WORLD

COMPLIANCE OVERVIEW

Annual Compliance Requirements 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. 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 Oct. 15 of each year, and
- 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. The calendar will note whether the specific date is based on the calendar year or the plan year.

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

- 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.

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Annual Compliance Requirements

COVID-19-Related Deadline Extensions

As a temporary measure in the spring of 2020, the DOL issued Disaster Relief Notice 2020-01 to extend the time to furnish benefit statements and other notices and disclosures required under ERISA, so that plan sponsors would have additional time to meet their obligations during the COVID-19 outbreak. Under this guidance, an employee benefit plan will not be in violation of ERISA for a failure to timely furnish a notice, disclosure or document that must be furnished between March 1, 2020, and 60 days after the announced end of the COVID-19 National Emergency, if they act in good faith. This means the plan must furnish the documents as soon as administratively practicable under the circumstances. The National Emergency was most recently extended on February 24 for an additional 90 days. (The emergency period will end after 90 days unless extended again). The general requirements are expected to revert to their pre-COVID-19 deadlines. In the event they do not, this caveat will continue to apply.

JANUARY		
DEADLINE	**REQUIREMENT**	**DESCRIPTION**
Jan. 31	**Form W-2**	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).
March 2	**Form 1095-C or Form 1095-B—Annual Statement to Individuals**	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. 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. There was a permanent extension to the filing deadline to 30 days after January 31 (which will typically fall on March 2). 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 with the permanent extension of the deadline.

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FEBRUARY		
DEADLINE	**REQUIREMENT**	**DESCRIPTION**
Feb. 28 (March 31, if filing electronically)	**Section 6055 and 6056 Reporting**	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, as well as information about 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 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. This deadline applies to non-calendar year plans regardless of the plan year.

MARCH		
DEADLINE	**REQUIREMENT**	**DESCRIPTION**
March 1 (calendar year plans; adjust the dates accordingly for non-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.

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JULY		
DEADLINE	**REQUIREMENT**	**DESCRIPTION**
August 1 (in 2022 as July 31 falls on a Sunday)	**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 filing deadline is the same for calendar and non-calendar year plans. However, the amount of the fee is determined based on the last day of the plan's year.
August 1(in 2022 as July 31 falls on a Sunday)(calendar year plans; adjust the dates accordingly for non-calendar year plans)	**Form 5500**	Employee benefit plans (note, non-ERISA plans, such as church plans and non-electing government plans) must file Form 5500 by the last day of the seventh month following the end of the plan year. 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. 17 in 2022) to file Form 5500 (and are 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 affirmatively informs such plans that they should not file. 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 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.

		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; adjust the dates accordingly for non-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 (including any 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. A sample SAR for welfare plans is available from the DOL. *Note: See COVID-19-related deadline extensions above*

OCTOBER

DEADLINE	REQUIREMENT	DESCRIPTION
Oct. 14	**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 plan participants (which includes any 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 as long as they are sent by Oct. 14. The Oct. 14 deadline applies to non-calendar year plans as well. Model disclosure notices are available on CMS' website.

ANNUAL NOTICES – Not tied to specific dates *Note: See COVID-19-related deadline extensions above*	
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 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 in that state. The annual CHIP notice can be provided at any time during the year. Employers with annual enrollment periods 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 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 typically prepares the SBC and that is the form the employer should distributed (assuming the issues 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 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

ANNUAL NOTICES – Not tied to specific dates

Note: See COVID-19-related deadline extensions above

TYPE OF NOTICE	DESCRIPTION
	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 (provided the employer is "hands-off" of protected health information), 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. 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 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. 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.
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

ANNUAL NOTICES – Not tied to specific dates

Note: See COVID-19-related deadline extensions above

TYPE OF NOTICE	DESCRIPTION
	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 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.