WORLD

EMPLOYEE BENEFITS

2024 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. Certain deadlines for non-calendar year plans may vary. The dates references are based on calendar year requirements unless otherwise specified to be based on the plan year.

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 other than.

JANUARY	FEBRUARY	MARCH
• **Form W-2** – ACA reporting of the aggregate cost of employer-sponsored group health plan coverage – Jan. 31	• **Section 6055 and 6056 Reporting** – Feb. 29 (April 1, if filing electronically)* • **Medicare Part-D Disclosures to CMS** – Feb. 29	• **Form 1095-C or 1095-B Annual Statements to individuals** – March 1* • **Form M-1 filing** with DOL – March 1* • **Forms 1094/95-C and/or 1094/95-B** to the IRS – March 31 (April 1 if filing electronically)*
APRIL	**MAY**	**JUNE**
• **Deadline for corrective distributions** from HSA to avoid penalties – April 15*		• **RxDC** **– Drug Cost Reporting with the Centers for Medicaid and Medicare Services (CMS) – June 1*
JULY	**AUGUST**	**SEPTEMBER**
• **PCORI Fee**** – Deadline for filing IRS Form 720 and paying Patient-Centered Outcomes Research Institute (PCORI) fees for the previous year – July 31* • **Form 5500** – July 31. Can be automatically extended by filing form 5558 – July 31	• **SBC, CHIP, WHCRA and other Open Enrollment notices** to employees – Aug. 31	• **Medical Loss Ratio ***** (MLR) rebates, if any – Sept. 30* • **MLR rebate** determination and allocation to be completed – within 90 days of receipt* • **Summary Annual Report** – Sept. 30
OCTOBER	**NOVEMBER**	**DECEMBER**
• **Medicare Part D** – Creditable Coverage Notices to all Medicare Part D eligible individuals – Oct. 14* • **Medicare Part D Disclosure** to CMS – Oct. 31*		• **Summary Annual Report** distribution, if 5500 was extended – Dec. 15 • **CMS Prohibited Gag Clause Attestation**** – Dec. 31* • Employer-paid **domestic partner coverage**, include imputed income (if any) – EOY

Generally, if a due date falls on a weekend or holiday, the due date is extended to the next business day, except that the Medicare Part D Disclosure Notice must be distributed by Oct. 14.
* These deadlines do not change based on the plan year.
** Fully Insured plans can usually rely on insurance carriers to meet the obligation but should get confirmation from carrier.
*** Does not apply to self-funded plan.

ANNUAL COMPLIANCE REQUIREMENTS

CALENDAR YEAR DEADLINES

The following 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.

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).

FEBRUARY

Section 6055 and 6056 Reporting

Deadline is February 28 *(April 1, if filing electronically.)*

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 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

Medicare Part-D Disclosures to CMS
Deadline is March 1

Group health plans providing 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. 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 1095-C or 1095-B Annual Statements to individuals
Deadline is March 1

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). 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.

Form M-1 Filing with DOL
(if applicable)
Deadline is March 1

Employers that are part of 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 DOL explanation here to determine if the MEWA rules apply.

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 prescription drug costs for the plan 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) plans that are self-funded.

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 are complying with the obligation.

JULY

PCORI Fee
Deadline is July 31

Deadline for filing IRS Form 720 and paying Patient-Centered Outcomes Research Institute (PCORI) fees for the previous year. **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
(Based on calendar year plans, adjust accordingly for non-calendar year plans.)

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 (i.e., Oct 16) 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.

COMPLIANCE OVERVIEW

SEPTEMBER

Medical Loss Ratio (MLR) rebates
Deadline is September 30

All employer sponsored group health plans, regardless of size, must submit a report outlining prescription drug costs for the plan 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) plans that are self-funded.

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 are complying with the obligation.

Summary Annual Report
Deadline is September 30
(Based on calendar year plans, adjust dates accordingly for non-calendar year plans.)

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 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.

OCTOBER

Medicare Part D – Creditable Coverage Notices
Deadline is October 15

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 (which includes any non-employee beneficiaries) before October 15th 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 they are sent by Oct. 15. The Oct. 15 deadline also applies to non-calendar year plans. Model disclosure notices are available on CMS' website.

DECEMBER

CMS Prohibited Gag Clause Attestation
Deadline is December 31

Starting in 2023, Plans and issuers must annually submit an attestation of compliance with the prohibition of gag clauses under the CAA's transparency provisions. The CAA prohibits plans and issuers from entering into contracts with health care providers, TPAs or other service providers that would restrict the plan or issuer from providing, accessing or sharing certain information about provider price and quality of deidentified claims.

If the issuer for a fully insured health plan provides the attestation, the plan does not also need to provide an attestation. Also, employers with self-insured health plans can enter into written agreements with their TPAs to provide the attestation, but the legal responsibility remains with the health plan.

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 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 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.
CHIPRA 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.

ANNUAL NOTICES NOT TIED TO A SPECIFIC DATE

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.*

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, and 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 prior to the time of 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.

ANNUAL NOTICES NOT TIED TO A SPECIFIC DATE

Wellness Notice of Availability of Reasonable Alternative Standard

If the ***employer offers a health-contingent wellness reward*** subject to HIPAA, it must disclose the existence of a reasonable alternative standard to qualify for the incentives. That disclosure must be included in all plan materials describing the wellness program, it must include the contact information for obtaining the alternative standard and a statement that recommendations of a personal physician will be accommodated.

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 Program EEOC Notice

If the employer offers a ***wellness program that includes medical related inquiries about the employee and/or family members, or requires medical examinations*** (i.e. health risk assessment, biometric screening or wellness exam requirement), it must distribute a wellness program notice that notifies the participant about how their medical information will be protected under the Americans with Disabilities Act (ADA) and/or the Genetic Information Nondiscrimination Act (GINA).

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 EEOC has prepared a sample notice that satisfies both wellness program notice requirements.

Transparency in Coverage (TIC) Public Disclosure of Pricing Data

Offer an internet-based, consumer pricing transparency tool that provides personalized, out-of-pocket cost estimates and other price related data for 500 pre-determined items and services under the Transparency in Coverage rule. Disclosure of required information should also be made available on paper, upon request.

No Surprise Act (NSA) Model Notice

Medical/Rx plans with public websites must post a Notice describing surprise billing protections under the No Surprises Act, and pursuant to state law, as applicable. Most plans do not have public websites and can satisfy the notice obligation if the insurer/TPA posts the notice on its own website on the plan's behalf. However, the plan remains liable for any failure by the insurer/TPA to comply.

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

Michelle's Law

If a group health plan requires certification of student status for coverage under the plan, Michelle's Law notice should be included in plan materials. Note: Due to ACA, this law has little impact since most plans extend dependent eligibility to age 26 regardless of student status.

Exchange Notice

The ACA requires employers to provide ***all new hires*** with a written notice about health insurance Exchanges, that Employers must provide all new hires with an Exchange notice that:

- Includes information regarding the existence of the Exchange, as well as contact information and a description of the services provided by the Exchange;
- Explains how an employee may be eligible for a premium tax credit if the employee purchases a qualified health plan through the Exchange; and
- Contains a statement informing the employee that, if the employee purchases a qualified health plan through an Exchange, the employee may lose the employer contribution (if any) to any health benefits plan offered by the employer and that all or a portion of this employer contribution may be excludable for federal income tax purposes.

The DOL has provided model Exchange notices for employers to use, which will require some customization.