date for filing Form 5500, with extensions)	**Summary Annual Report** A summary annual report (SAR) is a narrative summary of the Form 5500 and includes a statement of the right to receive the annual report. Plans that are exempt from the annual 5500 filing requirement are not required to provide an SAR. Large, completely unfunded health plans are also generally exempt from the SAR requirement.
60 days after the beginning of the plan year	**Medicare Part D Disclosure to CMS** Health plan sponsors that provide prescription drug coverage to Medicare Part D eligible individuals must provide a Medicare Part D disclosure notice to CMS. The notice discloses whether the health plan's prescription drug coverage is creditable.

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