WORLD

EMPLOYEE BENEFITS

2025 ANNUAL COMPLIANCE CALENDAR

Requirements for Health Plans

WHAT'S IN THIS DOCUMENT

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. For example, employers with group health plans may be required to:

- File a Form 5500 by the last day of the seventh month following the end of the plan year (or request a filing extension)
- Provide Medicare Part D creditable coverage disclosures to plan participants by October 15 of each year
- Pay Patient-Centered Outcomes Research Institute (PCORI) fees by July 31 of each year

This Compliance Calendar 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.

2025 ANNUAL COMPLIANCE REQUIREMENTS - QUICK VIEW

The quick-view calendar is based on a January plan year. As a World Insurance client, your local service team can provide you with a calendar specific to your plan year if January is not aligned to your renewal.

JANUARY		FEBRUARY		MARCH	
Form W-2	Jan. 31	Section 6055 and 6056 Reporting	Feb. 28	Medicare Part-D Disclosures	March 1
				Form M-1 filing with DOL	March 1
Form 1095	Jan. 30	Summary of Material Modifications	Feb. 28	File ACA Forms 1094 Electronically with IRS	March 31

APRIL		MAY		JUNE	
				Drug Cost Reporting with the Centers for Medicaid and Medicare Services (CMS)	June 1

JULY		AUGUST		SEPTEMBER	
PCORI Fee	July 31			Medical Loss Ratio (MLR) rebates, if any	Sept. 30
Form 5500	July 31*			Summary Annual Report	Sept. 30**

OCTOBER		NOVEMBER		DECEMBER	
Medicare Part D – Creditable Coverage Notices	Oct. 14			Massachusetts Health Insurance Responsibility Disclosure	Dec. 15
				CMS Prohibited Gag Clause Attestation	Dec. 31
				Imputed Income Reminder *(or resolve any nondiscrimination failures)*	

ANNUAL NOTICES NOT TIED TO A SPECIFIC DATE

Women's Health and Cancer Rights (WHCRA)	Grandfathered Plan Notice	Wellness Notice HIPAA
CHIP Notice	Notice of Patient Protections	Wellness Notice ADA
Summary of Benefits and Coverage (SBC)	HIPAA Privacy Notice	Michelle's Law (if applicable)
	HIPAA Special Enrollment Notice	

* Calendar year plans; adjust the dates accordingly for non-calendar year plans – 7 months following the end of the plan year. Automatic extension to October 15 (calendar year plans) if requested.
** Calendar year plans; adjust the dates accordingly for non-calendar year plans.

2025 ANNUAL COMPLIANCE REQUIREMENTS

CALENDAR YEAR DEADLINES

This chart addresses recurring calendar year compliance requirements. 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 this chart. State and local laws may impose additional obligations. Users of this chart should refer to the specific federal or state law at issue for complete information.

ADDITIONAL NOTES

- New obligation for 2025 – health plans must comply with new requirements to demonstrate that the plan's mental health benefits are substantially equivalent to the plan's medical and surgical benefits. Fully insured plans can rely on the health plan's insurance carrier to provide that analysis. Self-funded plans must perform that analysis as most carriers have refused to do so. World has vendors who can perform that analysis, so employers should speak with their account teams to access that service.
- Health plan sponsors should work with their advisors to determine which recurring requirements apply to them.
- The rules have been changing at an accelerating pace. Therefore, it's important for plan sponsors to monitor legislative and regulatory developments.

The calendar will note whether the specific date is based on the calendar year or the plan year.

JANUARY

Form W-2 **Deadline is January 31**	The ACA requires employers that file 250 or more Forms W-2 to report the aggregate cost (i.e., the sum of the employer and employee costs) of employer-sponsored group health plan coverage on their employees' Forms W-2. This Form W-2 reporting requirement is currently optional for small employers (those who file fewer than 250 Forms W-2).
Form 1095 *Upon request* **Deadline is Jan. 31** (or 30 days after request if later)	The Paperwork Burden Reduction Act eliminated the requirement to automatically furnish proof of ACA-qualified coverage to covered employees in employer group plans. Starting in 2025, that obligation is only required if requested by employees. Employers with employees in jurisdictions with individual mandates (California, Massachusetts, New Jersey, Rhode Island, Vermont, and Washington, DC) can expect requests from those employees. They may find it administratively simpler (but are no longer required) to continue to send the forms to all employees.

FEBRUARY

Section 6055 and 6056 Reporting (Forms 1094 and 1095)

Deadline is Feb. 28 if filing on paper
(Only available if filing fewer than 10 returns)

Applicable Large Employers ("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.

ALEs that sponsor self-insured plans are required to report information to the IRS about health coverage provided and offers of health coverage. ALEs that sponsor self-insured plans generally use a combined reporting method on Form 1094-C and Form 1095-C to report information under Sections 6055 and 6056.

All forms must be filed with the IRS annually, no later than March 31, following the calendar year to which the return relates. (If the reporting entity is filing fewer than 10 returns, paper filing is still available but has a Feb. 28 deadline) This deadline applies to all plans regardless of the plan year.

Summary of Material Modifications

Deadline is Feb. 28
(if applicable)

Summary of Material Modifications (SMM) should be distributed to plan participants no later than 210 days after the end of the plan year in which the change is adopted; however, if benefits or services are materially reduced, the SMM must be provided within 60 days from adoption. An employer may also choose to distribute an updated Summary Plan Description (SPD) to employees, to reflect plan changes.

MARCH

Medicare Part-D Disclosures

Deadline is March 1
(Calendar year plans; adjust the dates accordingly for non-calendar year plans)

Group health plans providing prescription drug coverage to Medicare Part D-eligible individuals must disclose to the Centers for Medicare & Medicaid Services (CMS) whether the plan's prescription drug coverage is creditable. Generally, 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
- 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.

Form M-1 Filing with DOL
(If applicable)

Deadline is March 1

Employers participate in a multiple employer welfare arrangement (MEWA) must file a Form M-1 annually with the Department of Labor (unless they meet an exception as set out in the instructions). See the DOL explanation here to determine if the MEWA rules apply.

MARCH CONTINUED

Form 1095-C or Form 1095-B Annual Statement to Individuals
(This requirement has been changed to "upon request" – see comment above for that revision)

Deadline is March 2
(March 3 in 2025)

Applicable large employers (ALEs) subject to the ACA's employer-shared responsibility rules (i.e., the "pay or play" requirement) 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.

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. There was a permanent extension to the filing deadline to 30 days after Jan. 31 (which will typically fall on March 2, but is March 3 in 2025 as March 2 is on the weekend). That deadline had been extended on an ad hoc basis previously, and a reasonable, good faith standard would be applied to avoid penalties if the deadline was missed. The deadline was recently permanently extended, and the reasonable, good faith standard relating to the imposition of penalties was eliminated.

Applicable large employers (ALEs) subject to the ACA's employer-shared responsibility rules (i.e., the "pay or play" requirement) must furnish Form 1095-C (Section 6056 statements) annually to their full-time employees.

File ACA Forms 1094 Electronically with IRS

Deadline is March 31
(A single 30-day extension in automatically available for both groups provided a Form 8809 is filed by the original due date.)

Applicable Large Employers ("ALEs") are required to file forms 1094-C and 1095-C no later than March 31 each year. (Paper filing is available for only for employers with fewer than 10 yearly returns).

Non-ALEs (employers with fewer than 100 FTEs or the equivalent) that sponsor self-insured plans are required to file Forms 1094-B and 1095-B no later than March 31 each year.

JUNE

Drug Cost Reporting with the Centers for Medicaid and Medicare Services (CMS)

Deadline is June 1

All employer-sponsored group health plans, regardless of size, must submit a report outlining the plan's prescription drug costs to the CMS. Fully insured plans can rely on the filing by the insurance carriers. However, all self-funded plans, including level-funded plans and minimum premium plans must comply at the plan level. That also applies to minimum essential coverage (MEC) self-funded plans.

Most plans will rely on the plan's Pharmacy Benefit Manager (PBM) and Third-Party Administrator (TPA) to comply with the filing obligation. Nevertheless, the employer has the ultimate responsibility and should follow up with the plan vendors to ensure they comply with the obligation.

JULY

PCORI Fee

Deadline is July 31

The deadline for filing IRS Form 720 and paying Patient-Centered Outcomes Research Institute (PCORI) fees for the previous year is July 31. For fully 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 filing deadline is the same for calendar and non-calendar year plans. However, the fee is determined based on the last day of the plan's year.

Form 5500

Deadline is July 31

(Calendar year plans; adjust the dates accordingly for non-calendar year plans – seven months following the end of the plan year)

Automatic extension to October 15 (calendar year plans) if requested

Employee benefit plans must file Form 5500 by the last day of the seventh month following the end of the plan year. (Non-ERISA plans, such as church plans and non-electing government plans, do not have this requirement.) Form 5500 reports information on a plan's financial condition, investments (not a typical issue for welfare benefit plans), and operations.

Form 5558 is used to apply for an extension of two and one-half months (Oct. 16, 2023) to file Form 5500 (and is automatic if requested).

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. In fact, the instructions specifically provide that such plans should not file the 5500.

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

Medical Loss Ratio (MLR) Rebates

Deadline is September 30

The deadline for insurance issuers (this does not apply to self-funded plans) to pay medical loss ratio (MLR) rebates 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 quality improvement activities. Issuers that do not meet the applicable MLR percentage must pay rebates to consumers.

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.

Summary Annual Report (SAE)

Deadline is September 30

(Calendar year plans; adjust the dates accordingly for non-calendar year plans)

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 (including any extension).

Plans 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.

A sample SAR for welfare plans is available from the DOL.

This Compliance Calendar is not exhaustive, and your plan may have additional deadlines, particularly with respect to some state and local requirements, that might not have been addressed. In addition, this information does not constitute legal advice and you should contact your legal counsel for specific legal information.

OCTOBER

Medicare Part D – Creditable Coverage Notices

Deadline is October 14

Group health plans providing prescription drug coverage to Medicare Part D-eligible individuals must disclose whether the prescription drug coverage is creditable. Medicare Part D creditable coverage disclosure notices must be provided to plan participants (including non-employee beneficiaries) before Oct. 14 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. Because employers may not know whether any specific individual is enrolled in Medicare most employers will send a creditable coverage notice to all participants.

Many employers will include these notices with open enrollment materials if sent by Oct. 14. The Oct. 14 deadline also applies to non-calendar year plans. Model disclosure notices are available on CMS' website.

DECEMBER

Massachusetts Health Insurance Responsibility Disclosure *(HIRD)*

Deadline is December 15

Employers (even out-of-state employers) with six or more employees in Massachusetts in the last 12 months are required to submit a separate form that describes an employer's group medical plan to Massachusetts via the MassTaxConnect portal. Employers are permitted to use other vendors (such as payroll providers or TPAs) to submit the forms, but the obligation remains that of the employer.

CMS Prohibited Gag Clause Attestation

Imputed Income Reminder *(or resolve any nondiscrimination failures)*

Deadline is December 31

Group health plans are prohibited from offering coverage or entering into an agreement with a healthcare provider that restricts the plan from providing cost or quality of care information about providers. Plans submit the attestations via a form on the CMS website. If the insurer for a fully insured health plan provides the attestation, it satisfies the plan's obligation. Self-funded plans can enter into written agreements with their TPAs to provide the attestation, but the legal responsibility remains with the health plan.

Several items in employer plans can result in imputed income (not actual compensation but items that must be reported as taxable income on employees' W-2s, if applicable). Employers should remember to inform employees of these items and submit the information so that it can be reported on the annual W-2s sent in January. Common items include:

- Domestic partner (who is not a tax dependent) coverage in an employer group health plan.
- Group term life insurance over $50,000
- Nondiscrimination failures (most common in dependent care FSAs)

This Compliance Calendar is not exhaustive, and your plan may have additional deadlines, particularly with respect to some state and local requirements, that might not have been addressed. In addition, this information does not constitute legal advice and you should contact your legal counsel for specific legal information.

ANNUAL NOTICES NOT TIED TO A SPECIFIC DATE

Women's Health and Cancer Rights (WHCRA)	The Women's Health and Cancer Rights Act (WHCRA) requires group health plans that provide medical and surgical benefits for mastectomies and 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 annually 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 are generally well advised to include the annual notice with their open enrollment materials to make it a part of the general plan practice. 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 there. The annual CHIP notice can be provided at any time during the year. Employers with annual enrollment periods are generally well advised to provide the CHIP notice with their open enrollment materials to make it a part of the general plan practice. The DOL has a model notice that employers may use.
Summary of Benefits and Coverage (SBC)	Group health plans and health insurance issuers must 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 shopping for or enrolling in health plan coverage. Federal agencies have provided a template for the SBC, which health plans and issuers must use. The issuer for fully insured plans typically prepares the SBC, which is the form the employer should distribute (assuming the issuer does not). The SBC must be included in open enrollment materials. If renewal is automatic, the SBC must be provided no later than 30 days before 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 the group health insurance coverage 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.

ANNUAL NOTICES NOT TIED TO A SPECIFIC DATE

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 a 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 provides 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 privacy notices. Special rules apply, however, for fully insured plans. Under these rules, the health insurance issuer, not the health plan itself (provided the employer is "hands-off" on protected health information), is primarily responsible for the privacy notice. Self-insured health plans are required to send privacy notices 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. However, since a three-year cadence can be easily missed, employers with open enrollment periods are generally well advised to include this notice with their open enrollment materials to make it a part of the general plan practice. The Department of Health and Human Services (HHS) has model Privacy Notices for health plans to choose from.
HIPAA Special Enrollment Notice	At or before enrollment, a group health plan must provide all eligible employees with a notice of their 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 informing employees of 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. Employers with open enrollment periods are generally well advised to include this notice with their open enrollment materials to make it a part of the general plan practice. Sample language is available in the DOL's compliance assistance guide.

ANNUAL NOTICES NOT TIED TO A SPECIFIC DATE

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 health information and have enough time to decide whether to participate in the program. Employers implementing a wellness program for the upcoming plan year should include this notice in their open enrollment materials to make it a part of the general plan practice. This is not an annual requirement, so employers can decide whether to continue to include the notice in open enrollment materials. The Equal Employment Opportunity Commission has provided a sample notice for employers to use.
Michelle's Law *(if applicable)*	Under Michelle's Law (which is largely inapplicable after the ACA changes) if a dependent over age 26 is eligible for coverage under the employer health plan, they must be provided a notice that health plan provides dependent coverage beyond age 26 but bases eligibility for such dependent coverage on student status and set out the dependent child's rights under the plan in the event student status is lost.