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Annual Compliance Deadlines for Health Plans

Employers that provide group health plan coverage to their employees are subject to numerous compliance requirements throughout the year, such as requirements for reporting, participant disclosure and certain fee payments. Some of these requirements have been in existence for many years (for example, the Form 5500), while others have been added more recently by the Affordable Care Act (ACA).

This Compliance Overview contains a high-level summary of the various compliance requirements and associated deadlines that health plan sponsors should be aware of throughout the year. It also summarizes annual notice requirements for group health plans. Please note that certain deadlines for non-calendar year plans may vary from what is outlined below.

CALENDAR YEAR DEADLINES

This chart only addresses **recurring calendar year compliance deadlines**. The chart does not include other requirements that are not based on the calendar year. For example, a plan administrator must provide a COBRA Election Notice to a qualified beneficiary after a qualifying event occurs. This type of notice requirement is not addressed in the chart below. Also, state laws may impose additional obligations. Users of this chart should refer to the specific federal or state law at issue for complete information.

HIGHLIGHTS

AFFECTED EMPLOYERS

- Employers that sponsor group health plans are subject to numerous compliance requirements throughout the year.
- Not all of these compliance requirements will apply to every employer.

ACTION STEPS

- Health plan sponsors should work with their advisors to determine which recurring deadlines apply to them.
- In addition to the compliance requirements described in this chart, it's important for plan sponsors to monitor ongoing ACA developments.

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JANUARY

DEADLINE	REQUIREMENT	DESCRIPTION
Jan. 31	Form W-2	Deadline for providing Forms W-2 to employees. The ACA requires employers to report the aggregate cost of employer-sponsored group health plan coverage on their employees' Forms W-2. The purpose is to provide employees with information on how much their health coverage costs. Certain types of coverage are not required to be reported on Form W-2. This Form W-2 reporting requirement is currently **optional for small employers** (those who file fewer than 250 Forms W-2). Employers that file 250 or more Forms W-2 are required to comply with the ACA's reporting requirement.
Jan. 31	Form 1095-C or Form 1095-B—Annual Statement to Individuals	Applicable large employers (ALEs) subject to the ACA's employer shared responsibility rules must furnish Form 1095-C (Section 6056 statements) annually to their full-time employees. Employers with self-insured health plans that are not ALEs must furnish Form 1095-B (Section 6055 statements) annually to covered employees. The Forms 1095-B and 1095-C are due on or before Jan. 31 of the year immediately following the calendar year to which the statements relate. Extensions may be available in certain limited circumstances. However, an alternate deadline generally is not available for ALEs that sponsor non-calendar year plans.

FEBRUARY

DEADLINE	REQUIREMENT	DESCRIPTION
Feb. 28 (March 31, if filing electronically)	Section 6055 and 6056 Reporting	Under Section 6056, ALEs subject to the ACA's employer shared responsibility rules are required to report information to the IRS about the health coverage they offer (or do not offer) to their full-time employees. ALEs must file Form 1094-C and Form 1095-C with the IRS annually. Under Section 6055, self-insured plan sponsors are required to report information about the health coverage they provided during the year. Self-insured plan sponsors must generally file Form 1094-B and Form 1095-B with the IRS annually.

		ALEs that sponsor self-insured plans are required to report information to the IRS under Section 6055 about health coverage provided, as well as information under Section 6056 about offers of health coverage. ALEs that sponsor self-insured plans will generally use a combined reporting method on Form 1094-C and Form 1095-C to report information under both Sections 6055 and 6056. All forms must be filed with the IRS annually, no later than Feb. 28 (March 31, if filed electronically) of the year following the calendar year to which the return relates. Reporting entities that are filing 250 or more returns must file electronically. There is no alternate filing date for employers with non-calendar year plans.

MARCH

DEADLINE	REQUIREMENT	DESCRIPTION
March 1 (calendar year plans)	**Medicare Part D Disclosure to CMS**	Group health plan sponsors that provide prescription drug coverage to Medicare Part D eligible individuals must disclose to the Centers for Medicare & Medicaid Services (CMS) whether prescription drug coverage is creditable or not. In general, a plan's prescription drug coverage is considered creditable if its actuarial value equals or exceeds the actuarial value of the Medicare Part D prescription drug coverage. Disclosure is due: ✓ Within 60 days after the beginning of each plan year; ✓ Within 30 days after the termination of a plan's prescription drug coverage; and ✓ Within 30 days after any change in the plan's creditable coverage status. Plan sponsors must use the online disclosure form on the CMS Creditable Coverage webpage.

JULY

DEADLINE	REQUIREMENT	DESCRIPTION
July 31	PCORI Fee	Deadline for filing IRS Form 720 and paying Patient-Centered Outcomes Research Institute (PCORI) fees for the previous year. **For insured health plans**, the issuer of the health insurance policy is responsible for the PCORI fee payment. **For self-insured plans**, the PCORI fee is paid by the plan sponsor. The PCORI fees are temporary—the fees do not apply to plan years ending on or after Oct. 1, 2019. This means that, for calendar year plans, the PCORI fees do not apply for the 2019 plan year.
July 31 (calendar year plans)	Form 5500	Plan administrators of ERISA employee benefit plans must file Form 5500 by the last day of the seventh month following the end of the plan year, unless an extension has been granted. Form 5500 reports information on a plan's financial condition, investments and operations. Form 5558 is used to apply for an extension of two and one-half months to file Form 5500. Small health plans (fewer than 100 participants) that are fully insured, unfunded or a combination of insured/unfunded, are generally exempt from the Form 5500 filing requirement. The Department of Labor's (DOL) website and the latest Form 5500 instructions provide information on who is required to file and detailed information on filing.

SEPTEMBER

DEADLINE	REQUIREMENT	DESCRIPTION
Sept. 30	Medical Loss Ratio (MLR) Rebates	The deadline for issuers to pay medical loss ratio (MLR) rebates for the 2014 reporting year and beyond is Sept. 30. The ACA requires health insurance issuers to spend at least 80 to 85 percent of their premiums on health care claims and health care quality improvement activities. Issuers that do not meet the applicable MLR percentage must pay rebates to consumers. Also, if the rebate is a "plan asset" under ERISA, the rebate should, as a general rule, be used within **three months** of when it is received by the plan sponsor. Thus, employers who decide to distribute the

		rebate to participants should make the distributions within this three-month time limit.
Sept. 30 (calendar year plans)	**Summary Annual Report**	Plan administrators must automatically provide participants with the summary annual report (SAR) within nine months after the end of the plan year, or two months after the due date for filing Form 5500 (with approved extension). 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.

OCTOBER

DEADLINE	REQUIREMENT	DESCRIPTION
Oct. 15	**Medicare Part D—Creditable Coverage Notices**	Group health plan sponsors that provide prescription drug coverage to Medicare Part D eligible individuals must disclose whether the prescription drug coverage is creditable or not. Medicare Part D creditable coverage disclosure notices must be provided to participants before the start of the annual coordinated election period, which runs from Oct. 15-Dec. 7 of each year. Coverage is creditable if the actuarial value of the coverage equals or exceeds the actuarial value of coverage under Medicare Part D. This disclosure notice helps participants make informed and timely enrollment decisions. Disclosure notices must be provided to all Part D eligible individuals who are covered under, or apply for, the plan's prescription drug coverage, regardless of whether the prescription drug coverage is primary or secondary to Medicare Part D. Model disclosure notices are available on CMS' website.

ANNUAL NOTICES

TYPE OF NOTICE	DESCRIPTION
WHCRA Notice	The Women's Health and Cancer Rights Act (WHCRA) requires group health plans that provide medical and surgical benefits for mastectomies to also provide benefits for reconstructive surgery. Group health plans must provide a notice about the WHCRA's coverage requirements at the time of enrollment and on an annual basis after enrollment.

	The initial enrollment notice requirement can be satisfied by including information on WHCRA's coverage requirements in the plan's summary plan description (SPD). The annual WHCRA notice can be provided at any time during the year. Employers with open enrollment periods often include the annual notice with their open enrollment materials. Employers that redistribute their SPDs each year can satisfy the annual notice requirement by including the WHCRA notice in their SPDs. Model language is available in the DOL's compliance assistance guide.
CHIP Notice	If an employer's group health plan covers residents in a state that provides a premium subsidy under a Medicaid plan or CHIP, the employer must send an annual notice about the available assistance to all employees residing in that state. The annual CHIP notice can be provided at any time during the year. Employers with annual enrollment periods often provide the CHIP notice with their open enrollment materials. The DOL has a model notice that employers may use.
Summary of Benefits and Coverage (SBC)	Group health plans and health insurance issuers are required to provide an SBC to applicants and enrollees each year at open enrollment or renewal time. The purpose of the SBC is to allow individuals to easily compare their options when they are shopping for or enrolling in health plan coverage. Federal agencies have provided a template for the SBC, which health plans and issuers are required to use. The issuer for fully insured plans usually prepares the SBC. If the issuer prepares the SBC, an employer is not also required to prepare an SBC for the health plan, although the employer may need to distribute the SBC prepared by the issuer. The SBC must be included in open enrollment materials. If renewal is automatic, the SBC must be provided no later than 30 days prior to the first day of the new plan year. However, for insured plans, if the new policy has not yet been issued 30 days prior to the beginning of the plan year, the SBC must be provided as soon as practicable, but no later than seven business days after the issuance of the policy.
Grandfathered Plan Notice	To maintain a plan's grandfathered status, the plan sponsor or must include a statement of the plan's grandfathered status in plan materials provided to participants describing the plan's benefits (such as the summary plan description, insurance certificate and open enrollment materials). The DOL has provided a model notice for grandfathered plans. *This notice only applies to plans that have grandfathered status under the ACA.*
Notice of Patient Protections	If a non-grandfathered plan requires participants to designate a participating primary care provider, the plan or issuer must provide a notice of patient protections whenever the SPD or similar description of benefits is provided to a participant. This notice is often included in the SPD or insurance certificate provided by the issuer (or otherwise provided with enrollment materials). The DOL provided a model notice of patient protections for plans and issuers to use.

HIPAA Privacy Notice	The HIPAA Privacy Rule requires self-insured health plans to maintain and provide their own privacy notices. Special rules, however, apply for fully insured plans. Under these rules, the health insurance issuer, and not the health plan itself, is primarily responsible for the privacy notice. Self-insured health plans are required to send the privacy notice at certain times, including to new enrollees at the time of enrollment. Thus, the privacy notice should be provided with the plan's open enrollment materials. Also, at least once every three years, health plans must either redistribute the privacy notice or notify participants that the privacy notice is available and explain how to obtain a copy. The Department of Health and Human Services (HHS) has model Privacy Notices for health plans to choose from.
HIPAA Special Enrollment Notice	At or prior to the time of enrollment, a group health plan must provide each eligible employee with a notice of his or her special enrollment rights under HIPAA. This notice should be included with the plan's enrollment materials. It is often included in the health plan's SPD or insurance booklet. Model language is available in the DOL's compliance assistance guide.
Wellness Notice HIPAA	Employers with health-contingent wellness programs must provide a notice that informs employees that there is an alternative way to qualify for the program's reward. This notice must be included in all plan materials that describe the terms of the wellness program. If wellness program materials are being distributed at open enrollment (or renewal time), this notice should be included with those materials. Sample language is available in the DOL's compliance assistance guide.
Wellness Notice ADA	To comply with the Americans with Disabilities Act (ADA), wellness plans that collect health information or involve medical exams must provide a notice to employees that explains how the information will be used, collected and kept confidential. Employees must receive this notice before providing any health information and with enough time to decide whether to participate in the program. Employers that are implementing a wellness program for the upcoming plan year should include this notice in their open enrollment materials. The Equal Employment Opportunity Commission has provided a sample notice for employers to use.